Organizational Approach to Developing a Stress Program

National Institute of Justice
Grant 98-FS-VX-0006

Sponsored by the
Longview Police Guild
Longview, Washington
May 2000

Stress...

Special acknowledgement goes to these members of the LPG Taskforce that honored their commitment to this project to make it successful...

Det. Jeff Davis,	President of the Longview Police Guild
Chief Bob Burgreen	Longview Police Department
Ken Terhaar	Kaiser Permanente
Garnie DeForest	Regence Blue Shield
Linda Swanson	City of Longview Human Resources
Officer Mike Cowan	Kelso Police Department
Lori Hendrickson	Cowlitz County Emergency Management, wife of Officer Erik Hendrickson
Shelly Reeves	Cowlitz County dispatch and wife of Officer John Reeves of Longview Police Department
Sgt. Vic Tiehen	Longview Police Department
Det. Ty Mauck	Longview Police Department and member of the Longview Police Guild

Special thanks to Kaiser Permanente and Longview Police Department for use of their facilities for meetings and to Connie Budge and Kathy McCurdy for their technical assistance.

This project was facilitated and coordinated by Facilitation Resources, Jeanne Harris, of Vancouver, Washington

Submitted to the National Institute of Justice May 31, 2000

187779

Executive Summary

Organizational Approach to Developing a Stress Program
NIJ grant 98-FS-VX-0006

This National Institute of Justice grant was awarded December 1998 to the City of Longview Police Guild because it offered a unique opportunity for stakeholders in the community that have not traditionally sat down to discuss and address stress issue for police officers to work together. With representatives from labor, city and police department administration, the insurance and medical providers, family members, neighboring police jurisdictions and ancillary services including dispatch and the prosecutor's office the taskforce team was designed to be diverse and creative.

The taskforce followed a linear approach to project development with a series of educational meetings bringing the community in to talk about it's resources as well as utilizing local, regional and national information via the internet, books and periodical articles. They met 18 times and utilized brainstorming and prioritizing to develop program criteria and subsequent program design.

Dr. Ellen Kirschman, author of I Love a Cop was brought in from California to provide a one day workshop on police risk and protective factors for stress for the taskforce at the beginning of the process. Magellan was hired via a request for proposal (RFP) and provided stress training to approximately one half of the officers and families towards the end of the process. A survey of 12 officers (25% of the force) and 9 spouses attending the training was taken beforehand to determine current knowledge of stress risk and protective factors and a post survey of the training session attendees was done to measure any change in knowledge. The intent of the survey was to also find out the types of services the officers and families felt they would benefit from or be most likely to use regarding stress issues.

Ranking high in the survey was confidential counseling that was local. The results were split between officer and spouse on whether counseling would be used if it were not covered by insurance. In other words, 55% of the spousal response considered having the service available more important than having the service covered by insurance, however 91% of the officer response said they would want the service covered by insurance. Other statistics include:

- 58% of the officers and 77% of spouses said they would use it if there were co-pay.

- Peer support teams were supported by 100% of the officers responding and 77% of the spouses.
- Officers interested in stress training, presentations on stress, counseling by someone knowledgeable in law enforcement were 83% and higher and spouses were 77% and higher.
- Current use of stress prevention or treatment among officers was 92% for officers and 100% for spouses had not used services.
- The highest symptom of stress reported by both the officers and spouses was fatigue. The highest reported reason for reluctance to see a mental health professional was confidentiality for officers and cost for spouses.

Program recommendations prioritize an Employee Assistance Program, as it's highest priority. Following that, a new hire orientation for officer and spouse and annually for veteran officers and family that includes training and awareness around the eight change areas determined by the taskforce as financial, health, lifestyle, family, community, career development / job organizational structure, critical incident and spirituality. Also among the recommendations are the use of technical reserves for peer support, mentoring and advocacy, programs to incentive good health practices as well as on-going training in stress prevention, sensitivity and diversity. In addition recommendations include providing support systems for officer and family, making changes to the organizational structure to help in career development and addressing negative cultural norms.

Members of the taskforce, the community and the families have taken a conceptual approach to the implementation plan with emphasis on holistic and grassroots with specific suggestions for marketing and rollout.

The model benefits program is concise and to the point having been gleaned from the research and the educational segments the taskforce undertook.

Training curriculum used the one-day training session for officers and spouses was developed and provided by Magellan.

Overall the taskforce found it's work to be challenging and interesting working through the normal stages of group development to get to a level of function that supported production of a targeted and effectual stress prevention program for Longview police officers and their families.

Process Report

Longview Police Guild Stress Prevention Grant
Sponsor; Longview Police Guild

Background

Longview Police Guild Stress Prevention Grant was Awarded December 1998 with a Completion date December 1999. An extension was granted to May 2000. The award was $49,292.

In 1997 a cultural assessment of the Longview police department was done. At that time the department had 57 commissioned officers of which one-third of its patrol officers have been on the job less than one year. The City of Longview was facing a significant budget shortfall that year which was responsible for reducing funds for purchases of officer training and equipment. Rating indicators were low in a LPD cultural assessment.

Based on the cultural assessment which was administered at roll call and was a self reporting survey the following indicators scored at four or below:

- Ninety-two percent indicated there was more suspicion than trust in the department;
- 92% said they did not understand organizational or team objectives;
- 84% felt information sharing was not open and authentic;
- 84% reported that authority was used inappropriately;
- 87% said there was no genuine concern for each other;
- 97% indicated that conflicts were not identified, accepted and worked through;
- 97% believed the management team was not fully used;
- 97% said team members were not risk takers;
- 92% indicated the organizational environment was not open, supportive and respecting of individual differences;
- 100% said they didn't understand the organizational direction;
- 100% said decision making was limited to a few;
- 100% felt that creativity was not encouraged;
- and 100% said attitudes toward change were negative and discouraged.

Based on stress prevention and treatment literature it was determined that all of these indicators were significant producers of stress.

A Grant was written in 1997 with the Guild's goal for this project to develop a comprehensive stress prevention and treatment program for law enforcement personnel and their families. A taskforce would be assembled and after receiving training in stress prevention and treatment, the task force would assess the organizational culture of the LPD and develop ways to minimize organizational sources of stress as well as assess the needs of the LPD officers and their families regarding stress issues. The taskforce would also review current policies and practices of the task force member groups (Guild, police department, insurance carrier, service provider and city government) for their impact on developing and operating an effective stress program and evaluate the current stress prevention and treatment program services available. Based on the information collected above, the taskforce would design a stress prevention and treatment program that can be replicated by other law enforcement agencies.

The taskforce

In May 1999 the taskforce was assembled and included:

Det. Jeff Davis, President of the Longview Police Guild
Chief Bob Burgreen of the Longview Police Department
Ken Terhaar of Kaiser Permanente
Garnie DeForest of Regence Blue Shield
Linda Swanson of the City of Longview Human Resources
Officer Mike Cowan of the Kelso Police Department
Lori Hendrickson of the Cowlitz County Emergency Management, wife of Officer Erik Hendrickson
Shelly Reeves of the Cowlitz County dispatch and wife of Officer John Reeves of Longview Police Department
Sgt. Vic Tiehen of Longview Police Department
Ms. Sue Baur of the Prosecutor's office
Det. Ty Mauck of the Longview Police Department and member of the Longview Police Guild
Chaplain Lyle Prather

This taskforce was unique in that it assembled representatives from healthcare, city administration, the police guild, family members, ancillary departments, the religious community and neighboring police jurisdictions that had not typically come to the table to discuss police stress before this grant.

The process

In December a facilitator/program coordinator, Kathy McCurdy, was hired but was not able to continue with the project when a serious illness was discovered in April. Another facilitator, Jeanne Harris, was hired in late April and began work on the project in May 1999.

May 1999

The taskforce held a total of 18 meetings with it's first meeting in May 1999 to establish itself, review the grant, decide how the group was going to function, look at the timeline and decide on meeting dates. A workshop for training the taskforce was scheduled for June 5th with Dr. Ellen Kirschman, noted psychologist in the field of police stress and author of the book, I Love A Cop.

June 1999

Dr. Kirschman was flown in from California and the workshop was held at the Cowlitz PUD auditorium on Saturday, June 5, 1999 from 8:00 am - 2:00 pm. Lunch was provided and the workshop was videotaped for those that could not attend. Dr. Kirschman covered what stressors are for police officers and discussed risk and protective factors using examples from her book, professional career and videotape of officers and their families. She related that information to what officers and families in Longview might look at for needs and assessment.[1]

The task force met on June 17, 1999 to complete the work on ground rules, expected outcomes of the grant, timelines[2] and meeting dates and how they might learn from resources in the community about risk and protective factors for police officers and their families around stress. Each member of the taskforce took responsibility for an educational segment at a meeting of the taskforce.

Education

Meeting Date	Topic	
July 17	San Diego's Programs	Chief
July 22	Critical Incident	Jeff
Aug 12	The effects of physical wellness/health on stress	Ty
Aug 26	Employee Assistance Programs	Linda
Sept 9	What role does spiritual support play in stress?	Chaplain

[1] Notes from Dr. Kirschman's workshop; Appendix A
[2] Product Timeline and objectives and products list; Appendix A

Sept 23	Healthcare; Kaiser & Regence Blue Shield	Ken/Garnie
Oct 14	Financial planning for officers and families	Shelly
Oct 28	Career Development	Mike

July 1999

The taskforce meeting on July 22, 1999 centered around developing a mission statement for the taskforce and an action plan to deliver on the mission statement. There was also discussion on the tools for the evaluation survey that would need to be taken to find out what the police officers and their families knew about stress so a training session could be developed and delivered later in the year. The education presentation was Chief Burgreen relating his experiences around police stress in San Diego, California when he was a member of the department and later Chief of Police.

August 1999

In August the taskforce met and approved its mission statement and action plan.

LPD Stress Prevention Taskforce Mission Statement

The mission of the LPG Stress Prevention Taskforce is

- to review the current policies and programs available for stress prevention and treatment for the LPD officers and their families.
- to assess the current knowledge and use of stress prevention treatment among LPD officers and their families.
- to develop and deliver a plan to enhance the use of present services as well as make recommendation for any additional employee benefits, training or support services that would reduce work related stress for LPD officers and their families.

Action plan to deliver on the mission statement

This will be done by assessing the needs of the officers and their families in their knowledge and use of current stress prevention programs and treatment by distribution of a survey.

A plan for a stress prevention program which includes policies, treatment plans, support services, and training curriculum will be

developed that meets the specific needs of the LPD and their families by engaging taskforce members into work teams to utilize information gained from:

- the results of the survey
- research on other programs available to police and public safety officers throughout the country
- information from guest speakers on selected topics

And finally, deliver a plan by way of a model, which includes current and recommended benefits, training and support services, which can be implemented to address these needs.

The taskforce looked at the draft survey that had been developed from materials suggested and offered by members of the taskforce. A subcommittee volunteered to work on the development, delivery and assessment of the survey and agreed to decide on a time to meet. Because of varying work schedules and commitments the sub committee was not able to meet. Because of scheduling conflicts Chaplain Lyle Prather agreed to present his educational segment on the role of spirituality and stress instead of critical incident. The taskforce learned of the services that were available to the officer's county wide as well as the need to support those services and offered the Chaplain opportunities to meet with the guild to explain what he does.

Work teams were assigned for more focused work on reviewing current policies, assessing current knowledge and researching other programs, benefits, support services and training. A notebook of research articles was presented to each taskforce member and everyone was asked to pick two articles to read and report back to the group on so everyone would benefit from all the information without having to read it all.

The taskforce met again on August 26, 1999 and learned that the evaluator, Kathy Oxborrow would take responsibility for the further development of the assessment survey. A review of the product timeline was presented and it was identified that items 6 – 9 would need work teams to explore and report back on the following four areas:

1. Assess the organizational culture of the LPD
2. Develop criteria for what the ideal program would look like
3. Review existing services
4. Review policies and procedures of the LPD

Linda Swanson of the City of Longview human resources did a presentation on Employee Assistance Programs. Linda brought Ronald Lehto, MS, NCC from Riverview Psychiatric and Counseling Service to discuss the services they provide.

A financial planner, Mel Love, presented information on the importance of financial planning for officers and offered his services for the development of curriculum for formalized classes for officers and their families. It was also suggested to consider an officer advocate program to provide peer counseling when officers were experiencing stress from financial concerns.

Members of the taskforce signed up for articles they would read and report back on.

September 1999

The September 9th meeting began with a grant review regarding officer training. A product of the grant was to provide a training session to officers and their families about stress. A pre assessment survey[3] needed to go out to determine what they knew about stress risk and protective factors, go to the training and then be post assessed to see if the training provided any new information or awareness. An RFP was developed and sent out to a short list of specific trainers and social workers to hire the trainer for this session.

Dr. Dan Clark, psychologist for the Washington State Patrol gave an excellent presentation on Critical Incident Stress Management. Dr. Clark trains for the National and International CISM Network.[4]

The taskforce had been working for nearly six months now and attendance had been dropping. Sgt. Vic Tiehen had been assigned to several other projects that kept him from attending and announced formally withdrawing from the taskforce. Chief Burgreen had experienced several conflicts prohibiting attendance and several others so it was agreed to personally contact those that were missing and encourage their attendance.

The taskforce discussed and agreed to send the facilitator, Jeanne Harris, to the Washington State CISM conference in November and Jeanne also

[3] Pre Assessment Survey; Appendix A
[4] CISM presentation notes Dr. Dan Clark; Appendix B

reported her attendance at a police stress prevention seminar in Edmonds, Washington.

The grant officially received an extension until the end of May 2000 because of the delayed start date.

Shelly Reeves did an article report. The educational segment was on healthcare. Kaiser Permanente's Ken Terhaar sponsored Jane Spence, RN, M.Ed. Administrator, mental Health and Recovery Resources and Regence Blue Shield's Garnie DeForest sponsored Laura Bryan, MSW, LCSW; Director of EAP Services Cape Employee Assistance Program from Magellan Health Services. Both presented services available for stress prevention and treatment related to police officers and families.[5]

Attendance improved at the October 14th meeting. The RFP for a trainer had received only one response so it was decided to go back out and try a different list of respondents. A broader net would be cast using organizations as well as individuals.

The education segment was presented by Janice Stixrud and John Crawford of Kaiser Permanente on the effects of wellness on stress including programs for changing eating patterns and physical fitness habits that are detrimental to good health and related it specifically to police work.[6]

Lori Hendrickson reported on her article "Male Law Enforcement Officer's and their Spouses Perceptions to Post-Shooting Reactions".[7]

October 1999

The October 28th meeting saw a drop in attendance. Dates were discussed for work that needed to be done since this was the last educational segment and now it was time to start formulating a program based on what they had learned.

Mike Cowan reported on career development emphasizing the need for strong communication classes and evaluation and re-evaluation of career goals. Mike also emphasized that officers be given the opportunity to take a proactive role in their career development including getting

[5] Magellan EAP materials; Appendix B
[6] Personal Wellness Profile; Appendix B
[7] Male Law Enforcement Officers' and Their Spouses Perceptions to Post-shooting Reactions report by Lori Hendrickson; Appendix B

education and being involved in the community as well as having an assessment center to help officers in making choices for an exciting and rewarding career in law enforcement.

It was decided to start brainstorming the program and see what was left to be done at the next meeting.

November 1999

Attendance at the November 18, 1999 meeting was very small. All police officers and guild representatives were being stressed to maximum levels because of workload and could not attend. One member, Shelly Reeves, was giving birth to twins.

Two members reported on articles they had read and information they had found on the Internet regarding family support systems they thought were pertinent.

Several qualified candidates were responding to the request for proposal[8] for a trainer and that a sub committee would meet to award the RFP. The facilitator, Jeanne Harris, reported on her attendance to the state CISM conference[9] and recommended CISM peer teams be developed for Cowlitz County.

The taskforce then discussed their feelings about attendance and how they felt they needed to have the police representatives present to create a meaningful program for them. The group decided to move forward and brainstormed on everything they had learned over the last several months. It was decided that much of what they had heard was centered around change and mapped all the areas in a police officers life including job, health, career, finances, organizational change, critical incidents, social and family, lifestyle, community, spiritual and personal and professional changes. They asked the question what was available and how does their culture support them or not support them around changes in these areas. How are officers and families asked to cope, to find solutions, find support and when they do what is available for recovery and re-entry and adjustment. And most importantly, how do we prevent

[8] Request for Proposal for training on stress risk factors and protective factors for municipal police officers and their families October 1999; Appendix C

[9] CISM Conference in Chelan, Washington Nov 4 – 7, 1999 Report by Jeanne Harris; Appendix B

impacts from stress? How can we be proactive? What does the officer and their families need?

It was a break through meeting and those in attendance left excited and feeling a sense of accomplishment. The months of learning were starting to create results.

January 2000

Dates were adjusted and the next meeting was held January 6, 2000. Attendance was up. Product timelines were reviewed and the objectives were reviewed. The RFP for training was awarded to Magellan and the training would take place on February 26, 2000. There would be a sign up sheet for 20 officers and their significant others. It was decided to limit the number of officers for the training due to the recommendations of Magellan to keep the numbers smaller for better attendance and results. Another session would be offered for others later in the year. The taskforce then brainstormed the areas that had been identified in the previous meeting and identified five questions to address for each area of change.

The questions were: define the intent of the area identified, what were the existing resources/programs, what were the existing barriers, what support was currently in place or should be in place and what should program elements be.

The taskforce brainstormed financial, health, lifestyle and family.

At the January 19, 2000 meeting sub groups reported their findings on organizational culture, criteria for the ideal program, existing services and review of policies and procedures.

Much of this information became apparent in the brainstorming of the change areas, especially on criteria for the ideal program. Information was incorporated from the research the taskforce had done from programs in other parts of the country. The organizational culture had been examined in determining the need for the stress prevention grant in 1997 and was used as the basis for the assumptions regarding current attitudes and cultural norms effecting behaviors contributing to stress presently in the department. Existing services were identified in the program development phase and it was discovered there are no formal policies and procedures for stress related events or issues to address stress protective and risk factors.

Enhanced program development took place in the change areas of financial, health, lifestyle, and family.

February 2000

The February 17th meeting included an overview of the cluster conference report in Washington DC and continued work on program development in the change areas of community, career development/job organizational structure. The results of the pre assessment survey were presented.[10]

March 2000

The taskforce met again on March 2, 2000. Discussion around the insurance carriers report question of "Does anything need to be changed in order to implement a stress prevention and treatment program? Both Regence Blue Shield and Kaiser reported the prevention piece is only available through EAP's. Regence has an EAP available through a contract. Kaiser does not. Both provide treatment through the health benefits plans and adjustment reactions are covered, which appear after stress-related symptoms but not pre-stress treatment. Both will not pay for stress prevention such as intervention for family, exercise programs, etc.

The taskforce debriefed the stress training for officers and significant others on February 26, 2000[11] and the following points were made:

- Spouses – weren't notified separately ahead of time
- Clarify purpose – is it for officers and their spouse, S/O or can spouse go w/o officer
- Stick to our date – we changed dates for Magellan for one of their trainers and then he didn't show for this training
- Lead time – good lead time, no less than 6 weeks
- Needs to be more interactive in the training – small groups
- Saw people reacting – seemed to be opening their eyes to new information
- Different levels of training for different groups or officers length of service Ex: orientation vs. two year officer

[10] Pre Assessment Survey Officers and Spouses results; Appendix A
[11] LPD Stress Training and Critical Incident Stress Management, February 2000; Appendix C

- Need training specific to high stress events for people who have been there or want to know
- Critical incident – shooting, dead baby calls

Program development continued for the change areas of critical incident and spirituality.

April 2000

The last meeting of the taskforce took place on April 6, 2000. Used as an opportunity to wrap up last minute issues the taskforce discussed some implementation ideas and recommendations for the benefits model.

Observations

The use of the taskforce model is certainly not a new one. What was unique about this process was the make up of the taskforce team...a combination of private and public sector with stakeholders from groups that do not traditionally sit down together. In this case the police guild, police administration, family members and insurance carriers. At times there were tensions among the group as they not only struggled to develop through the stages of group development but to also understand the complexities of each other's areas of concern. The irony of this exercise was that often times it played out the academic questions the group was exploring around stressors for police officers. One member was the wife of an officer and had discovered she was pregnant at the beginning of the project. She and her husband experienced stressors from the pregnancy, work and family. The officers on the taskforce experienced extreme stressors with high caseloads and unusual crime events during this project. Which in turn created friction in the group when the police officers weren't able to attend meetings. Every team member's commitment to the process was unquestionable. But evidence of stress appeared often which only confirmed the need for change in the way stress for police officers and family was acknowledged and dealt with.

Existing Services Review and Stress Program Design Report

Change areas that can contribute to stress...

- *Financial*
- *Health*
- *Lifestyle*
- *Family*
- *Community*
- *Career development/ job organizational structure*
- *Critical incident*
- *Spirituality*

Eight aspects of life were identified as influential change areas in the lives of Longview police officers. Influential enough to have impacts effecting stress in the officer's lives. If addressed it is assumed the incidence or at least the impact of stress can be mitigated. Consequently program recommendations deal with these eight effectual areas. In each of the following areas of change a definition was given to the change area and existing services were identified. Barriers and support systems were determined which resulted in recommendations for program elements relative to this change area.

Financial

Officers often experience increased income and increased debt because they do not have the benefit of financial education or planning. Because of the dangerous nature of police work officers often worry about finances but don't always have the resources or feel comfortable seeking financial advice. An officer doesn't want to worry about the paycheck being there. They need to know "If I got hurt, I can still feed my family"

Existing
Currently the City of Longview offers its police officers a deferred compensation plan, city retirement and payroll deduction as well as public employees CU and supplemental term life.

Barriers
A barrier to offering programs for financial education could be the city budget with limited resources for financial advice.

Support
Systems that could help the officer would be volunteer financial educators, perhaps from the LPD guild (specialized member or reserve) or a reserve program (technical reserves).

Program Recommendations
On staff financial planner and/or confidential financial advisors using technical reserves-making presentations on all finances and making sure

the officers know what they have for benefits via statements - as identified compensation. Providing education: benefits regarding divorce, LODD, new family, extended family. Providing an orientation program when hired for the officer and spouse/SO.

Health

Health issues are a major area of stress for officers. Routinely there is increased exposure to sick/injured people and long hours/shift work as well as exposure to environment, poor eating habits and the impacts of heavy and cumbersome work related equipment that effect an officer's health.

Existing

Currently the LPD offers equipment - weight room, FMLA, administers a non-smoker hiring policy and offers family medical leave and paid sick leave and long term disability, workers comp Leoff II and six months disability Leoff I. The job description for an LPD officer calls for fitness for duty

Barriers

Shift work/staffing levels creating barriers to staying healthy. The long work hours contribute to fatigue as well as the heavy equipment / belt / gear / gun.

Support

The LPD currently provides availability of food storage/preparation equipment such as a microwave and refrigerator at the station, a fitness room, health education and a generous paid time off policy.

Program recommendations

Recommendations to enhance what is already available and encourage continued emphasis on maintaining a healthier lifestyle are to offer reduced or group rates at fitness centers such as the YMCA. To also institute fitness incentives such as requiring a mandatory cooper test for all officers with a success bonus as offered by the Redmond PD. On staff fitness representative/trainers and financial incentive for sick leave (no abuse of) paid time off should also be considered. Officers could also benefit from being offered nutrition and health awareness programs and converting to personal time off rather than sick leave, vacation - change how time off is offered. The way sick and vacation time is paid and allowed to accrue actually incentives officers not to take time off. It becomes more lucrative to wait and cash out sick and vacation rather than take it as leave. The city could provide targeted communication

regarding current discounts available from local vendors and provide motivators for being healthy - safety on the job campaigns. Because officers are often reluctant to take longer vacations that are more beneficial to stress reduction, especially when an officer is exposed to long periods of high stress it is recommended to require mandatory vacation in longer time frames.

Lifestyle

Recognizing that police officers are constantly exposed in high profile positions in the community and are subject to high public expectations and scrutiny the lifestyle of an officer can often contribute to high stress.

Existing

There is a double jeopardy (judicial and workplace results) issue. When something goes wrong in one's personal life it impacts the ability to work as well. It should also be noted the feelings of separation and segregation officers often feel. Especially the higher one goes in their career, the less social contacts, and even more so in the case of higher administration such as deputy chief or chief. There is also the existence of lack of respect or negligence for an officer's work. Disregard for the fact that they are a professional and often personal time is interrupted by friends, family and citizen's wanting help for personal situations such as "that ticket I got" which results in the difficulty in keeping job and home life separate. These differences often manifest between spouse and officer who want to live a "normal" life with family and friends but feel they can't because of the officers' call to duty.

Barriers

Barriers to improving the situation are job expectations including the self imagined and publicly imposed "John Wayne" syndrome and the frustration in dealing with the publics worst side. Officers often deal with dual personality issues such as being tough on shift and off shift being loving and dutiful spouse. How do they relax?

Support

Officers can engage in family/community involvement such as 4H, soccer, scouting, and church, which help to ground officers in "normal" life experiences and provides positive feedback.

Program recommendations

Provide education and opportunities for coping mechanisms such as peer groups/ support/ advocacy and mentoring. Also career development

work such as communication classes. Provide opportunities for honest discussions on how to defuse/relax, develop personal and professional communication skills and help encourage creating "another" life away from police life. Discouraged a dual career. Because of the rotating 12 hour shifts officers end up with several days off during the week that is being used to run a dual career. Officers need help in realizing off shift time is time to relax, be with family, engage in hobbies or other non stress activities.

Family

The officer's relationship with spouse, significant other, parents, children, and extended family are critical for providing reduction to stress but often produce just the opposite. Police officers suffer one of the highest rates of divorce of all industries.

Existing

Officers must deal with shift work, which are now 12 hours, as well as working holidays and overtime which often create friction in the home. The higher standards expected of the officer also impact the family, which also creates wariness of the public. Because of what the officer does the family is vicariously effected. Often family communication is difficult.

Barriers

Because of the two different worlds of work and family life often co-worker pressure to socialize can create barriers for families. Fatigue from long hours, media attention and the lack of privacy – the public expects the officer to be 24/7 and so does the officer. The officer's own family members in trouble with the law or with a criminal history can cause friction or tension. Jealousy often occurs because the spouse is worried about the officer being with other possible mates or jealous of large amounts of time spent at work or with co-workers off duty.

Support

There is some peer support and informal mentoring available now but not in a formal manner.

Program recommendations

Provide a spouse academy to help spouses learn about the job and the tools involved. Officer/family support such as the Portland Police Bureau Roses which formed after the LODD of Officer Thomas

Jeffries[12]or counseling and officer's spouse peer groups as well as encouraging family ride-alongs so they can better understand the work the officer does. Provide on-going workshops and training sessions for officers and family in risk and protective factors around stress for the police family such as the training provided by Magellan to the LPD officers and families on February 26, 2000.[13]

Community

The way the community looks at the officer and family and how they do or don't fit into their community.

Existing

The community often takes officers for granted; especially it seems on holidays. Officers often suffer from a condition called hyper vigilance, which is precipitated by constant surveillance by the officer. Officers are trained to scan for something out of the ordinary, possibly illegal and often times dangerous and life threatening. After a while the officer can become overly sensitive to perceptions that the community is constantly watching them as they are watching it. The officer is often called upon to play different roles in their community which can become confusing or difficult to maintain such as undercover work on duty and then trying to lead a normal life off duty. Officers serve on community boards, commissions or school volunteer and deal with being considered a "normal" person.

Barriers

The officer is expected to be role models and live more than perfect lives as well as being expected to be an officer 24 hours, 7 days a week.

Support

The City funds – 2 school officers – 1 DARE, and CSO's and helps with funding for a canine (dog) officer. The City of Longview is engaged in problem oriented policing (POP) and neighborhood mediation programs and block watch. So the community is actively taking part in public safety as well as the officer and the officer is able to play a more normal role in the community.

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[12] Oregon Live: 05-11-98, Group offers insight into unique world of police work; www.oregonlive.com/todaysnews/9805/st051105.htm, Appendix B

[13] see training curriculum; appendix C

Program recommendations
Encourage police officer sponsored charity events such as the popular car show and to be a part of service organizations such as Rotary and Kiwanas. Consider reinstating the Bugs bunny club and look at such public relations programs as baseball cards/stickers to kids. Encourage the community to show support for officers such as the buddy bear donations – do at the mall or the fair. Encourage and honor diversity. Rethink the policy that supports enabling the community to expect officers for all incidents.

Community Development and/or job organizational structure

What is available to the officer for career path development and does the structure of law enforcement inhibit career growth or add to stress?

Existing
Currently there is concern around compensation for expanded duties such as OIC (officer in charge) and the fact that the department is top heavy providing less opportunity for advancement as well as an officer's own personal questions around how do I get out? Am I trapped behind the badge?

Barriers
Currently the department is on 12 hour rotating shifts, which can lead to burnout. The department is currently top heavy with young Sergeants which is perceived as no where to go. There is the concern that the department is minimally staffed, in fact understaffed for the number of units developed in the structure and there is not enough money for the over time for training which can help in career development or can bridge the gap when moving to another industry.

Support
The 12 hour shift which is considered a barrier is also considered a support because it can offer time to go to school and there is tuition reimbursement, training for EVOC, firearms and specialty units get training in such areas as domestic violence, hostage negotiations.

Program recommendations
Redesign the job duties of Sgt./Capt. and restructure the organization to be less top heavy. Offer training –industry specific – and conferences as well as home schooling, use of the computer for long distance learning and encourage advanced degrees.

Critical Incident

A critical incident is an event that is outside the norm and produces an unusual physiological and emotional response. Response could be triggered by an accumulation of critical incidents.

Existing

There is little to nothing available in the Longview Police Department. Debrief is not used and is not offered – the employee needs to ask for it. There is no team or peer support and no support for family, which has resulted in unresolved traumas that manifest psychologically and physiologically.

Barriers

The need is not recognized and there is a lack of knowledge around what critical incident's are. There are assumptions it is just when there is a shooting. There is a lack of training for debriefing creating an environment where the officers are psychologically and physiologically faced with it on a constant basis.

Support

Currently there are informal networks of support in the chaplain, coworkers, family, friends, church and mental health providers though not specifically trained for police issues.

Program recommendations

The development of peer support teams and a TIC – traumatic incident committee (team) as well as spouse support teams. Support the increased use of shift debriefing using a trained peer de-briefer who is available on every shift. Provide an orientation to prepare for autopsies and ongoing training sessions / workshops around different aspects of critical incident. Institute an EAP that offers mental health coverage that is law enforcement specific.

Spirituality

The way we act, we think, we work… our overall belief system, values, morals from within – and how they are being challenged / compromised. For example an officer comes in contact with domestic violence between two gay men and he doesn't believe in homosexuality yet he is required and expected to handle the situation fairly, without bias and by the law. All the while in direct conflict with his own moral beliefs.

Existing
The officer is expected to interpret and to uphold the law yet is often subjected to internal pressures such as the blue code (turn the other way) in the case of another officer or situations that conflict with his moral beliefs. There are issues around prejudice – growing diversity issues in the department which confronts the officer such as being aware of an unethical action by a coworker and wondering how to deal with it. In order to fit in the culture of the department encourages officers to adopt an "us against them" attitude towards the bad guy which can be stressful for officers not willing to succumb to the environments norms.

Barriers
There are currently attitudes in the department that don't support others belief systems and there is the expectation that an officer will uphold the laws, even when they are in conflict with an officer's personal value systems and not be effected by it. There is a lack of confidentiality in the department. Current policies and procedures support that lack of confidentiality because they require reporting up the chain of command. The civil law Garrity is sited which can force an officer to talk thereby destroying any opportunity to break the cycle of supportive silence.

Support
Officers have access to organized religion and the chaplain for guidance.

Program recommendations
Institute a confidentiality policy for the reporting officers. Provide sensitivity training in dealing with stereotypes and diversity training in orientation as well as on going.

Program criteria

The number one concern was that the program be confidential. If the officer or family were to use mental health services that they must be confidential and that reports would not be released to any other jurisdictional body, including administration of their own jurisdiction. The mental health portion of the program needed to be available close by but not necessarily in Longview for reasons of confidentiality. It was important that providers be knowledgeable and practiced specifically to the unique issues police officers and family face. It was also important that the police community the program was serving have input into the services provided specific to their needs and that the program have elements that were proactive in addressing stress risk and protective factors. The use of peers, such as advocates was recommended and the importance of on-going training and training specific to the officer and

families length of service was emphasized. A new officer will have different needs than a veteran. A new wife of an officer will have different needs than a veteran wife.

Program recommendations

- *Institute an Employee Assistance Program that offers mental health coverage contracted with providers trained in law enforcement issues.*
- *Provide orientation around all eight change areas during the first two weeks of service on the job with follow-up over the next six months and then bi-annually for all officers.*
- *Use technical reserve officers for confidential advice and education or mentoring.*
- *Institute programs to incentive good health practice and lifestyle and encourage use of personal leave for activities that contribute to stress reduction.*
- *Target communications to officers and family regarding perk plans and promote safety on the job by making healthy lifestyles acceptable and honored.*
- *Develop relationships in the community that support the officer's desires to live healthy.*
- *Provide stress education and opportunities for coping mechanisms such as peer groups/support as well as peer advocacy and mentoring of officers and families.*
- *Provide communication classes.*
- *Support creating another life away from police life that is relaxing and enjoyable such as a hobby or community service, not a dual career.*
- *Provide a spouse academy and family support opportunities*

- *Provide ways for the officer to interface with the community in "positive" and/or non-threatening ways.*
- *Rethink the policy that supports enabling the community to expect officers for all incidents*
- *Institute a confidentiality policy for reporting officers.*
- *Provide sensitivity training in dealing with stereotypes.*
- *Encourage and honor diversity. Provide diversity training and support zero tolerance in the workplace.*
- *Develop CISD peer support teams and a traumatic incident committee (TIC)*
- *Provide orientations and training sessions for stress incidents.*
- *Restructure the organization to be less top heavy and or provide career opportunities.*
- *Support professional training and advanced degrees that bridge transitions to the private sector.*

Implementation Plan

Recognition of stress risk and protective factors and then addressing them with preventative measures is elemental in the implementation of a stress prevention and treatment program for police officers in Longview. Therefore access and monetary coverage or contribution is critical. The service or program must be easy to access and must not be financially detrimental or the officer will not participate.

Recommendations

An implementation team must be involved in deciding on program elements, contracting services based on the recommended programs and benefits package and marketing strategies.

Policies and procedures are currently not in place around stress issues. Standard Operating Procedures must be developed using a committee of stakeholders and incorporating outreach to other agencies[14] utilizing best practices and capturing current informal procedures.

Programs that can be implemented in the workplace with minimal disruption of work, minimal inconvenience and even perceived as contributory to the work experience could result in the highest success. Changing the culture of the work environment to reflect a holistic approach to health, well being and stress reduction is critical. Redefining what is acceptable behavior and reactions to stress will be necessary. When officers no longer feel their jobs, reputations and self-esteem are at stake by admitting they are feeling stress from work then they will be more likely to seek help before stress is an issue.

Finding ways to incorporate these norms towards stress reduction into the culture will be necessary. One method that is strongly recommended is the new officer orientation where they can be indoctrinated into a mindset of preventative actions around stress.

The culture of the police department must change to reflect these new values as well. Veteran officers that may be uncomfortable or resistant to change will need incentives and constant reinforcement. Visual reminders will be necessary such as posters. Training sessions that are

[14] City of Vancouver Chapter 5 Personnel Rules, Policies and Procedures and Tulsa Oklahoma Police Department's Policy and Procedure Manual for Critical Incident Response Team policy, Appendix D

consistent and often will be needed. Peer teams and mentor programs should be implemented to help veteran officers learn by teaching, being asked to set the example. And disciplinary actions may be necessary when there is resistance that may be destructive to the behavioral changes that are expected. Instituting the cooper test and providing monetary compensation for compliance is recommended. However so is disciplinary action for non-compliance.

Awareness is a number one tool in preventing stress. It is important to help officers and families know when they have or are being exposed to stress and then give them tools to do something about it. Whether it is a one on one debrief with a peer support team member or counseling from a mental health provider or simply making time to get more exercise or attending a seminar with their spouse on learning how to eat more healthy.

Repetition of concepts is important and incorporating them in overlapping programs will reinforce change as well. And setting examples and then modeling success will help those that are reluctant.

Clear expectations with help in setting parameters from those directly impacted will need to take place for higher compliance. Feedback from officers and families is critical in making sure programs are meeting needs and if not what can be done differently.

Support from the community is important as well. Finding citizens and business that will offer discounts and incentives and offer verbal and written support. Raising awareness of police stress issues without raising concern that officers are not being effectual. In fact, just the opposite by having stress reducing resources available to them officers will be even more effectual.

Emphasizing benefits supports attitudinal change. "What's in this for me?" is the question that should be answered in the implementation phase of any program. Why would someone want to participate and the address that. An officer might be resistant to attending a seminar on financial planning. Why should an officer care about financial planning? What do officers fear? Leaving family unprotected and vulnerable in the event of tragedy on the job? Address those issues. Young officers might not see the value. After all, they are invincible and nothing will happen to them. A combination of training and mentoring by a veteran who has experienced his mortality could benefit this young officer and his family. Whatever the change area to be addressed using concepts from multiply

programs to reinforce benefits to the officer and family should be utilized.

Patience is necessary when implementing a new program. Slow and gradual awareness with inclusion of stakeholders along the way is important and will result in higher acceptance and ultimate change. A top down mandatory approach will not work. Trust needs to be built and understanding of the scope of impact that the program could have on the current and future health and well being of officers and families needs to be understood.

Consistency is critical. Everyone must participate and no one is excepted. The program must be adequately funded but more importantly there must be a commitment from the top that this program is valuable and will be a priority in the budget and the way the department treats it's officers and families.

The message must be clear and concise. The officer's and their families' health and well being are important to this organization and this is what we do to support that. The program must have an identity. It should be a collaborative effort by stakeholders of the program. Stakeholders might include city administration, police officers and family members, police department administration, insurance providers and union representatives.

Marketing

It is recommended that the roll out be graduated and include such elements as an orientation for officers and family together, offer training specific to the service being rolled out and marketing events that attract interest in the service.

Marketing strategies suggested by the taskforce include sending a newsletter directly to the home so spouses and significant others have direct access to the information. As discovered in the research phase of this grant, officers often will attempt to shield their families from their stressors resulting in the withholding of information from the family that may be deemed by the officer as detrimental. That is way direct mail to the family is important.

Family events sponsored to promote a service have been used by other agencies with success. The taskforce recommended a bowling night, family picnic, dance and dinner with a DJ, softball game, kid's night

with a potluck to encourage officer and family to attend together and receive information at the same time. The use of canvas bags printed with the program and information in the bags along with promotional items was helpful in getting the information into the hands of family.

Promotional items marked with name and contact number of the program were suggested by the taskforce and included balloons, pencils and pens, refrigerator magnets, picture magnets, mugs, stickers, car fresheners, nerf balls, baseball hats, tee-shirts, key chains, or coloring books.

Funding

Most of the program recommendations can be implemented with relatively minor funding adjustments within the department because they can be done using technical reserves that are citizens who are sworn volunteers to provide these services to the department. There will be training costs for internal staff in developing peer teams and contracting costs for some training sessions. There are resources within the state for support of this type of program that should be explored in volunteer training or staff sharing for training. The Washington State Patrol has Dr. Dan Clark on board as state psychologist and is available for CISM training. The guild could consider fundraising to support the program and community and non-profit as well as federal and state matching funds for such programs should be solicited.

A major funding barrier will be in offering an Employee Assistance Program with the levels of mental health coverage that are being recommended in the benefit package recommendation. This issue will need to be addressed by city staff, insurance providers and city council.

It is recommended that a presentation be developed to present to city council representing the benefits of implementation of an EAP and what the costs and cost benefit would be to the city.

Insurance and Medical Providers Report

Both Regence Blue Shield and Kaiser reported any prevention services are only available through EAP's. Regence has an EAP available through a contract. Kaiser does not. Both provide treatment of stress related issues through the health benefits plans and adjustment reactions are covered, however these are conditions which appear after stress-related symptoms manifest. There is no pre-stress treatment or coverage for services that might reduce or prohibit stress before it happens. Both

providers will not pay for stress prevention such as intervention for family, exercise programs, counseling or anything considered preventative.

Model Benefits Program

The benefits package being recommended should include the following;

- No less than five mental health visits per year per incident per family member
- Memberships for fitness facilities and discounts for family
- Totally confidential
- Must be local
- Must be available to officer's on shift as well as off
- Childcare onsite and 24/7 for officer's families through the age of 12
- Mental health phone support 24/7 and 800 number

It is recommended to explore the current EAP's available in the marketplace. The taskforce discovered at least one in the Portland Metro area, Magellan, which offers quality and confidential services with qualified treatment providers knowledgeable in law enforcement issues. Magellan is contracted through Regence Blue Shield.

Training Curriculum

Magellan provided the Stress Training and Critical Incident Stress Management session on February 26, 2000 for 20 officers and spouses. Their curriculum is available to Longview Police and included in the appendix.

Report Dissemination

It is recommended that the report, Organizational Approach to Developing a Stress Program be disseminated by means of announcement to the following local, state and national associations that are in confluence with the police industry. An appropriate fee should be charged for copy and mailing.

International Association of Police Chiefs
515 N. Washington St
Alexandria, Virginia 22314

Washington State Lodge of the Fraternal Order of Police
2527 W Kennewick Ave # 207

Kennewick, WA 99336
Association of Washington Cities
1076 Franklin Street SE
Olympia, WA 98501

Association of Washington Counties
206 Tenth Ave SE
Olympia, WA 98501

Municipal Research & Services Center of Washington
1200 5th Avenue, Suite 1300
Seattle, WA 98101-1059

Washington Association of County Officials
206 Tenth Avenue SE
Olympia, WA 98501-1311

State of Washington
Department of Personnel
PO Box 47500
Olympia, WA 98504-7500

WorldatWork (formly American Compensation Association)
14040 N. Northsight Blvd.
Scottsdale, AZ 85260

Northwestern Association for Behavior Analysis
Warren R. Street
Department of Psychology
Central Washington University
Ellensburg, WA 98926-7575

Society of Human Resource Management
Marilyn Hoppen, SPHR
Area V Manager
P.O. Box 510
Gig Harbor, WA 98335

Washington Association of Marriage and Family Therapists
17233 - 140th Ave., SE
Renton, WA 98058

American Association of Marriage and Family Therapists
1133 - 15th Street, NW, Suite 300

Washington, D.C. 20005-2710
National Associate of Legal Professionals
EDUCATION DIRECTOR
Wendy Heurter
Law Office of Earl F Angevine
325 Pine St, Ste A
Mt Vernon, WA 98273

Washington Correctional Association
P. O. Box 5853
Lacey, WA 98509-5853

Washington Council of Police and Sheriffs
200 Union Avenue SE
Olympia, WA 98501-1393

Washington Counseling Association
Pam VanderDoes, WCA Member Services,
840 Elm Drive
Goldendale, WA 98620

Washington Insurance Council
1904 3rd Avenue, Suite 925
Seattle, WA 98101-1123

Washington Self-Insurers Association
1401 4th Ave. East
Olympia, Washington 98506

Washington Association of Fire Chiefs
605 E 11th Ste 211
PO Box 7964
Olympia WA 98507-7964

Washington State Council of FireFighters
1069 Adams Street SE
Olympia, WA 98501

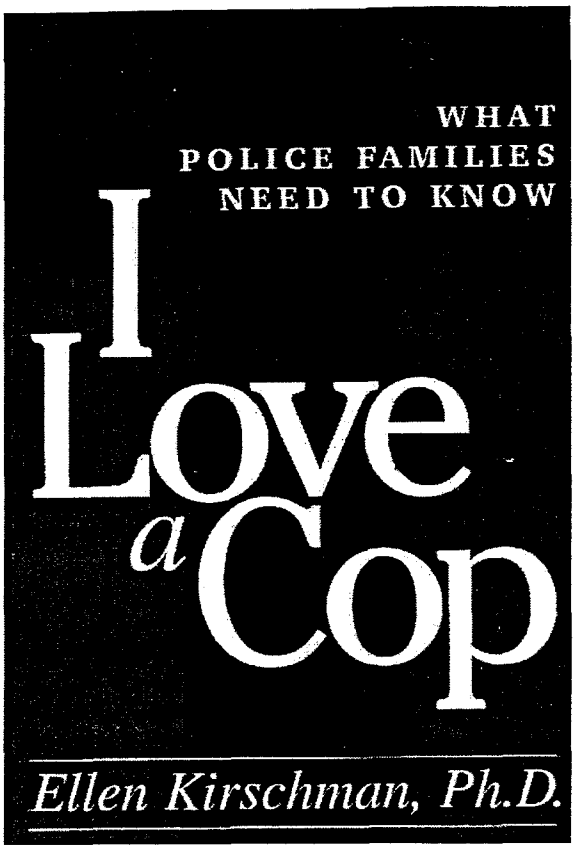
The Washington State Psychological Association
P.O. Box 2016
Edmonds, WA 98020-9516

Appendix A

Products of the Grant

Contents

1. Notes from Dr. Kirschman's workshop
2. Product Timeline and objectives and products list
3. Pre Assessment Survey
4. Pre Assessment Survey Officers and Spouses results



Longview Police Guild Stress Prevention & Treatment Task Force Workshop

Presented by
Dr. Ellen Kirschman, Ph.D.

Saturday, June 5, 1999
8:00 am – 2:00 pm

Cowlitz PUD Auditorium
961 12th Ave
Longview Wa 98632

This workshop is an interactive opportunity to learn from one of the foremost experts in public safety work and it's stresses. Dr. Ellen Kirschman is a clinical psychologist and consultant who has been working with police officers and their families for 20 years. Dr. Kirschman has been an invited guest at the FBI academy and is a member of the Psychology Section of the International Association of Chiefs of Police. Her book, "*I Love a Cop, What Police Families Need to Know*", has been sent to you to preview before this workshop to help facilitate questions.

This is an opportunity for everyone on the task force to gain an in-depth understanding of the realities of the police officers work and home life, even for those already involved in public safety. Dr. Kirschman will provide an informative foundation for the task force to apply to the stress prevention and treatment project.

Look forward to seeing you all there. A light lunch will be provided.

For further information contact:

Det. Jeff Davis
Longview Police
577.3157
jeff.davis@ci.longview.wa.us

Jeanne Harris
facilitator
360.896.0422
jeanne@pacifier.com

Longview Police Guild Stress Prevention and Treatment Taskforce Workshop
Dr. Ellen Kirschman, Ph.D.
June 5, 1999

Agenda

- Introductions w/expectations
  - Grant overview
  - Break out – What are the stressors on police officers
  - Risk factors/officers
- Break
  - Group – Stressors on the police family
  - Risk factors/families
- Lunch
  - Group – What are the needs of police and families in Longview
  - Protective factors/action plan

Expectations

- Clarity on issues
- On the job/at home
- Help w/communication w/guild
- Lay groundwork for program
- Part of the group
- Help develop the plan
- Better comm/jurisdictions
- Wants to see something available
- Recognize problems before critical
- Define goals and objectives

Break outs
What are the Stressors on Police Officers? (officers)

- Situational ethics
- Office politics/organization
- Work schedules
- Police culture vs everyone else
- Negative environment
- Public influences

What are the Stressors on Police Officers? (non-officers)

1. Administration
2. Hours – shiftwork
3. Disruption in family life
4. Promotions – yes or no
5. Discipline/termination/disability possibilities
6. Accident/shootings
7. City council decisions
8. City mgr decisions
9. Chief's decisions
10. Guild positions

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Phone 360.896.0422 **Fax** 360.883.9248 **Pager** 360.690.8638
Website www.jeanneharris.com **Email** jeanne@pacifier.com

11. Maturity of individual officer (PHASES)
12. Secret life
13. Public scrutiny
14. Home life/friendships
15. Is there life after copdom?
16. Legal system not taking them into account

Risk factors for officers?

- ❑ Negative culture
- ❑ Admin
- ❑ Acknowledgment/rewards
- ❑ Trauma/exposure
- ❑ Hypervigilence/trust
- ❑ Dead-end job/handcuffed to job
- ❑ Financial aspects
- ❑ Isolation
- ❑ Ambiguity
- ❑ Change

Why should we care about stressors on police families?

- ❑ Divorce
- ❑ Families are real life
- ❑ Families are support system
- ❑ Better cop
- ❑ Families doing the job too
- ❑ Worried about family
- ❑ Kids – making decision based on job separates them from peers
- ❑ Live in glass box
- ❑ Identify self by the job
- ❑ CK's (church kids) family supposed to live higher standard – over react/rebellion
- ❑ Kids wanting to be a cop (acting out cop activity)
- ❑ Families alone
- ❑ Shiftwork
- ❑ Kids friends won't come over

Protective factors for families

- ❑ Talking w/the family
- ❑ Include the family in decisions
- ❑ Problem-solving together

San Francisco Model

Peer support teams – refer from within
PPO's > contract w/list of therapists preferred provider panel

- Ride alongs
- Interviewed by officers
- Firearms sim
- In house orientation

- Co pay $20
- Dependents emps
- Substance abuse

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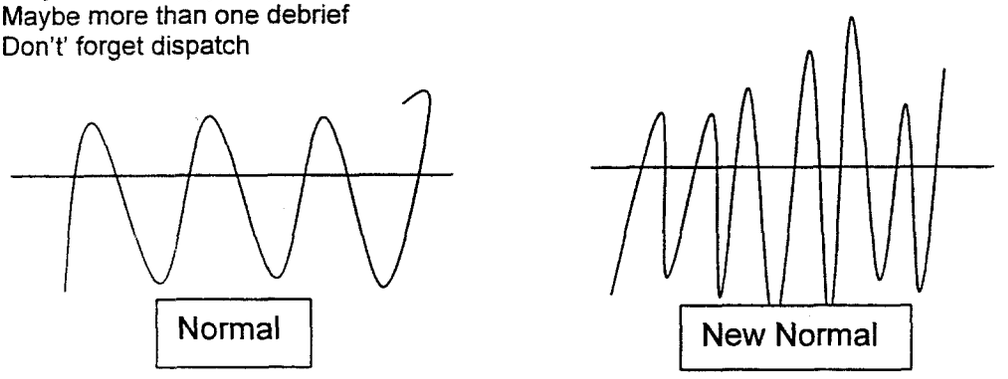
- Run by cops
- On call therapist – diffuser (de-brief)
- 72 hours formal de-brief mandatory
- pre-incident educations
- avoid fitness for duty
- concern for officer's safety

Formal De-brief

Individual as well as group
Only those directly involved
Maybe more than one debrief
Don't' forget dispatch



How normal changes when exposed to continual stress

Protective Factors

- Peer support
- Personal coping mechanisms
- Personal problem-solving skills
- Education/training
- Management support
- Effective communication
- Awareness of stress
- Knowledge of triggers
- Professional support/therapists
- Family support mechanisms
- Support for the family consistency
- Another life – other than police work
- Critical incident debrief
- Policies/procedures
  - Long term consistency
- Sense of fairness – legal/moral/ethical
- System that integrates experience and time in the department
- System that changes shifts
- Child care/family support systems especially for shift work
- Organization that keeps current w/stress factors and addresses them
- Addressing career needs
  - Career tracks
- Planning for the future
- Learning from other industries

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LPG Stress Prevention and Treatment Taskforce

August 1999

Product Timeline	Status	Assign Date	Due Date
1. Develop an evaluation plan and collect baseline data	done		
2. Deliver training for officers, families and task force....			June
(a training session was held for task force only)	done		
3. Establish a work plan			
Task force team	done		
4. Identify and collect research			
Task force team	done		
5. Review service needs as identified by officers, families and research			
Needs assessment – Kathy Oxborrow	done		Oct
6. Assess organizational culture of the LPD			
Task force team – to be assigned	done	Oct and Nov	Dec
7. Develop criteria for what the ideal program would look like based on needs assessment, research and training			
Task force team – to be assigned	done	Oct and Nov	Dec
8. Review existing services			
Task force team – to be assigned	done	Oct and Nov	Dec
9. Review policies and procedures of the LPD, Guild, city government, insurance carriers and service providers.			
Task force team – to be assigned	done	Oct and Nov	Dec
9A. RFP for consultant train officers and families in stress risk and protective factors	done	Oct - Dec	Jan

LPG Stress Prevention and Treatment Taskforce

August 1999

Product Timeline	Status	Assign Date	Due Date
10. Design a stress program based on criteria developed by task force			
Task force team – to be assigned	done	Dec – Feb	Mar
11. Identify policies and procedures that need to be revised, eliminated or created			
Task force team – to be assigned	done	Dec – Feb	Mar
12. Identify which services need to be changed, added or eliminated to concur with proposed program			
Task force team – to be assigned	done	Dec – Feb	Mar
13. Prepare model benefits			
Task force team – to be assigned	done	Dec – Feb	Mar
14. Prepare draft stress program – get comments			
Jeanne and team members?	Done	Mar and Apr	May
15. Revise draft based on comments			
Jeanne and team members?	Done	Mar and Apr	May
16. Prepare final program design report			
Jeanne and team members?	Done	Mar and Apr	May

LPG Stress Prevention and Treatment Task force

Summary of Objectives and Products

Objective One - Task Force

Establish a task force of approximately ten members representing:

Objective Two - Curriculum Development, Training Delivery and Needs Assessment

A consultant will be retained to develop curriculum and jointly train the task force and all LPD officers and their families in the treatment and prevention of stress

Objective Three - LPD Organizational Culture Assessment

The task force will assess the organizational culture of the LPD for its impact on officers acknowledging and seeking stress prevention and treatment services.

Objective Four - Program Criteria

Develop criteria for what an "ideal" program would look like based on the needs identified by the officers and families.

Objective Five - Existing Services Review

Review existing services to determine what is available to build on, what services need to be tweaked, what services need to be added and what services may be unnecessary.

Objective Six - Policies and Procedures Review

The task force will review the policies, procedures and practices of the partners in the current delivery system for their impact on the "ideal" program.

Objective Seven - Stress Program Design

Including what is already in place and working, the task force will design a stress program based on the criteria developed in objective four. This is the time where the "ideal" meets the "real"

Objective Eight - Implementation Plan

Develop a plan to implement the proposed stress program, including potential funding sources. The plan will cover strategies

Objective Nine - Process Report

A report will be produced that outlines the innovative process the task force used to develop and design an effective stress prevention and treatment program.

Objective Ten - Program Design Report

A report will be prepared that outlines the stress prevention and treatment program designed by the task force.

Objective Eleven - Report Dissemination

The project results will be widely disseminated as described in the section on "Plan for Disseminating Results."

LPG Stress Prevention and Treatment Task force

Summary of Objectives and Products

Products

- **Product #1: Program Design Report.**

  This report will describe the stress prevention and treatment program designed by the task force.

- **Product #2: Insurance Carriers Section Report.**

  This is a sub category of product #1. The section of the program report describing the role of insurance carriers in developing an effective stress program will be augmented.

- **Product #3: Medical Providers Section Report.**

  This is also a sub category of product #1. Medical providers may have policies, procedures and practices that could impede the availability, use and effectiveness of stress program services for officers and their families.

- **Product #4: Process Report.**

  This report will describe the innovative process the task force used to develop and design an effective stress prevention and treatment program.

- **Product #5: Implementation Plan.**

  The detailed implementation plan for the stress program (product #1) will cover strategies for insurance carriers, medical service providers, LPD, Guild and the City of Longview. These strategies will include the necessary changes in policies, procedures and practices these entities need to undertake to create an effective stress program.

- **Product #6: Training Curriculum.**

  This training curriculum will cover the prevention and treatment of stress for officers and their families and can be used by other agencies.

- **Product #7: Model Benefit Package.**

  A model benefit package will be developed for the insurance carriers to offer the LPD and other law enforcement agencies. The benefit package will ensure that officers and their families receive quality and confidential services.

Longview Police Department
Stress Prevention and Treatment Survey
January 2000

In 1997 the Longview Police Guild applied for and received a federal grant from the National Institute of Justice Corrections and Law Enforcement Family Support Program (CLEFS). The purpose of the grant is to develop a comprehensive stress prevention and treatment program to meet the needs of the Longview Police Department officers and their families. The grant enables a taskforce made up of volunteer members from the Guild, LPD officers, their families and management, city of Longview staff, insurance carriers and service providers to meet to do several things;

- Assess the needs of the officers and their families
- review the current policies and practices of each participating group
- assess the organizational culture of the LPD
- review current stress program services

Based on the information gathered the task force will design a new stress prevention and treatment program and a plan for implementing the program to insure its creation.

It is the goal of this task force to collect as much information as possible to develop a comprehensive plan for preventing and treating job-related stress in criminal justice environments. It is anticipated by the grant provider that this plan can and will be used by other jurisdications or peripheral industries hoping to accomplish the same goal.

The task force is asking for your help by filling out this anonymous survey. This information will be tabulated and used for analysis in the assessment of the stress prevention and treatment needs of LPD officers and their families as well as non-commissioned staff and LPD management.

Your participation is critical to the taskforce as they assess what current options are successful and what is needed to enhance the system of options. This is your chance to ask for the services that you would like to see provided in the event of work-related stress.

Thank you for you cooperation in filling out this survey. Please answer the questions candidly. Your responses are important to the development of stress prevention and treatment options that are needed and wanted and how they might be delivered.

Directions

When you are finished please insert your survey in the blank envelope provided and seal it. Deposit your envelope in the large mailing envelope labeled "A" if you will **not** be attending the stress prevention training on February 26, 2000 or in the large envelope labeled "B" if you **will** be attending the training and your survey will be sent directly to a tabulation firm.

Thank you.

Longview Police Department
Stress Prevention and Treatment Survey
January 2000

Please circle the response that best reflects your opinions on the statements listed below.

	Strongly Agree	Somewhat agree	Somewhat disagree	Strongly disagree
1. I experience stress from my/my spouse's law enforcement work.	1	2	3	4
2. I experience an unusual amount of stress in my/my spouse's law enforcement work most of the time.	1	2	3	4
3. I experience stress at home because of the work I/my spouse do/does in law enforcement most of the time.	1	2	3	4
4. I understand what the symptoms of stress are.	1	2	3	4
5. When I feel the effects of stress it is usually physical; such as headaches, upset stomach teeth grinding, fatigue	1	2	3	4
6. When I feel the effects of stress it is usually cognitive; such as hyper vigilance, disorientation of time, place or person	1	2	3	4
7. When I feel the effects of stress it is usually emotional; such as guilt, denial, depression, intense anger, panic, anxiety	1	2	3	4
8. When I feel the effects of stress it is usually behavioral: such as withdrawal, loss/increase of appetite, change in social activity, can't sleep	1	2	3	4
9. When I feel the effects of stress it usually impacts the family	1	2	3	4
10. I cope with stress by exercising	1	2	3	4
11. I cope with stress by talking to a co-worker, friend, other	1	2	3	4
12. I cope with stress by using alcohol	1	2	3	4
13. I cope with stress by using drugs	1	2	3	4
14. I am familiar with the stress prevention and treatment options available to me right now	1	2	3	4
15. I am familiar with the stress prevention and treatment options available to me right now and I choose to use them	1	2	3	4
16. I feel the stress prevention and treatment options available to me right now are adequate	1	2	3	4

Longview Police Department
Stress Prevention and Treatment Survey
January 2000

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
17. I feel comfortable using the resources available to me if I'm feeling too much stress related to work or home	1	2	3	4
18. If confidential counseling is available to me for stress related to work or home I would use the service	1	2	3	4
19. If confidential counseling is available to me for stress related to work or home I would use the service but only outside the local area	1	2	3	4
20. I would use stress prevention programs and treatment even if it were not covered by my insurance	1	2	3	4
21. I would use stress prevention programs and treatment even if there was a co-pay option with my insurance	1	2	3	4
I know what a critical incident is.	1	2	3	4
22. I would be interested in having peer support teams available to me for debrief after a critical incident	1	2	3	4
23. I would be interested in training to be on a peer support team for critical incidents	1	2	3	4
24. I would like my family to have stress related prevention and treatment available to them	1	2	3	4
25. I/my spouse have experienced a critical incident in the last twelve months	1	2	3	4
26. I have observed stress related behaviors in members of my family	1	2	3	4
27. I have children that are acting out stress related behaviors related to my/my spouse's work in law enforcement	1	2	3	4
28. I have experienced marital problems due to my/my spouse's work in law enforcement	1	2	3	4
29. Sometimes I wish I/my spouse could leave law enforcement But I don't know how or what I would do	1	2	3	4
30. I would be interested in opportunities for education and career development that would help me/my spouse in my/their law enforcement career	1	2	3	4

| | Strongly agree | Somewhat agree | Somewhat disagree | Strongly disagree |

31. If available I would be interested in presentations that helped me and my family learn more about stress and it's effects	1	2	3	4
32. If available I would be interested in training for coping with stress that is related to law enforcement	1	2	3	4
33. If counseling were available do you believe the provider should be someone knowledgeable in stress related to law enforcement	1	2	3	4

34. Have you or your family used current programs or services relating to stress prevention or treatment offered by the City of Longview? Yes No

If you have used programs and services, what programs or services have you used and why? Did you find them helpful?

_____
_____
_____
_____

If you have not used any programs or services, why not?

_____
_____
_____
_____

35. Check any of the following critical incidents that you have been exposed to in your personal or professional experience, in the last 24 months:

__ Motor vehicle accident
__ Observing or being aware of an unethical act by a coworker/colleague
__ Industrial accident involving serious injury or fatality
__ Sudden or unexpected death of a relative or colleague
__ Injury or death of a child
__ Witnessing or being the subject of an armed robbery
__ Observing a murder or having someone you know murdered
__ Acts of harm to persons in the care of others
__ Discharge of firearm or explosive device
__ Aggravated and sexual assaults; rape
__ Suicide or attempted suicide
__ Psychological abuse
__ Publicity
__ Natural disaster
__ Catastrophe caused by failed equipment
__ Threats of harm to self or loved ones
__ Other_____
__ Domestic violence and abuse
__ Destruction of one's home

36. Please check the symptoms of stress you have experienced in the last 24 months.

__ Chills
__ Thirst
__ Fatigue
__ Nausea
__ Fainting
__ Twitches
__ Vomiting
__ Dizziness
__ Weakness
__ Chest pain
__ Headaches
__ Elevated BP
__ Rapid heart rate
__ Muscle tremors
__ Shock symptoms
__ Grinding of teeth
__ Visual difficulties
__ Profuse sweating
__ Difficulty breathing
__ Confusion
__ Nightmares
__ Uncertainty
__ Hyper-vigilance
__ Suspiciousness
__ Other_____

__ Intrusive images
__ Blaming someone
__ Poor problem solving
__ Poor abstract thinking
__ Poor concentration/memory
__ Disorientation of time, place or person
__ Difficulty identifying objects or person
__ Heightened or lowered alertness
__ Increased or decreased awareness of surrounding
__ Fear
__ Guilt
__ Grief
__ Panic
__ Denial
__ Anxiety
__ Agitation
__ Irritability
__ Depression
__ Intense anger

__ Apprehension
__ Emotional shock
__ Emotional outbursts
__ Feeling overwhelmed
__ Los of emotional control
__ Inappropriate emotional response
__ Withdrawal
__ Antisocial acts
__ Inability to rest
__ Intensified pacing
__ Erratic movements
__ Change in social activity
__ Change in speech patterns
__ Loss or increase of appetite
__ Hyper alert to environment
__ Increase alcohol consumption
__ Change in usual communications

37. Where do you experience the most stress? In the family, the workplace, in the community?

_____
_____
_____
_____

38. What behaviors relative to stress are you observing in your spouse and/or kids?

_____
_____
_____
_____

39. What services would you like to see be made available for stress prevention and treatment for you and your family?

_____
_____
_____
_____

Longview Police Department
Stress Prevention and Treatment Survey
January 2000

Demographic Information:

40. Years with the Longview Police Department: Please circle one.

1 to 5 6 to 10 11 to 15 16 to 20 21+

41. Years of police experience: Please circle one.

1 to 5 6 to 10 11 to 15 16 to 20 21+

43. My age is: Please circle one.

20 to 30 31 to 40 40+

Optional:

44. ____ I am management

45. ____ I am not management

46. ____ I am a family member

47. I/my spouse will stay in law enforcement no matter what the stresses are at work or home.

Yes_____ No_____ Unknown_____

48. If I was reluctant to see a Mental Health Professional, the reasons would include (check all that apply):

_____ Fear of Confidentiality issues
_____Cost
_____ Stigma: what would others think?
_____ Control: I can handle my own problems
_____My spouse won't go with me
_____I am not reluctant to see an MHP
_____MHPs don't understand my problems
_____Location: No MHP near my home/work
_____It's no one's business
_____No one can help me
_____I don't have problems
_____ Other_____

Will you be attending the stress prevention training on February 26, 2000 being provided by the Longview Police Guild? Yes No

OFFICERS ATTENDING TRAINING
LONGVIEW POLICE DEPARTMENT
STRESS PREVENTION AND TREATMENT SURVEY
January 2000

		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Blank
1	I experience stress from my/my spouse's law enforcement work.	3	6	2	0	1
2	I experience an unusual amount of stress from my/my spouse's law enforcement work most of the time.	0	2	5	4	1
3	I experience stress at home because of the work I/my spouse do/does in law enforcement most of the time.	0	5	4	3	
4	I understand what the symptoms of stress are.	5	6	1	0	
5	When I feel the effects of stress it is usually physical; such as headaches, upset stomach, teeth grinding, fatigue.	0	10	2	0	
6	When I feel the effects of stress it is usually cognitive; such as hyper vigilance, disorientation of time, place or person.	1	1	7	3	
7	When I feel the effects of stress it is usually emotional; such as guilt, denial, depression, intense anger, panic, anxiety.	2	6	3	1	
8	When I feel the effects of stress it is usually behavioral; such as withdrawal, loss/increase of appetite, change in social activity, can't sleep.	2	7	2	2	
9	When I feel the effects of stress it usually impacts the family.	1	10	1	0	
10	I cope with stress by exercising.	3	7	2	0	
11	I cope with stress by talking to a co-worker, friend, other.	1	8	3	0	
12	I cope with stress by using alcohol.	0	1	2	9	
13	I cope with stress by using drugs.	0	0	1	11	
14	I am familiar with the stress prevention and treatment options available to me right now.	2	1	6	3	
15	I am familiar with the stress prevention and treatment options available to me right now and I choose to use them.	0	1	7	4	
16	I feel the stress prevention and treatment options available to me right now are adequate.	0	2	6	4	1
17	I feel comfortable using the resources available to me if I'm feeling too much stress related to work or home.	0	4	4	5	
18	If confidential counseling is available to me for stress related to work or home I would use the service .	0	8	4	0	

		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Blank
19	If confidential counseling is available to me for stress related to work or home I would use the service but only outside the local area.	0	5	6	1	
20	I would use stress prevention programs and treatment even if it were not covered by my insurance.	0	1	7	4	
21	I would use stress prevention programs and treatment even if there were a co-pay option with my insurance.	0	7	5	0	
22	I know what a critical incident is.	8	4	0	0	
22 (a)	I would be interested in having peer support teams available to me for debrief after a critical incident.	7	5	0	0	
23	I would be interested in training to be on a peer support team for critical incidents.	6	4	1	1	
24	I would like my family to have stress related prevention and treatment available to them.	4	8	0	0	
25	I/my spouse have experienced a critical incident in the last twelve months.	2	4	2	4	
26	I have observed stress related behaviors in members of my family.	3	6	3	0	
27	I have children that are acting out stress related behaviors related to my/my spouse's work in law enforcement.	1	0	3	7	1
28	I have experienced marital problems due to my/my spouse's work in law enforcement.	0	3	5	3	1
29	Sometimes I wish I/my spouse could leave law enforcement but I don't know how or what I would do.	1	3	2	6	
30	I would be interested in opportunities for education and career development that would help me/my spouse in my/their law enforcement career.	4	7	1	0	
31	If available I would be interested in presentations that helped me and my family learn more about stress and its effects.	4	6	2	0	
32	If available I would be interested in training for coping with stress that is related to law enforcement.	2	10	0	0	
33	If counseling were available do you believe the provider should be someone knowledgeable in stress related to law enforcement.	8	3	1	0	

34. Have you or your family used current programs or services relating to stress prevention or treatment offered by the City of Longview?

Yes	No
1	11

If you have used programs and services, what programs or services have you used and why? Did you find them helpful?

- N/A.
- N/A.

If you have not used any programs or services, why not?

- What programs or services.
- Not needed.
- Unaware of availability.
- Do not know of any.
- Not needed yet.
- Haven't felt the need.
- Not that stressed.
- Not available.

35. Check any of the following critical incidents that you have been exposed to in your personal or professional experience, in the last 24 months:

4	Motor vehicle accident
7	Observing or being aware of an unethical act by a coworker/colleague.
1	Industrial accident involving serious injury or fatality.
2	Sudden or unexpected death of a relative or colleague.
2	Injury or death of a child.
0	Witnessing or being the subject of an armed robbery.
1	Observing a murder or having someone you know murdered
2	Acts of harm to persons in the care of others
1	Discharge of firearm or explosive device.
8	Aggravated and sexual assaults; rape.
7	Suicide or attempted suicide.
2	Psychological abuse.
1	Publicity.
1	Natural disaster.
1	Catastrophe caused by failed equipment.
4	Threats of harm to self or loved ones.
0	Other _____
7	Domestic violence and abuse.
1	Destruction of one's home.

36. Please check the symptoms of stress you have experienced in the last 24 months.

0	Chills	0	Difficulty identifying objects or person
0	Thirst	3	Heightened or lowered alertness
10	Fatigue	2	Increased or decreased awareness of surroundings
1	Nausea	1	Fear
0	Fainting	1	Guilt
2	Twitches	0	Grief
0	Vomiting	0	Panic
0	Dizziness	1	Denial
1	Weakness	5	Anxiety
1	Chest pain	3	Agitation
2	Headaches	6	Irritability
1	Elevated BP	4	Depression
1	Rapid heart rate	0	Intense anger
0	Muscle tremors	4	Apprehension
0	Shock symptoms	0	Emotional shock
6	Grinding of teeth	0	Emotional outbursts
0	Visual difficulties	5	Feeling overwhelmed
0	Profuse sweating	0	Loss of emotional control
0	Difficulty breathing	0	Inappropriate emotional response
0	Confusion	5	Withdrawal
2	Nightmares	0	Antisocial acts
1	Uncertainty	1	Inability to rest
0	Hyper-vigilance	0	Intensified pacing
3	Suspiciousness	0	Erratic movements
1	Intrusive images	1	Change in social activity
1	Blaming someone	1	Change in speech patterns
1	Poor problem solving	2	Loss or increase of appetite
2	Poor abstract thinking	0	Hyper alert to environment
4	Poor concentration/memory	1	Increase in alcohol consumption
0	Disorientation of time, place or person	1	Change in usual communications

1	Other: Lower back pain.

37. Where do you experience the most stress? In the family, the workplace, in the community?

- Family.
- Workplace.
- Family financial.
- The family.
- The family, the workplace.
- Workplace.
- Workplace and family.
- Workplace.
- Workplace.
- Workplace.
- Workplace.
- Probably within my family. My spouse and I both work which leaves us little time together and with our kids.

38. What behaviors relative to stress are you observing in your spouse and/or kids?

- Spouse - depression, fatigue, headaches, nausea. Kid is not affected - not at home and is adult.
- Worry, anxiety.
- Mood swings, impatience.
- Kids crying.
- Anxiety, anger.
- Fighting.
- None.
- None.
- Lack of sleep.
- My spouse is irritable at times and complains about how little time we spend together. My oldest child acts out from not being able to spend time with us.

39. What services would you like to see be made available for stress prevention and treatment for you and your family?

- Unknown.
- Unknown.
- Counseling.
- A counseling program, if spouses and families want to use it.

Demographic Information:

40. Years with the Longview Police Department: Please circle one.

1 to 5	6 to 10	11 to 15	16 to 20	21+
4	3	0	1	4

41. Years of police experience: Please circle one.

1 to 5	6 to 10	11 to 15	16 to 20	21+
2	4	1	1	4

42. My age is: Please circle one.

20 to 30	31 to 40	40+
3	4	5

Optional:

43. ___1___ I am management. .....3..... Blank

44. ___7___ I am not management.

45. ___0___ I am a family member.

46. I/my spouse will stay in law enforcement no matter what the stresses are at work or home.

Yes ___6___ No ___2___ Unknown ___4___.

47. If I was reluctant to see a Mental Health Professional, the reasons would include (check all that apply):

5	Fear of Confidentiality issues	1	MHPs don't understand my problem
2	Cost	0	Location: no MHP near my home/w
3	Stigma: what would others think?	0	It's no one's business
3	Control: I can handle my own problems	0	No one can help me
0	My spouse won't go with me	1	I don't have problems
4	I am not reluctant to see an MHP	0	Other

Will you be attending the stress prevention training on February 26, 2000 being provided by the Longview Police Guild?

Yes ___12___ No ___0___.

*1 officer wrote, "Most stress caused by political environment by management.

SPOUSES ATTENDING TRAINING
LONGVIEW POLICE DEPARTMENT
STRESS PREVENTION AND TREATMENT SURVEY
January 2000

		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Blank
1	I experience stress from my/my spouse's law enforcement work.	1	3	4	0	1
2	I experience an unusual amount of stress from my/my spouse's law enforcement work most of the time.	0	2	4	2	1
3	I experience stress at home because of the work I/my spouse do/does in law enforcement most of the time.	0	2	4	2	1
4	I understand what the symptoms of stress are.	6	3	0	0	
5	When I feel the effects of stress it is usually physical; such as headaches, upset stomach, teeth grinding, fatigue.	2	5	2	0	
6	When I feel the effects of stress it is usually cognitive; such as hyper vigilance, disorientation of time, place or person.	0	1	1	7	
7	When I feel the effects of stress it is usually emotional; such as guilt, denial, depression, intense anger, panic, anxiety.	1	5	2	1	
8	When I feel the effects of stress it is usually behavioral; such as withdrawal, loss/increase of appetite, change in social activity, can't sleep.	1	4	3	1	
9	When I feel the effects of stress it usually impacts the family.	4	3	2	0	
10	I cope with stress by exercising.	2	3	4	0	
11	I cope with stress by talking to a co-worker, friend, other.	4	3	2	0	
12	I cope with stress by using alcohol.	1	1	0	7	
13	I cope with stress by using drugs.	0	0	0	9	
14	I am familiar with the stress prevention and treatment options available to me right now.	1	6	1	1	
15	I am familiar with the stress prevention and treatment options available to me right now and I choose to use them.	1	1	2	4	1
16	I feel the stress prevention and treatment options available to me right now are adequate.	1	3	2	2	1
17	I feel comfortable using the resources available to me if I'm feeling too much stress related to work or home.	2	4	3	0	
18	If confidential counseling is available to me for stress related to work or home I would use the service .	5	2	2	0	

		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Blank
19	If confidential counseling is available to me for stress related to work or home I would use the service but only outside the local area.	0	0	5	4	
20	I would use stress prevention programs and treatment even if it were not covered by my insurance.	2	3	1	3	
21	I would use stress prevention programs and treatment even if there were a co-pay option with my insurance.	4	3	2	0	
22	I know what a critical incident is.	5	2	1	1	1
22 (a)	I would be interested in having peer support teams available to me for debrief after a critical incident.	5	2	1	0	1
23	I would be interested in training to be on a peer support team for critical incidents.	6	2	1	0	
24	I would like my family to have stress related prevention and treatment available to them.	6	3	0	0	
25	I/my spouse have experienced a critical incident in the last twelve months.	2	0	3	4	
26	I have observed stress related behaviors in members of my family.	1	7	1	0	
27	I have children that are acting out stress related behaviors related to my/my spouse's work in law enforcement.	0	0	2	5	2
28	I have experienced marital problems due to my/my spouse's work in law enforcement.	1	0	4	4	
29	Sometimes I wish I/my spouse could leave law enforcement but I don't know how or what I would do.	2	0	1	6	
30	I would be interested in opportunities for education and career development that would help me/my spouse in my/their law enforcement career.	4	1	2	2	
31	If available I would be interested in presentations that helped me and my family learn more about stress and its effects.	1	7	0	1	
32	If available I would be interested in training for coping with stress that is related to law enforcement.	1	6	2	0	
33	If counseling were available do you believe the provider should be someone knowledgeable in stress related to law enforcement.	5	4	0	0	

34. Have you or your family used current programs or services relating to stress prevention or treatment offered by the City of Longview?

Yes	No
0	9

If you have used programs and services, what programs or services have you used and why? Did you find them helpful?

- I saw a psychologist not related to LPD due to severe stress due to political games played at LPD which almost destroyed my marriage and myself - spouse works at LPD!
- Yes, at Kaiser.
- N/A.

If you have not used any programs or services, why not?

- LPD needs some programs for stress for families if there were any safe - any confidential people to run them due to the many infidelity and political things happening there - I'm fearful that several families are going to be destroyed by infidelity that is occurring now.
- N/A - We have been a part of Longview for only 6 months.
- My husband is from a much larger and higher crime area. I believe our stress level is much higher than most. The incidents that have happened here seem very minute compared to Dallas, Texas.
- Knock on wood! So far my experience with my husband in law enforcement has been pretty good.
- Did not know they existed.
- The stress level in our family has not been at a level where we have felt the need for outside services.
- Have not felt like we needed it.
- Have not felt as though we needed it "yet."

35. Check any of the following critical incidents that you have been exposed to in your personal or professional experience, in the last 24 months:

1	Motor vehicle accident
3	Observing or being aware of an unethical act by a coworker/colleague.
0	Industrial accident involving serious injury or fatality.
2	Sudden or unexpected death of a relative or colleague.
0	Injury or death of a child.
0	Witnessing or being the subject of an armed robbery.
0	Observing a murder or having someone you know murdered
1	Acts of harm to persons in the care of others
1	Discharge of firearm or explosive device.
0	Aggravated and sexual assaults; rape.
1	Suicide or attempted suicide.
0	Psychological abuse.
0	Publicity.
0	Natural disaster.
0	Catastrophe caused by failed equipment.
1	Threats of harm to self or loved ones.
1	Other: Financial stress.
0	Domestic violence and abuse.
0	Destruction of one's home.

36. Please check the symptoms of stress you have experienced in the last 24 months.

0	Chills	0	Difficulty identifying objects or person
0	Thirst	1	Heightened or lowered alertness
6	Fatigue	0	Increased or decreased awareness of surrounding
1	Nausea	2	Fear
0	Fainting	1	Guilt
2	Twitches	2	Grief
0	Vomiting	2	Panic
0	Dizziness	1	Denial
3	Weakness	4	Anxiety
1	Chest pain	3	Agitation
5	Headaches	4	Irritability
0	Elevated BP	3	Depression
2	Rapid heart rate	2	Intense anger
0	Muscle tremors	2	Apprehension
0	Shock symptoms	0	Emotional shock
6	Grinding of teeth	5	Emotional outbursts
0	Visual difficulties	5	Feeling overwhelmed
0	Profuse sweating	2	Loss of emotional control
0	Difficulty breathing	1	Inappropriate emotional response
0	Confusion	0	Withdrawal
3	Nightmares	1	Antisocial acts
1	Uncertainty	2	Inability to rest
0	Hyper-vigilance	0	Intensified pacing
1	Suspiciousness	1	Erratic movements
0	Intrusive images	0	Change in social activity
2	Blaming someone	0	Change in speech patterns
2	Poor problem solving	1	Loss or increase of appetite
0	Poor abstract thinking	0	Hyper alert to environment
1	Poor concentration/memory	2	Increase in alcohol consumption
0	Disorientation of time, place or person	1	Change in usual communications

	Other:

37. Where do you experience the most stress? In the family, the workplace, in the community?

- Family, no longer working and always staying home to take care of children.
- In my workplace, sometimes family.
- In the workplace - some at home with 4 children and multiple activities.
- Workplace.
- Workplace.
- Workplace.
- Workplace.
- Workplace.
- Family.

38. What behaviors relative to stress are you observing in your spouse and/or kids?

- My 6 year old always wanting my attention, interrupting - whining a lot.
- Not wanting to talk, kids acting out.
- Trying to coordinate all of our family activities and work hours. Getting everyone where thy need to be on time.
- Silence.
- My husband handles stress very well - he is level headed and is a great problem solver. The kids have more stress about school work than family life at home.
- Frustration.
- Anxiety, sadness, worry.
- Increase sadness, depression (situational).
- High emotions - child.

39. What services would you like to see be made available for stress prevention and treatment for you and your family?

- Would be nice to have a spouse group. Where they get together once/month.
- Just the availability of a program for stress prevention and treatment would be helpful and making sure it is available at all times since you are not able to control when and the levels of stress.
- Counseling, training, guest speakers.
- I feel fortunate that Longview has places to go i.e., Lower Columbia Mental Health or Behavior Health at St. John Medical Center - there are also crisis lines to call. I believe if we needed help we'd find it. Also, family is a great support help.
- Symptom identification, symptom elimination.
- Some safe, confidential places where people can talk and share their feelings and feel there is somewhere to go to get help and find out what is happening to their loved ones. There is no place like that for LPD families!
- Treatment for children from divorced home.

Demographic Information:

40. Years with the Longview Police Department: Please circle one.

1 to 5	6 to 10	11 to 15	16 to 20	21+	Blank
5	0	0	1	2	1

41. Years of police experience: Please circle one.

1 to 5	6 to 10	11 to 15	16 to 20	21+	Blank
4	1	0	1	2	1

42. My age is: Please circle one.

20 to 30	31 to 40	40+
4	3	2

Optional:

43. 0 I am management. 0 Blank

43. 1 I am not management.

44. 9 I am a family member.

45. I/my spouse will stay in law enforcement no matter what the stresses are at work or home.

Yes 6 No 2 Unknown 2 (*1 spouse checked no and unknown)

47. If I was reluctant to see a Mental Health Professional, the reasons would include (check all that apply):

3	Fear of Confidentiality issues	0	MHPs don't understand my problems
5	Cost	0	Location: no MHP near my home/work
1	Stigma: what would others think?	0	It's no one's business
3	Control: I can handle my own problems	1	No one can help me
0	My spouse won't go with me	1	I don't have problems
2	I am not reluctant to see an MHP	1	Other: "I would not hesitate to seek professional help."

Will you be attending the stress prevention training on February 26, 2000 being provided by the Longview Police Guild?

Yes 9 No 0 .

Appendix B

Taskforce Education

Contents

1. CISM presentation notes Dr. Dan Clark
2. Magellan EAP Executive Summary
3. Personal Wellness Profile
4. Male Law Enforcement Officers' and Their Spouses Perceptions to Post-shooting Reactions report by Lori Hendrickson
5. CISM Conference in Chelan, Washington Nov 4 – 7, 1999 Report by Jeanne Harris
6. Oregon Live: 05-11-98, Group offers insight into unique world of police work; www.oregonlive.com/todaysnews/9805/st051105.htm

LPG Stress Prevention and Treatment Taskforce

Longview, Washington
Det. Jeff Davis, LPG, Administrator

Jeanne Harris, facilitator

Basic Critical Incident Stress Management

Daniel W. Clark, Ph.D.

International Critical Incident Stress Foundation

Types of Interventions

* Pre-Incident Education
* On Scene Support Services
* Peer Support (Individual Consults)
* Defusing
* Demobilization
* Critical Incident Stress Debriefing

Critical Incident

Any event which has a significant amount of emotional power, sufficient enough to overwhelm a person's (or group's) ability to cope.

Critical Incident

In a career where day to day you respond to the abnormal events in other people's lives;

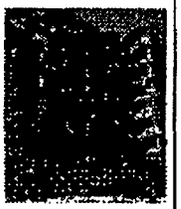
A critical incident is the *one* that, for whatever reason, is abnormal even for *experienced* personnel.

Critical Incident Stress

Normal reactions,
In normal people,
To highly abnormal events.

Critical Incidents
The Terrible 10

- Line of Duty Death
- Serious Line of Duty Injury
- Suicide of a Co-Worker
- Disaster / Multi-Casualty Incident
- Law Enforcement Shooting



Critical Incidents
The Terrible 10

- Events Involving Children
- Relatives of Known Victims
- Prolonged Incident - Especially with loss
- Excessive Media Interest
- Any Significant Event

Individual Factors

Demographic
Personality
Adaptive Behaviors
Previous Life Experience
Coping Skills
Support System

Intensity of Impact

Personal Relevance
Duration
Sense of Loss
Previous History
Guilt
Social Support
Coping Skills

Post-Traumatic Stress

Post - traumatic stress
is a normal reaction,
in a normal person,
to an abnormal event.

Post-Traumatic Stress

Post-traumatic stress is a survival mechanism, Post Traumatic Stress Disorder is a pathogenic version of that survival mechanism.

Post Traumatic Stress Disorder
Brief History

- First Named in DSM - III, 1980
- Military awareness
  - Civil War - nostalgia
  - WWI - war neurosis, shellshock
  - WWII - combat fatigue/exhaustion
  - Post Vietnam - PTSD

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Post Traumatic Stress Disorder
DSM-IV

- Anxiety Disorder
- Exposure to *"traumatic event"*
- Event is persistently reexperienced
- Persistent avoidance of reminders
- Persistent symptoms of arousal
- Diagnosis after 30 days
- Significant distress or impairment

PTSD

All emergency service providers are potentially vulnerable to PTSD.

Risk of Developing PTSD

- 1 - 2 % of General Population (US)
- 9% Young Urban Adults
- 16 - 20 % Emergency Service Personnel

Comprehensive CISM Programs

A comprehensive, systematic program for the mitigation of critical incident related stress.

Types of Interventions (cont.)

- Specialty Debriefings
- Significant Other Debriefings and Support
- Follow Up Services
- Mental Health Referral Services
- Community Assistance

Demobilization

- Transition from disaster work to routine duties or home.
- Allows personnel time to decompress.
- Used to process large numbers of people.
- Only used after large scale incidents.
- Not a substitute for a debriefing.

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tor

Demobilization cont.

- Provided by trained CISM personnel.
- 10 minute informational talk.
  - Describe stress reactions.
  - List signs and symptoms.
  - Outline stress survival strategies.
- 20 minute rest after talk is completed.

Defusing

A small group intervention applied within hours of a critical incident.

Defusing

- Provided by trained peers, clergy or MHP.
- Facilitated discussion.
- 20-45 minutes long.
- May eliminate need for CISD.
- Will increase effectiveness of CISD.

Defusing Objectives

- Rapid intervention
- Talk About Stressor
- Re-establish Social Network
- Restore Adaptive Functioning
- Mitigate impact of the event.
- Accelerate recovery process.
- Assess need for debriefing / other services.
- Reduce stress symptoms.

Debriefing

- Peer driven.
- Clinician guided.
- Group discussion of a traumatic event.
- Prevention program against PTSD.

Debriefing

Tasks

- Education
- Ventilation
- Reassurance
- Forewarning
- Reduce fallacy of uniqueness
- Reduce fallacy of abnormality
- Positive contact with mental health
- Group cohesiveness
- Interagency cooperation

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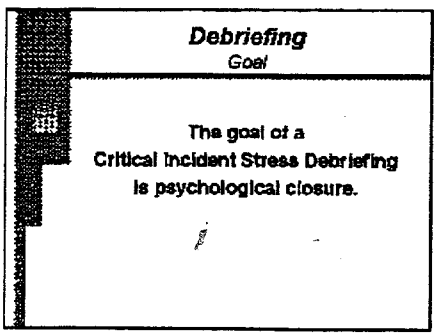

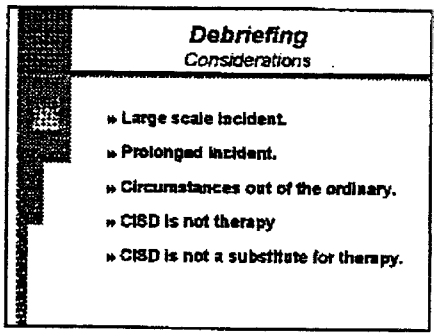

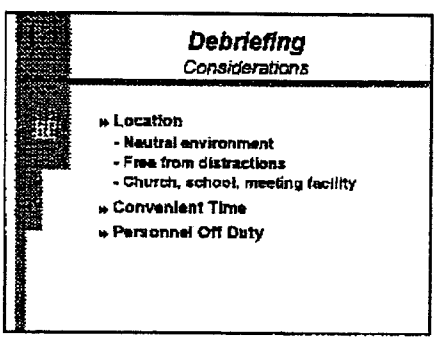

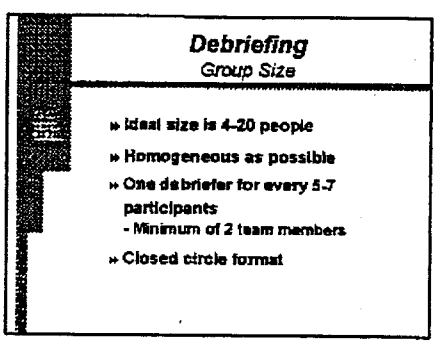

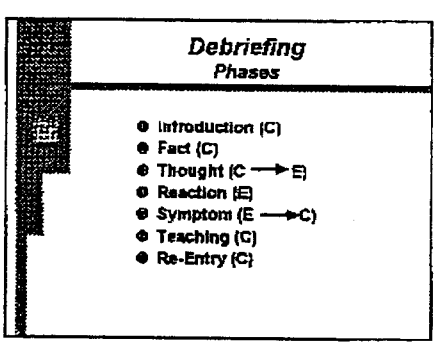

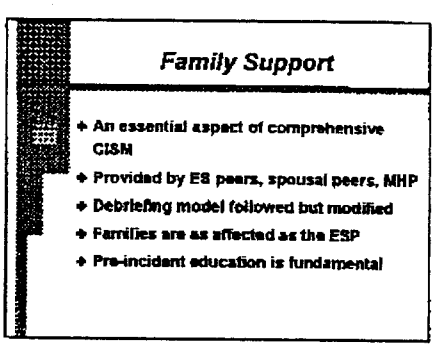

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EXECUTIVE SUMMARY

Enhancing your benefit package with an Employee Assistance Program (EAP) is a responsive and cost effective way to care for employees and their families.

Personal and emotional problems frequently affect performance and productivity in the workplace. The Magellan EAP offers a compassionate, yet systematic and efficient approach to restoring workplace performance and supporting the health and well being of employees and their families.

EAP counseling is action-oriented intervention designed to relieve symptoms, give the client perspective, and help restore and maintain functioning, in the workplace and in personal life.

A cornerstone of our EAP is support and consultation for managers and supervisors who are dealing with workplace issues. Managers and supervisors who call the EAP gain access to a variety of problem-solving resources.

Magellan has a long history of workplace-based programs. Our EAP formerly known as Maschhoff, Barr & Associates has served organizations in the Northwest and nationally since 1979, joining Green Spring in 1993 and becoming part of Magellan Behavioral Health in 1997. Our experience and commitment to quality have established a clear record of success in providing employee assistance programs serving a broad and diverse industry population.

The Magellan EAP is an employer-purchased service that provides confidential mental health and chemical dependency assessment, problem resolution, and referral services. Intervening at the earliest possible stage, and resolving problems that may potentially affect job performance helps improve the lives and health of employees and their family members, and keeps the workplace productive and safe.

The core of Magellan's EAP is the assessment and referral service. A single call to our 24 hour, toll free

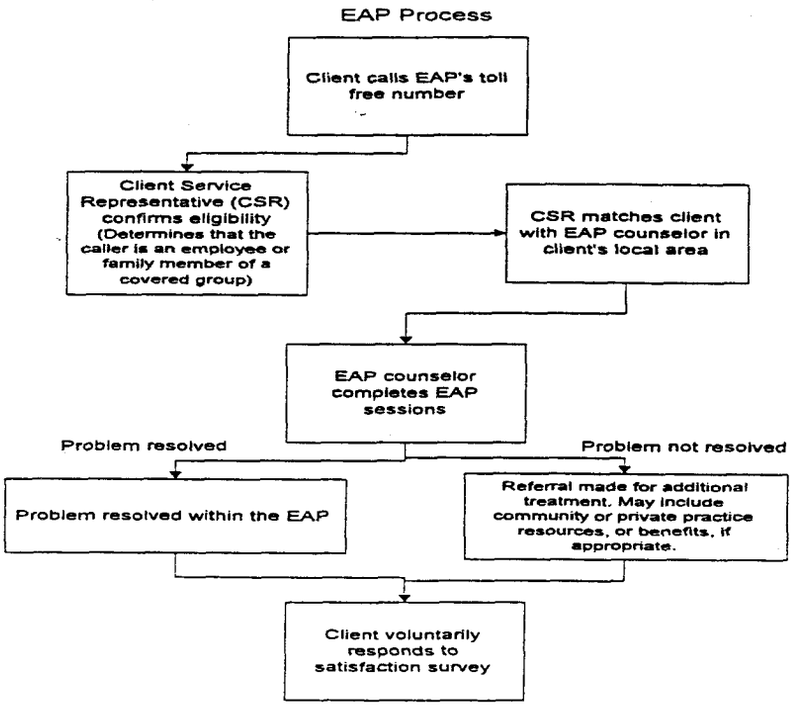
FIVE WAYS EAPS SAVE MONEY

- The EAPA reported that for every dollar invested in an employee support program a $5 to $7 loss is avoided. *Employee Assistance Professional Report, May 1995.*
- Absenteeism declined 66% among those who had been offered company-sponsored support programs. *Employee Assistance Professional Report, May 1995.*
- Seven of the ten most frequently reported employee health problems are routinely addressed by EAPs. These problems and their rank include: stress (#1), smoking (#3), weight control (#5), alcohol abuse (#6), drug abuse (#8), depression (#9), and mental health (#10). *EAP Digest, Jan/Feb 1992.*
- A study by Accountemps reported in the September/ October 1996 issue of *EAP Digest* estimated that dealing with employee issues takes up to 18% of a manager's time.
- EAPs rank third among 12 efforts to control disability management costs to organizations. EAPs were surpassed only by accident prevention/reporting and safety education/ awareness. *EAP Digest, Jan/Feb 1995.*

telephone number puts employees in touch with our nationwide EAP services -- any day, any time. A dedicated toll free TDD line gives access for the deaf and hearing-impaired. Our professionally trained staff match callers with EAP counselors who meet the caller's needs for geographic location and expertise based on the presenting problem.

Assessment, brief counseling, and referral take place at an in-person visit with a Master's or doctorate level counselor.

EAP Flowchart



Issues Addressed

Some of the issues typically addressed by the Magellan EAP include:

- Relationship difficulties
- Adolescent issues
- Anxiety
- Depression
- Substance abuse
- Sleep problems
- Workplace issues
- Parenting problems
- Eating disorders

Training

Groups may select EAP training on-site at their headquarters or largest site or by promotional materials and video only. Videos are included with on-site training; the group may also purchase on-site training for additional sites.

Management Support

In addition to providing mental health counseling to employees and their family members, the Magellan EAP also provides support to managers and supervisors.

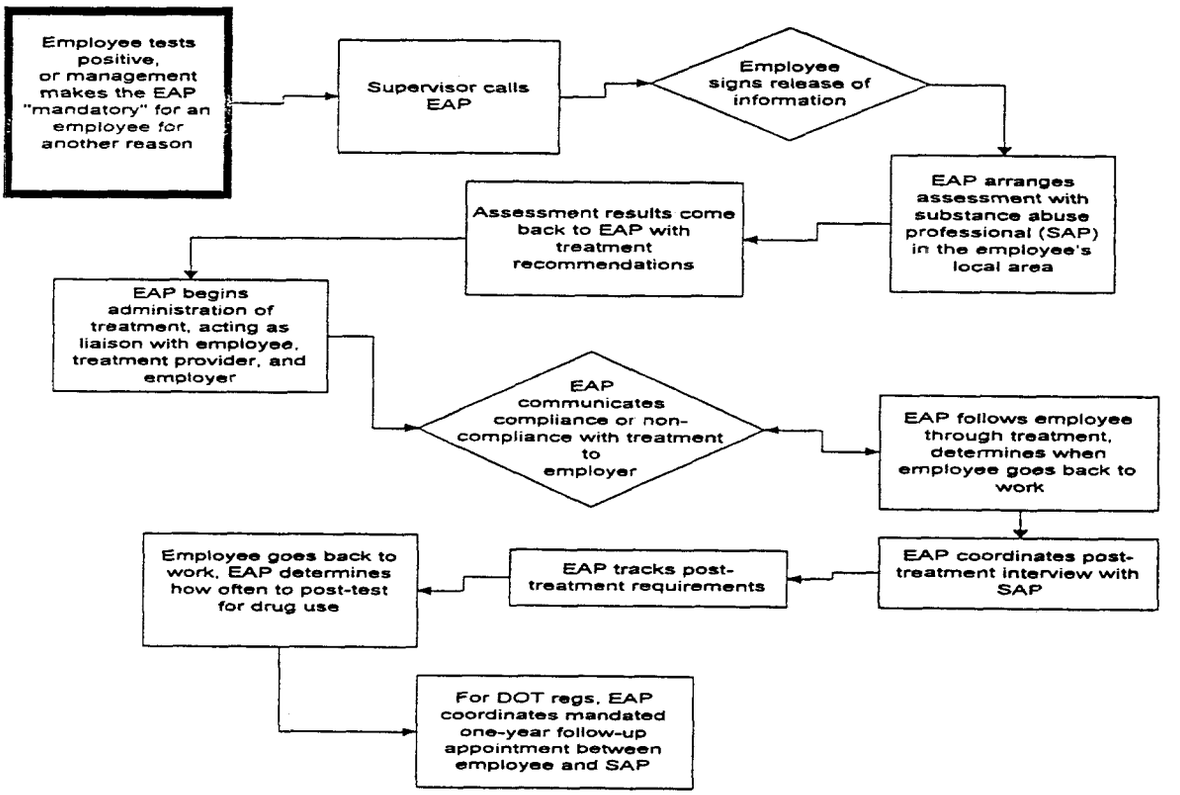
Managers and supervisors can call 24 hours-a-day to access the following services included in the EAP:

- Support with identifying and approaching the troubled employee
- Support in applying the company's policies and procedures
- Arranging for a Critical Incident Stress Debriefing (CISD)
- Referrals to the EAP's mandatory referral program

Mandatory Referrals

The Magellan Behavioral Health **mandatory referral program** provides assessment and referral for employees who are directed to contact the EAP by their employers because of a failed drug test or problems that are creating job performance issues. The procedure set up by the company usually includes return-to-work agreements and a release of information authorization from the employee.

Recent regulations from the Department of Transportation (DOT) mandate drug testing, evaluation and treatment for employees subject to commercial driver's license requirements. In the case of Department of Transportation drug testing, an initial assessment must be completed by a designated, certified substance abuse professionals(SAPs). Magellan's provider network currently has certified substance abuse professionals available locally to serve our client companies. As well, all Magellan staff mandatory referral program consultants are SAP-certified.



Optional Work/Life Services

Your employees may have special interests or needs that you would like the EAP to serve. A variety of additional services are available for a nominal charge to extend the value of your program. Pricing for these services is at the bottom of page 7.

The following services may be added to the Magellan EAP.

Legal Consult Line

Attorneys are available to provide assistance by telephone for a wide range of common legal problems. All carry Errors and Omissions coverage, and are certified by the Bar in the state(s) in which they practice.

Emergency consultations are available 24 hours a day, 7 days a week, giving employees access to an attorney by telephone anytime a legal problem arises. Non-emergency telephone consultations are typically scheduled within 24 hours.

This service is intended to provide basic legal advice. Attorneys who participate in the Legal Consult Line service may not self-refer; for complex legal issues, employees are encouraged to contact the local bar association.

Child Care Referral Services

Take the frustration out of searching for child care services through this national network to help employees locate what they need, where they need it.

- In-home family daycare providers
- Daycare centers
- Before/after school programs
- Preschool programs
- Nanny and *au pair* services
- Special needs
- Mildly ill child care services

The referral database is updated regularly, and includes only licensed providers. The service provides at least three referrals, with follow-up to assure that the client's needs are fully satisfied. There is no limit to the number of referrals a client may receive. A packet of informational materials accompanies the referrals to assist the client in making child care decisions.

Elder Care Referral Services

Many families are responsible for caring for older adults. The service connects families with a variety of day and residential programs, and other services geared to the elderly throughout the country.

- Assessment services
- Nutritional programs
- Volunteer programs
- Veteran programs
- Health agencies
- In-home assistance
- Housing
- Transportation
- Support groups
- Respite care
- Hospice

Informational materials included with the referral packet help clients make more fully informed decisions regarding available services.

Secure Health Nurse Advice Line

Secure Health™ nurse advice line is an integrated system of 24 hour, telephone-based services which assists participants in making more informed health care decisions and encourages more cost effective use of health care services. *Secure Health* nurses provide triage services, health information, and health decision counseling services.

Secure Health includes the following services:

- 24 hour, toll free access to registered nurses
- Emergency referral follow-up within 24-48 hours
- Promotes self-responsibility through use of the provided self-care guide
- Tape library of health information
- Quarterly participant satisfaction survey
- Facilitation of patient/physician process and relationship

Secure Health callers receive answers to their questions, educational information and health promotion materials. Participants also have the option to listen to a variety of health education tapes.

Secure Health nurses help callers determine the most appropriate care necessary and provide professional guidance and reassurance for situations when self- or home-care is appropriate.

Work/Life Education Topics

Work/Life education programs offer employees the knowledge and skills they need to successfully self-manage basic health concerns. Those who are well-informed are better able to take control of their lives, to engage in behaviors and activities that support and promote good health and well-being.

Through our network of professional trainers, Magellan can provide the following workshops and informational presentations:

- Living with Stress
- Coping with Change
- Balancing Work and Home
- Violence in the Workplace
- Grief in the Workplace
- Recognizing Drug and Alcohol Problems
- Communication Skills for the Workplace
- How to Have an Effective Meeting
- Drug/alcohol training to comply with special regulations
- Emotional Issues of Retirement

- **For groups of 200 - 500, <u>two</u> wellness hours are included in the contract.**
- **For organizations larger than 500, the number of additional hours is determined by group size.**
- **Groups smaller than 200 may purchase wellness hours as an optional service.**

Employee Assistance Program Summary of Services

- 24-hour, 7 days a week 800 line telephone coverage
- Complete face-to-face counseling services: 1–3 or 1–6 visit model, other models available
- Comprehensive nationwide network of qualified EAP counselors
- Stringent credentialing procedures and provider monitoring
- Complete services available in neighboring communities within a 30 minute/30 mile commute of the employee's workplace or home
- Structured referral for ongoing treatment and care
- Satisfaction survey sent to each individual who has an EAP visit
- Consultation to managers and supervisors about how to recognize, approach and support the troubled employee
- Threat-of-violence intervention
- Integration of EAP services with the organization's drug/alcohol policy, substance abuse testing policies, the Drug Free Workplace Act and agency policies and procedures
- Services of certified Substance Abuse Professionals when needed for compliance with federal drug/alcohol guidelines (DOT and DOD, etc.)
- Complete *mandatory referral program* to track drug/alcohol cases referred by management/ supervisors
- Annual program promotion, including letters of introduction, brochures, wallet cards, posters, and professionally produced video orientation tapes
- Quarterly newsletters
- Employee orientation; on-site annually at headquarters or primary site, or by video
- Supervisor training; on-site annually at headquarters or primary site, or by video
- Supervisor training manual
- Critical Incident Stress Debriefing (CISD) services
- Complete statistical reports
- TDD phone services available to the hearing impaired
- AT&T Language Line, providing translation services in over 140 languages
- Child care, elder care, LEGAL CONSULT LINE, nurse advice line, and work/life presentations available

EAP Rates and Service Options

Groups can customize their Employee Assistance Program with the choices below. All rates are per employee per month unless otherwise stated.

EAP Model: Visit and Training Choices

Groups with 50 or More Employees

Visit Model	Onsite Training*	Promotional Materials Only
1–3 EAP visits	$1.54	$1.44
1–6 EAP visits	$2.15	$2.05

Groups with 49 or Fewer Employees

Visit Model	Onsite Training*	Promotional Materials Only
1–3 EAP visits	$1.80	$1.65
1–6 EAP visits	$2.40	$2.25

*If purchased, onsite training is included at the headquarters or largest site. Groups purchasing onsite training also receive a video.

Services Included in All EAP Models Above

The services listed in the summary on the preceding page are included in all of the above EAP models. Optional Work/Life services are priced below.

Optional Work/Life Services

Service	Rate Groups with **50 or More** Employees	Rate Groups with **49 or Fewer** Employees
Child Care Referral	$0.22	$0.24
Elder Care Referral	$0.10	$0.12
Legal Consult Line	$0.12	$0.14
Health Advisor Line	$1.00	$1.05
Work/Life Sessions*	Sessions covering topics pertinent to the workplace are available at $95 per hour plus travel expenses	Sessions covering topics pertinent to the workplace are available at $95 per hour plus travel expenses

*2 Work/Life hours are included at no cost for groups larger than 200 employees.

Additional Information

- The cost per employee per month covers the employee and all family members at no additional charge.
- The rate is guaranteed for one year.
- Groups are billed monthly at the end of the month.
- A 100% employer contribution on 100% of the group's employees is required.

Questions?

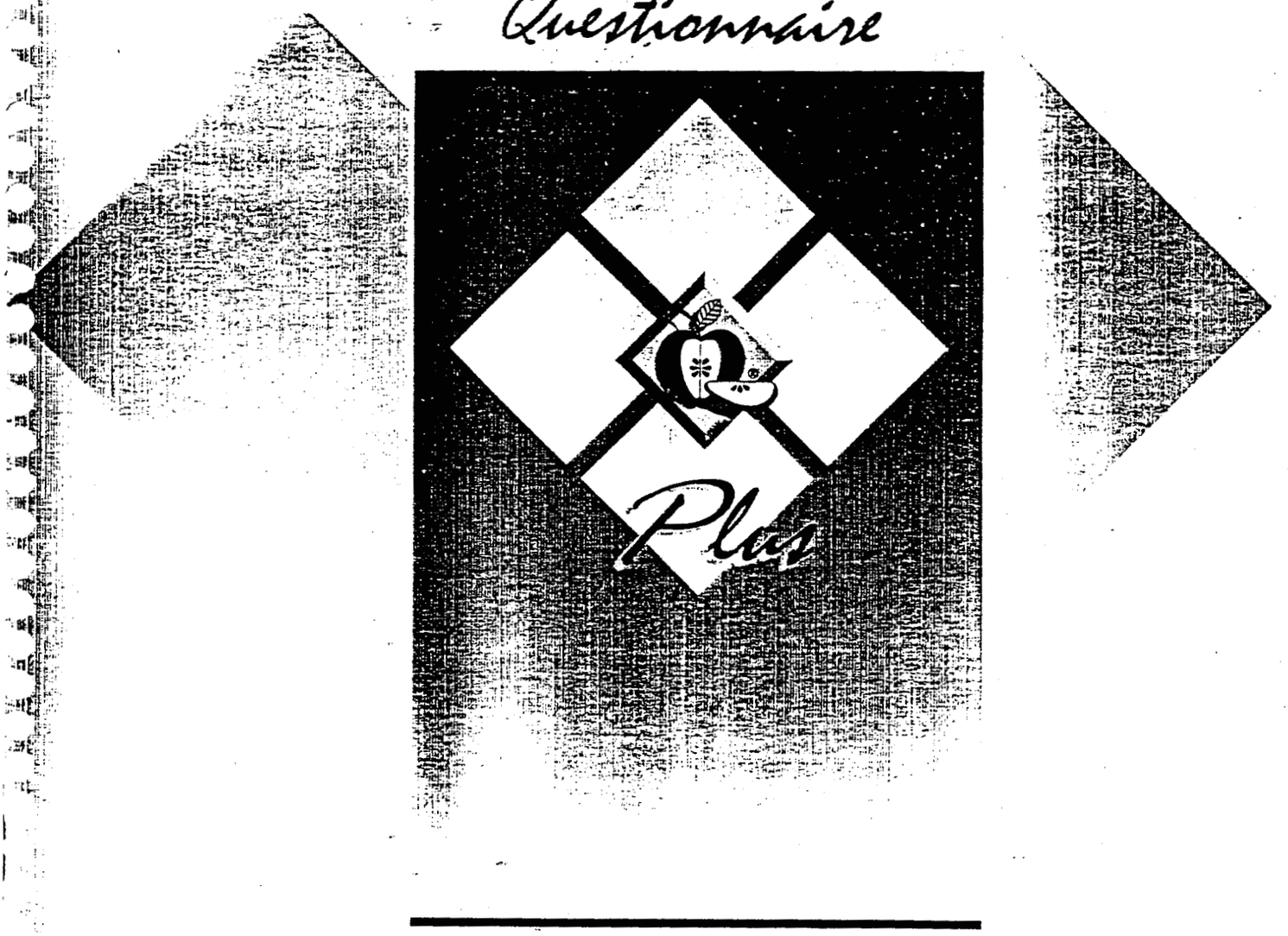
Call Kay Perret in the Magellan Marketing Department at **1-800-441-3119**.

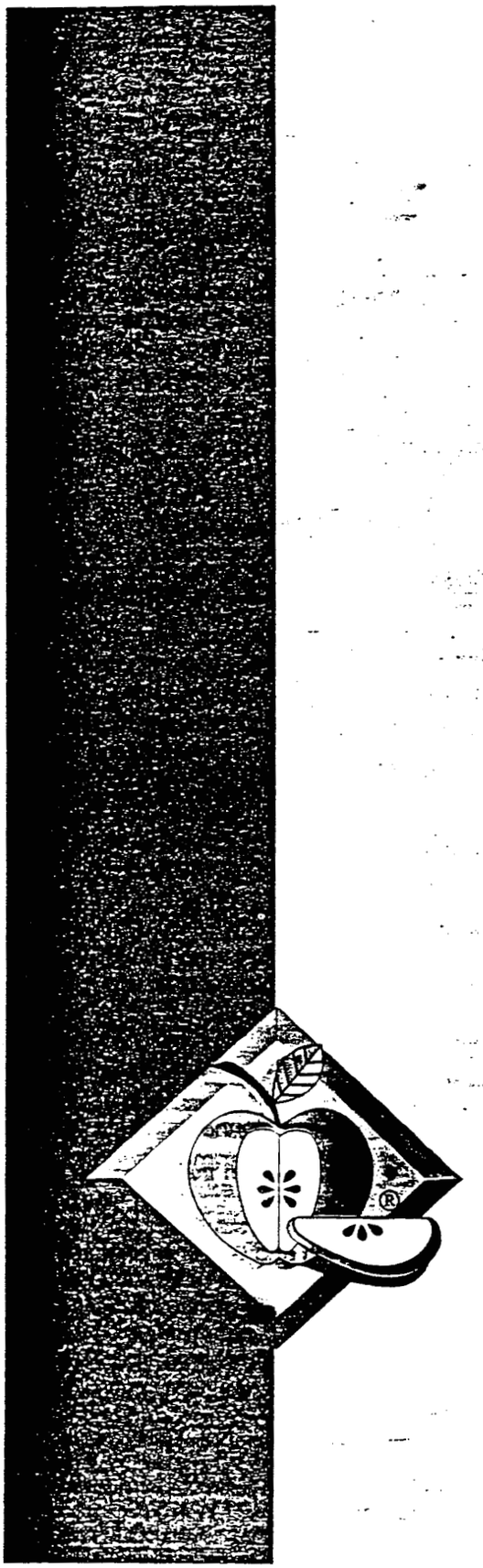
We can give you additional information about our services including a proposal that describes the EAP in detail.

Personal Wellness Profile™

Comprehensive Assessment

Questionnaire





Personal Wellness Profile PLUS

COMPREHENSIVE ASSESSMENT

Congratulations for choosing to participate in the Personal Wellness Profile. Look at this assessment as your first step to better health. By choosing to take personal responsibility for your good health now, you will live a longer, healthier, and happier life.

The PWP assessment helps you in these ways...

- *Identifies health risks you may have*
- *Offers suggestions for ways to improve your lifestyle*
- *Points out the benefits of good health habits*
- *Lets you know where you are doing well*
- *Tells you if you've made improvements over time*
- *Gives you information you need to take charge of your health*

Valuable information you'll get from your Personal Wellness Profile...

- *Your overall wellness rating*
- *Your current fitness level*
- *A personal heart health evaluation*
- *A look at how you cope with stress*
- *An evaluation of your eating habits*
- *Preventive exams recommended for you*
- *Preventive actions recommended based on your needs*

COMPREHENSIVE ASSESSMENT PLUS
Personal Wellness Profile

PRINT NAME AND ADDRESS CLEARLY

NAME

ADDRESS

CITY STATE

ZIP CODE PHONE DATE

Personal ID/SS No. (no dashes) | **Group ID Number**

LAST NAME - SPACE - FIRST NAME

About Your Personal Wellness Profile

Confidentiality

We want you to know that the personal information you share will remain just that, personal. Your confidentiality will be respected.

Purpose

The Personal Wellness Profile program is designed to improve the quality of your life by evaluating your present health status and making suggestions for the future. For the report to be accurate, all questions need to be answered to the best of your ability.

A Few Suggestions

There are no right or wrong answers. This is not a test. Answer each question in a way that best describes your current situation or health status. The following instructions will be helpful in completing this questionnaire properly.

BIRTHDAY

Enter the date of your birth.

– –

Month Day Year

AGE

Years

GENDER

① male
② female

FRAME SIZE

① small, *thin, lean build*
② medium, *most people*
③ large, *muscular build*

Enter your height and weight. If pregnant or nursing, put your pre-pregnant weight.

HEIGHT		WEIGHT
ft	ins	lbs
4		
5		
6		
7		
8		

Proper Mark ●
Improper Marks ⊘ ◐ ◒

- Use a **Number 2 pencil** only.
- **Print clearly** in the boxes and **fill in** the corresponding ovals.
- Make heavy black marks, **fill the oval completely.**
- **Erase** changes cleanly.
- **Check to be sure** you have answered every question.
- **Do not make any stray marks** on the questionnaire.
- **Do not fold or wrinkle** your questionnaire.
- When filling in the **Personal ID/ Social Security No., Group ID,** and **Name,** start filling in from the left and use only as many spaces as you need, and leave the remaining ones blank. ***DO NOT*** insert dashes or spaces between numbers.

PLEASE DO NOT WRITE IN THIS AREA

7263642

Health Information

1. Family health history Mark any of the following health problems found in your family (parent, brother, sister).

1. ① alcoholism
2. ① colorectal cancer
3. ① breast cancer
4. ① ovarian cancer
5. ① diabetes
6. ① coronary heart disease, heart attack, or coronary surgery before age 55 in men, before age 65 in women
7. ① obesity
8. ① high blood pressure
9. ① high blood cholesterol
10. ① osteoporosis
11. ① glaucoma
12. ① cataracts

2. Personal health history Has a doctor informed you that you currently have any of the following health problems? If yes, mark either yes, but not taking or yes, and taking medication, otherwise leave blank.

1 - yes, not taking medication
2 - yes, taking medication

1. ①② allergies
2. ①② arthritis
3. ①② asthma
4. ①② blindness or trouble seeing
5. ①② bones break easily, broken bone or stress fracture in past 10 years
6. ①② bowel polyps or inflammatory bowel disease
7. ①② cancer, skin
8. ①② cancer, other
9. ①② cataracts (cloudy lens impairing vision)
10. ①② chronic bronchitis or emphysema (COPD)
11. ①② coronary heart disease, congestive heart failure, angina, heart attack, or heart surgery
12. ①② diabetes (high blood sugar)
13. ①② deafness or trouble hearing
14. ①② glaucoma (high eye pressure)
15. ①② high blood pressure (140/90 or higher)
16. ①② high blood cholesterol (240 or higher)
17. ①② kidney disease
18. ①② macular degeneration in eye (AMD)
19. ①② sciatica or chronic back problem
20. ①② skin problems or dermatitis
21. ①② stroke or restricted blood flow to head or legs
22. ①② ulcer or bleeding in stomach or bowels
23. ①② other, list in shaded area only

3. Current symptoms Mark any of the following symptoms you have experienced within the past four weeks.

1. ① chest pain or discomfort, frequent palpitations or fluttering in the heart
2. ① unusual shortness of breath
3. ① unexplained dizziness or fainting
4. ① ankle edema
5. ① temporary sensation of numbness or tingling, paralysis, vision problem, or light-headedness
6. ① significant unexplained weight loss (10+ lbs.)
7. ① frequent urination and unusual thirst
8. ① frequent joint pain
9. ① any persistent change in bowel habits
10. ① blood in stool
11. ① frequent coughing, wheezing, difficulty breathing
12. ① frequent back pain
13. ① skin sores that won't heal
14. ① large moles, 6 or more, 1/4+ inch, flat or raised
15. ① have trouble reading newsprint (wearing glasses
16. ① have trouble sleeping lately
17. ① I've recently thought about ending my life
18. ① other symptoms or current health concerns, list in shaded area only

4. Risk factor for AIDS and STDs (optional) Have you or your partner had more than one sex partner in the past five years?

1. ① yes
2. ② no

5. Health view Mark any of the following that apply to you:

1. ① I'm as healthy as anybody I know.
2. ① I seem to get sick a little easier than other people.
3. ① I expect my health to get worse.
4. ① I have a serious health problem.
5. ① I would like to see a doctor about a health condition I am suffering from.
6. ① I tend to be more of a pessimist than an optimist

6. Bodily pain How much bodily pain have you had during the past four weeks?

① none
② very mild
③ mild
④ moderate
⑤ severe
⑥ very severe

Physical Activity

7. Daily activities The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so how much?

1 - yes, limited a lot
2 - yes, limited a little
3 - no, not limited at all

1. ①②③ lifting or carrying groceries
2. ①②③ moving a table, vacuuming
3. ①②③ climbing several flights of stairs
4. ①②③ walking several blocks

8. Exercise How many days per week do you engage in aerobic exercise of at least 20 to 30 minutes in duration (fitness walking, cycling, jogging, swimming, aerobic dance, active sports, or gardening)?

⓪ no exercise program
① one day per week
② two days per week
③ three days per week
④ four days per week
⑤ five days per week
⑥ six days per week
⑦ seven days per week

9. Physical activity status Mark the response that best describes your current activity level.

① I have ***no regular exercise*** program, generally avoid walking or exertion when possible.

② I ***occasionally*** walk for pleasure or exercise sufficiently to cause heavy breathing or perspiration (sweat).

③ I get regular exercise in work or recreation requiring ***modest physical activity*** such as golf, yard work, calisthenics, weight lifting, table tennis, ***up to 1 hour per week.***

④ I get regular exercise in work or recreation requiring ***modest physical activity*** such as golf, yard work, calisthenics, weight lifting, table tennis, ***more than 1 hour per week.***

⑤ I participate regularly in ***more active physical exercise*** (brisk walking, jogging, swimming, cycling, rowing, active sports like tennis or handball). <u>If yes</u>, indicate below how much time you spend exercising <u>each week</u>.

① less than 1 hour per week
② 1 hour, or run up to 5 miles weekly
③ 2 to 3 hours, or run 6 to 10 miles weekly
④ 4 to 5 hours, or run 11 to 15 miles weekly
⑤ 6 to 8 hours, or run 16 to 20 miles weekly
⑥ 9 to 11 hours, or run 21 to 25 miles weekly
⑦ 12+ hours, or run 26+ miles weekly

10. Strength exercises How many times per week do you do strength-building exercises such as sit-ups, push-ups, or use weight training equipment?

① none
② once a week
③ twice a week
④ three plus times weekly

11. Stretching exercises How many times per week do you do stretching exercises to improve flexibility of your back, neck, shoulders, and legs?

① none
② once a week
③ twice a week
④ three plus times weekly

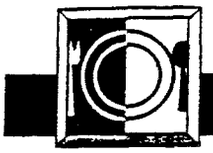
12. Exercise restriction Has a doctor instructed you <u>not to</u> exercise due to a health problem you have?

① yes
② no

13. Exercise preference Mark all activities that you:

1 - do regularly
2 - want to start doing

1. ①② active dancing
2. ①② active sports
3. ①② aerobics to music
4. ①② bicycling
5. ①② canoeing/rowing
6. ①② calisthenics
7. ①② golf, walking
8. ①② handball/squash
9. ①② hiking/backpacking
10. ①② racquetball
11. ①② rope skipping
12. ①② running
13. ①② skating
14. ①② skiing, x-country
15. ①② skiing, downhill
16. ①② stair stepping
17. ①② stationary cycling
18. ①② swimming
19. ①② tennis
20. ①② walking briskly
21. ①② weight/circuit training
22. ①② yard work, mowing



Eating Practices

14. Breakfast How often do you eat breakfast, more than just a roll and a cup of coffee?

① eat breakfast every day
② eat breakfast most mornings
③ eat breakfast two to three times per week
④ seldom or never eat breakfast

15. Snacks How often do you eat snack foods between meals (chips, pastries, soft drinks, candy, ice cream, cookies)?

① three or more times per day
② once or twice per day
③ few times per week
④ seldom or never eat typical snacks

16. Fast foods How often do you eat fast food meals such as hamburgers, tacos, fried chicken, hot dogs, french fries, milkshakes, etc.?

① four or more times per week
② two to three times per week
③ two to four times per month
④ seldom or never

17. Fat intake Indicate the kinds of foods you usually eat.

High fat examples: hamburgers, hot dogs, bologna, steaks, sour cream, cheese, whole milk, eggs, butter, cake, pastry, ice cream, chocolate, fried foods and many fast foods

Low fat examples: lean meats, skinless poultry, fish, skim milk, low fat dairy products, fruit desserts, gelatin, vegetables, pasta, legumes (peas and beans)

① nearly always eat the high fat foods
② eat mostly the high fat foods, some low fat
③ eat both about the same
④ eat mostly low fat foods, some high fat
⑤ eat only low fat foods

18. Breads and grains Indicate the kinds of breads and grains you usually eat.

Refined grain examples: white bread, rolls, regular pancakes and waffles, white rice, typical breakfast cereals, typical baked goods

Whole-grain examples: whole-grain breads, brown rice, oatmeal, whole-grain or high fiber cereals

① nearly always eat refined grain products
② eat mostly refined grain products
③ eat both about the same
④ eat primarily whole-grain products
⑤ eat only whole-grain products

19. Protein foods Indicate the kinds of protein food you usually eat.

Animal sources: meats, poultry, fish, cheese, eggs

Vegetable sources: legumes (peas, beans, lentils), tofu, soy meats, nut foods, veggie burger, vegetarian entrees

① nearly always eat animal proteins
② eat mostly animal proteins
③ eat both about the same
④ eat mostly vegetable proteins
⑤ eat only vegetable proteins

20. Dark leafy green vegetables How often do you eat dark leafy green vegetables?

Examples: spinach, kale, broccoli, turnip greens, collards

① five or more times per week
② two to four times per week
③ once per week
④ one to three times per month
⑤ seldom or never

21. Food groups How many servings do you eat of the following food groups each day?

SERVINGS PER DAY 0 2 4 6 8 10+	SERVING SIZE
GRAINS	
1. ⓪ ② ④ ⑥ ⑧ ⑩+	1 slice bread, 1 oz. dry cereal, 1/2 cup cooked cereal, rice, or pasta
SERVINGS PER DAY 0 1 2 3 4 5+	**SERVING SIZE**
VEGETABLES	
2. ⓪ ① ② ③ ④ ⑤+	1 cup raw, 1/2 cup cooked, 3/4 cup juice, 1 med. potato
FRUIT	
3. ⓪ ① ② ③ ④ ⑤+	1 med. apple, orange, banana, 1/2 cup cooked, 3/4 cup juice
DAIRY	
4. ⓪ ① ② ③ ④ ⑤+	1 cup milk or yogurt, 1.5 oz. natural cheese, or 2 oz. processed cheese
PROTEIN FOODS	
5. ⓪ ① ② ③ ④ ⑤+	2 to 3 oz. cooked lean meat, poultry, or fish, 1 large egg, 1 cup cooked beans, lentils, peas, 3 oz. tofu, 1 oz. nuts, 1 3 oz. vegetarian burger
SWEETS & DESSERTS	
6. ⓪ ① ② ③ ④ ⑤+	12 oz. soft drink, 1 sm. candy bar, 2 Tbs. sugar or jam, 2 sm. cookies, 1/2 cup ice cream, 1 slice of pie or cake
FATS	
7. ⓪ ① ② ③ ④ ⑤+	1 Tbs. butter, oil, or margarine, 2 Tbs. salad dressing or mayonnaise

22. Salt How often do you add salt to your food or eat salty foods (chips, pickles, soy sauce)?

① seldom or never
② some meals
③ most meals
④ nearly every meal

23. Water How many 8 oz. glasses of water do you usually drink each day?

① one or less
② two
③ three
④ four
⑤ five
⑥ six
⑦ seven
⑧ eight or more

24. Prior weight Compared to your weight 10 years ago, how much do you weigh now?

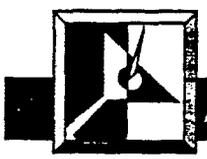
① 10 pounds more
② 20+ pounds more
③ weigh about the same
④ weigh less now

25. Calcium Do you take a calcium supplement regularly?

① yes
② no

26. Dieting Do you diet often, at least 1-2 times a year?

① yes
② no



Alcohol, Drugs, Smoking

27. Alcohol In the past two weeks, on how many days did you drink any alcoholic beverages such as beer, wine, or liquor?

⓪ never drink
⓪ none
① one day
② two days
③ three days
④ four days
⑤ five days
⑥ six days
⑦ seven days
⑧ eight days
⑨ nine days
⑩ ten days
⑪ eleven days
⑫ twelve days
⑬ thirteen days
⑭ fourteen days

28. Number of drinks In the past two weeks, on the days you drank an alcoholic beverage, how many drinks did you have per day, on the average?

One drink is the equivalent of a 12 oz. beer, 5 oz. wine, or 1.5 oz. liquor.

⓪ never drink or did not drink in past year
⓪ none in the past 2 weeks
① one drink
② two drinks
③ three drinks
④ four drinks
⑤ five or more drinks

29. Drinking pattern Do you often have three or more drinks in one day on the days that you do drink?

① yes
② no

30. Drugs How often do you use drugs or medicines that affect your mood, help you relax, or help you sleep?

① frequently, every week
② sometimes, once or twice a month
③ rarely, a few times per year
④ never

31. Medicines How many different medicines do you currently take (include over-the-counter and prescription drugs)?

⓪ none
① one
② two
③ three
④ four
⑤ five
⑥ six
⑦ seven
⑧ eight
⑨ nine
⑩ ten or more

32. Drug interactions When taking medicines, are you careful to tell your physician about other medicines you are taking, and to abstain from alcohol in order to prevent harmful drug interactions?

① yes, very careful about this
② don't always remember to do this
③ didn't know about drug interactions

33. Caffeine How many caffeinated drinks do you usually drink per day such as coffee, tea, and cola?

One drink is the equivalent of a cup of coffee or tea, or a 12 oz. cola drink.

⓪ none
① one per day
② two per day
③ three per day
④ four per day
⑤ five per day
⑥ six or more per day

34. Smoking status Mark the appropriate response.

① have never smoked
② quit smoking two or more years ago
③ quit smoking less than two years ago
④ smoke pipe or cigar only
⑤ currently smoke less than ten cigarettes daily
⑥ currently smoke ten or more cigarettes daily

35. Chewing tobacco Do you use chewing tobacco?

① yes
② no

36. Secondhand smoke Are you exposed regularly to secondhand smoke (other people's smoke) at home or work?

① yes
② no

Stress and Coping

37. Coping status How well do you feel you are coping with your current stress load?

① coping very well
② coping fairly well
③ have trouble coping at times
④ often have trouble coping
⑤ feel unable to cope any more

38. Stress signals Mark any of the items below that apply to you.

1. ① Minor problems throw me for a loop.
2. ① I find it difficult to get along with people I used to enjoy.
3. ① Nothing seems to give me pleasure anymore.
4. ① I am unable to stop thinking about my problems.
5. ① I feel frustrated, impatient, or angry much of the time.
6. ① I feel tense or anxious much of the time.

39. Feelings The next questions are about how you feel things have been with you during the past four weeks. For each question, please give the one answer that comes the closest to the way you have been feeling. How much of the time during the past four weeks...

1 - all the time
2 - most of the time
3 - a good bit of the time
4 - some of the time
5 - a little of the time
6 - none of the time

1. ①②③④⑤⑥ Have you felt calm and peaceful?
2. ①②③④⑤⑥ Did you have a lot of energy?
3. ①②③④⑤⑥ Have you felt down-hearted and blue?
4. ①②③④⑤⑥ Have you been a happy person?
5. ①②③④⑤⑥ Have you felt worthless, inadequate or unimportant?
6. ①②③④⑤⑥ Did you take the time to relax and have fun daily?

40. Emotional problems During the past four weeks to what extent have you accomplished less than you would like in your work or other daily activities as a result of emotional problems, such as feeling depressed or anxious?

① not at all
② slightly
③ moderately
④ quite a bit
⑤ extremely

41. Sleep On the average, how often do you get at least 7 to 8 hours of sleep each day?

① always or nearly always
② most of the time
③ less than half the time
④ seldom or never

Social Health

42. Social health Mark any of the following that currently apply to you.

1. ① I am single.
2. ① I live alone.
3. ① I feel very lonely much of the time.
4. ① I am a single parent with children at home.
5. ① I am having serious relationship problems.
6. ① I've recently experienced a personal crisis (lost a loved one, divorce, lost job).
7. ① I live or work in a high crime neighborhood.
8. ① My living situation is very crowded.
9. ① I am caring for an elderly parent.
10. ① I am exposed to domestic violence or abuse
11. ① There is a handgun in my home.

43. Violence Indicate how many times in the past year you witnessed or became involved in a violent fight or attack where there was a chance of a serious injury to someone.

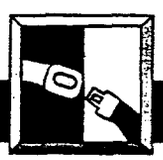
① none
② one time
③ 2 to 3 times
④ 4+ times

44. Social activity During the past four weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

① not at all
② slightly
③ moderately
④ quite a bit
⑤ extremely

45. Social support Do you have a good social support system (family, friends, church) with whom you can share problems and joys or to get help if needed?

① yes
② no



Safety

46. Seat belts When driving or riding in a car, how often do you wear a seat belt?

① always
② most of the time
③ less than half the time
④ seldom or never

47. Smoke detector Does your home have a working smoke detector near your sleeping area?

① yes
② no
③ not sure

48. Lifting When lifting heavy objects, how often do you make sure to use correct lifting technique?
Keep object close to body, bend at hips and knees, keep back in normal position with head and shoulders up, lift with legs.

① always
② most of the time
③ less than half the time
④ seldom or never, or don't know correct lifting technique

49. Helmets When bicycling or in-line skating, do you always wear a helmet?

① yes
② no
③ not applicable

50. Drinking and driving Do you sometimes drive when perhaps you've had too much to drink, or ride with such a person?

① yes
② no

51. Sun exposure Are you frequently exposed to the sun in work or recreation?

① yes
② no

52. Sun protection Are you very careful to protect your skin from sunburn by wearing protective clothing, using sunscreen, not sunbathing, etc.?

① yes
② no

53. Sunglasses Do you usually wear sunglasses when spending time outside in the bright sunlight?

① yes
② no

54. Occupational health Do you feel your employer is concerned about your health and safety?

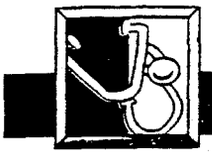
① definitely
② I think so
③ I'm not sure
④ no, not very concerned
⑤ not applicable

55. Job description Mark the description that best describes the kind of work you do.

① sales, office worker
② health professional
③ manager/professional
④ technical
⑤ service
⑥ homemaker
⑦ skilled craft/trade
⑧ agriculture/laborer
⑨ equipment operator
⑩ factory worker
⑪ unemployed
⑫ student
⑬ retired
⑭ other

56. Job How satisfied are you with your work life?

① very satisfied
② mostly satisfied
③ not very satisfied
④ dissatisfied
⑤ not applicable



Medical Care

57. Personal physician Do you currently have a primary care physician (PCP)?

① yes ② no

58. Health limitations During the past four weeks, how much difficulty did you have doing your work or other regular daily activities as a result of your physical health?

① none at all
② a little bit
③ some
④ quite a bit
⑤ could not do daily work

59. Physical Exam When was your last physical examination?

① within the past year
② within the past two years
③ within the past three years
④ within the past four years
⑤ five or more years ago

60. Preventive exams Mark the preventive exams you have had during the time frame listed:

1. ① **cholesterol check**, within the past 2-5 years
2. ① **blood pressure check**, every 1-2 years
3. ① **check for blood in stool**, Guaiac Test, within past year
4. ① **bowel exam**, or flexible sigmoidoscopy within past 3-10 years
5. ① **dental exam**, within past year
6. ① **vision**, within past 4 years
7. ① **hearing**, within past 1 to 2 years
8. ① **health, lifestyle assessment**, within past 1 to 2 years

immunizations

9. ① **childhood immunizations**, during your childhood
10. ① **tetanus**, within past 10 years
11. ① **pneumonia**, once
12. ① **flu**, within past year

women only

13. ① **Pap smear**, within past 1-3 years
14. ① **mammogram with breast exam**, within past 1-2 years
15. ① **breast self-exam**, monthly

men only

16. ① **testicular self-exam**, monthly
17. ① **PSA**, blood screening for prostate cancer, within past 1 to 2 years

61. Women's health issues Mark all that apply. Me skip to next question.

1. ① Currently pregnant.
2. ① Currently nursing a baby.
3. ① Planning a pregnancy in 1 to 2 years.
4. ① Gave birth before reaching age 30.
5. ① Reached or passed menopause.
6. ① Taking birth control pills.
7. ① Taking estrogen, female hormones.
8. ① Sometimes take laxatives, diuretics, or vomit to lose weight.

62. Doctor visits How many visits have you made during past 12 months to a doctor, emergency room, psychia trist, chiropractor, or other health care professional?

⓪ none ④ four ⑧ eight
① one ⑤ five ⑨ nine
② two ⑥ six ⑩ ten or more
③ three ⑦ seven

63. Sick days How many days did you miss from wo (or from school if a student) due to illness or injur during the past 12 months?

⓪ none ⑤ six
① one ⑦ seven
② two ⑧ eight
③ three ⑨ nine
④ four ⑩ ten or more
⑤ five

64. Hospital days How many days did you spend in the hospital due to sickness or injury during the past twelve months?

⓪ none ⑥ six
① one ⑦ seven
② two ⑧ eight
③ three ⑨ nine
④ four ⑩ ten or more
⑤ five

65. Blood pressure Indicate your usual blood pressur

① less than 130/85
② (130-139)/(85-89)
③ 140/90 or higher
④ don't know

66. Cholesterol Indicate your usual blood cholesterol l

① 180 or below (less than 4.7 mmol/L)
② 181-199 (4.7-5.17 mmol/L)
③ 200-239 (5.2-6.2 mmol/L)
④ 240 or higher (greater than 6.2 mmol/L)
⑤ don't know

Health View

67. Readiness to change Indicate how ready you are to make changes in your health in the following areas:

1 - haven't thought about changing
2 - plan a change in next 6 months
3 - plan to change this month
4 - recently started doing this
5 - do this regularly (last 6 mos.)

1. ①②③④⑤ be physically active
2. ①②③④⑤ practice good eating habits
3. ①②③④⑤ not smoke or use tobacco
4. ①②③④⑤ lose weight, or maintain healthy weight
5. ①②③④⑤ handle stress well
6. ①②③④⑤ drink alcohol only in moderation if at all
7. ①②③④⑤ live an overall healthy lifestyle

68. Confidence Rate your confidence in achieving and maintaining a healthy lifestyle in each of the following areas:

1 - very confident
2 - somewhat confident
3 - not very confident

1. ①②③ not smoking
2. ①②③ be physically active
3. ①②③ practice good eating habits
4. ①②③ achieve and maintain a healthy weight
5. ①②③ handle stress well
6. ①②③ drink alcohol only in moderation if at all
7. ①②③ live an overall healthy lifestyle

69. Perceived health Rate your health habits from excellent to poor in each of the areas listed below:

1 - excellent
2 - very good
3 - good
4 - fair
5 - poor

1. ①②③④⑤ nutrition and eating habits
2. ①②③④⑤ fitness and exercise habits
3. ①②③④⑤ weight, body fat level
4. ①②③④⑤ coping, how you cope with stress
5. ①②③④⑤ alcohol use
6. ①②③④⑤ in general, your overall health

70. Health trend Compared to <u>one year ago</u>, how would you rate your current health in the areas listed below?

1 - much better
2 - somewhat better
3 - about the same
4 - somewhat worse
5 - much worse

1. ①②③④⑤ nutrition and eating habits
2. ①②③④⑤ physical activity
3. ①②③④⑤ weight, body fat level
4. ①②③④⑤ coping, how you cope with stress
5. ①②③④⑤ alcohol use
6. ①②③④⑤ in general, your overall health

71. Health interests Mark any of the following health improvement opportunities that you would like to be personally notified about if available.

1. ①	Quitting smoking	12. ①	Alcohol/drugs
2. ①	Weight management	13. ①	Healthy back
3. ①	Aerobics to music	14. ①	Medical self-care
4. ①	A walking group	15. ①	Stress management
5. ①	A jogging group	16. ①	CPR training
6. ①	A fitness evaluation	17. ①	First aid
7. ①	Nutrition improvement	18. ①	Health evaluation
8. ①	Cholesterol reduction	19. ①	Women's health
9. ①	Blood pressure control	20. ①	Diabetes education
10. ①	Reducing coronary risk	21. ①	Communication skills
11. ①	Cancer risk reduction	22. ①	AIDS/preventing STDs
①	Do not notify me of health promotion opportunities		

72. Time If needed, when is the best time to contact you?
① morning ② afternoon ③ evening

73. Race (optional)
① Native American ④ Caucasian
② Asian ⑤ Hispanic
③ African American ⑥ Other

74. Education (optional)
① 8th grade or less ④ some college
② some high school ⑤ college graduate
③ high school graduate ⑥ graduate degree

75. Family income (optional)
① under $20,000 ④ $60,000-79,999
② $20,000-39,999 ⑤ $80,000 or more
③ $40,000-59,999

Section B - Optional

Use only if given additional questions for a Section B. If not, skip this section.

	Y N		Y N		Y N		Y N		Y N
1.	①②③④⑤	7.	①②③④⑤	13.	①②③④⑤	19.	①②③④⑤	25.	①②③④⑤
2.	①②③④⑤	8.	①②③④⑤	14.	①②③④⑤	20.	①②③④⑤	26.	①②③④⑤
3.	①②③④⑤	9.	①②③④⑤	15.	①②③④⑤	21.	①②③④⑤	27.	①②③④⑤
4.	①②③④⑤	10.	①②③④⑤	16.	①②③④⑤	22.	①②③④⑤	28.	①②③④⑤
5.	①②③④⑤	11.	①②③④⑤	17.	①②③④⑤	23.	①②③④⑤	29.	①②③④⑤
6.	①②③④⑤	12.	①②③④⑤	18.	①②③④⑤	24.	①②③④⑤	30.	①②③④⑤

Scientific Basis for PWP

The Personal Wellness Profile was developed by a team of health promotion specialists, including doctors, health educators, nutritionists, and exercise physiologists. Recommendations for risk reduction and health enhancement are drawn from currently established guidelines of leading health organizations in America, including:

American Cancer Society
Cancer Facts and Figures
American College of Sports Medicine
Guidelines for Exercise Testing and Prescription
American Heart Association and American Cancer Society
Living Well, Staying Well
Berkman and Breslow
Health and Ways of Living - The Alameda County Study
Canadian Government
Fitness and Amateur Sport, Canadian Standardized Test of Fitness
Department of Health and Human Services
Put Prevention into Practice, Clinician's Handbook of Preventive Services
Healthy People 2000 - National Health Promotion and Disease Prevention Objectives
U.S. Surgeon General's Report on: Fitness & Health, Nutrition & Health, and Smoking & Health
Health Outcomes Institute
Health Status Questionnaire User Guide
Johns Hopkins Medical Institutions
The Johns Hopkins White Papers on Health and Prevention
National Center for Health Statistics
Vital Statistics Reports - Life Tables and Advance Report of Final Mortality Statistics
National Committee For Quality Assurance
Standards for Accreditation
National Institutes of Health
Second Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults, The Fifth Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure
National Mental Health Association
How to Deal with Your Tensions
National Research Council
Diet and Health, Implications for Reducing Chronic Disease
U.S. Department of Agriculture
Dietary Guidelines for Americans, and The Food Guide Pyramid
U.S. Preventive Services Task Force
Guide to Clinical Preventive Services, 2nd Edition
University of California at Berkeley
Wellness Reports - Men's Health, Women's Health
University of Michigan
Worksite Wellness Cost/Benefit Analysis and Report, The Steelcase Study
World Health Organization
Diet, Nutrition, and the Prevention of Chronic Disease

Principal development under the direction of:
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Clinical Data - Staff Use Only

Height ft	Height ins	Weight lbs
	0 0	0 0 0
	1 1	1 1 1
	2	2 2 2
	3	3 3 3
4	4	4 4 4
5	5	5 5 5
6	6	6 6 6
7	7	7 7
8	8	8 8
	9	9 9

Waist Girth	Hip Girth
0 0 0	0 0 0
1 1 1	1 1 1
2 2 2	2 2 2
3 3 3	3 3 3
4 4 4	4 4 4
5 5 5	5 5 5
6 6 6	6 6 6
7 7 7	7 7 7
8 8 8	8 8 8
9 9 9	9 9 9

Body Composition Testing Method	Sum of skinfolds	Known % fat	Other
1 skinfolds 3-site UML	0 0 0	0 0	0 0 0
2 skinfolds 3-site UMM	1 1 1	1 1	1 1 1
3 skinfolds 7-site	2 2 2	2 2	2 2 2
4 known % fat	3 3 3	3 3	3 3 3
5 other 1	4 4 4	4 4	4 4 4
6 other 2	5 5 5	5 5	5 5 5
	6 6 6	6 6	6 6 6
	7 7 7	7 7	7 7 7
	8 8 8	8 8	8 8 8
	9 9 9	9 9	9 9 9

Desired Weight low	Desired Weight high
0 0 0	0 0 0
1 1 1	1 1 1
2 2 2	2 2 2
3 3 3	3 3 3
4 4 4	4 4 4
5 5 5	5 5 5
6 6 6	6 6 6
7 7 7	7 7 7
8 8 8	8 8 8
9 9 9	9 9 9

Desired % fat low	Desired % fat high
0 0	0 0
1 1	1 1
2 2	2 2
3 3	3 3
4 4	4 4
5 5	5 5
6 6	6 6
7 7	7 7
8 8	8 8
9 9	9 9

Resting Pulse	Blood Pressure systolic	Blood Pressure diastolic
0 0 0	0 0 0	0 0 0
1 1 1	1 1 1	1 1 1
2 2 2	2 2 2	2 2 2
3 3 3	3 3 3	3 3 3
4 4 4	4 4 4	4 4 4
5 5 5	5 5 5	5 5 5
6 6 6	6 6 6	6 6 6
7 7 7	7 7 7	7 7 7
8 8 8	8 8 8	8 8 8
9 9 9	9 9 9	9 9 9

PSA	Hemgl
0 0 0 0	0 0 0
1 1 1 1	1 1 1
2 2 2 2	2 2 2
3 3 3 3	3 3 3
4 4 4 4	4 4 4
5 5 5 5	5 5 5
6 6 6 6	6 6 6
7 7 7 7	7 7 7
8 8 8 8	8 8 8
9 9 9 9	9 9 9

Blood Tests
1 nonfasting
2 3 hr. fasting
3 12 hr. fasting

Blood Test Decimal Use
○ mg/dL (ignore decimal)
○ mmol/L (use decimal)

Cholesterol Total	Cholesterol HDL	Cholesterol LDL	Triglycerides	Glucose
0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0
1 1 1 1	1 1 1 1	1 1 1 1	1 1 1 1	1 1 1 1
2 2 2 2	2 2 2 2	2 2 2 2	2 2 2 2	2 2 2 2
3 3 3 3	3 3 3 3	3 3 3 3	3 3 3 3	3 3 3 3
4 4 4 4	4 4 4 4	4 4 4 4	4 4 4 4	4 4 4 4
5 5 5 5	5 5 5 5	5 5 5 5	5 5 5 5	5 5 5 5
6 6 6 6	6 6 6 6	6 6 6 6	6 6 6 6	6 6 6 6
7 7 7 7	7 7 7 7	7 7 7 7	7 7 7 7	7 7 7 7
8 8 8 8	8 8 8 8	8 8 8 8	8 8 8 8	8 8 8 8
9 9 9 9	9 9 9 9	9 9 9 9	9 9 9 9	9 9 9 9

Guaiac Test (blood in stool)
1 positive
2 negative

Smoking Test
1 positive
2 negative

Graded Exercise Test (GXT) Method
1 treadmill, Bruce
2 treadmill, Balke
3 treadmill, other max
4 treadmill, sub-max
5 treadmill, walk test
6 1 mile run
7 1 mile walk
8 1.5 mile run
9 CAFT step test
A The STEP FIT test
B cycle, Astrand
C cycle, Snell sub-max
D cycle, ACSM max
E cycle, sub-max
F cycle, AAPHERD
G known VO2 max

Exercise HR	Treadmill mph #1	Treadmill % grd	Bicycle #1 watts	Exercise HR	Treadmill mph #2	Treadmill % grd	Bicycle #2 watts	VO2 max ml/kg/min	Exer. Time min	Exer. Time sec	CAFT final stage
0 0 0	0 0 0	0 0	0 0 0	0 0 0	0 0 0	0 0	0 0 0	0 0 0	0 0	0 0	
1 1 1	1 1 1	1 1	1 1 1	1 1 1	1 1 1	1 1	1 1 1	1 1 1	1 1	1 1	1
2 2 2	2 2 2	2 2	2 2 2	2 2 2	2 2 2	2 2	2 2 2	2 2 2	2 2	2 2	2
3 3 3	3 3 3	3 3	3 3 3	3 3 3	3 3 3	3 3	3 3 3	3 3 3	3 3	3 3	3
4 4 4	4 4 4	4 4	4 4 4	4 4 4	4 4 4	4 4	4 4 4	4 4 4	4 4	4 4	4
5 5 5	5 5 5	5 5	5 5 5	5 5 5	5 5 5	5 5	5 5 5	5 5 5	5 5	5 5	5
6 6 6	6 6 6	6 6	6 6 6	6 6 6	6 6 6	6 6	6 6 6	6 6 6	6 6	6 6	6
7 7 7	7 7 7	7 7	7 7 7	7 7 7	7 7 7	7 7	7 7 7	7 7 7	7 7	7 7	7
8 8 8	8 8 8	8 8	8 8 8	8 8 8	8 8 8	8 8	8 8 8	8 8 8	8 8	8 8	
9 9 9	9 9 9	9 9	9 9 9	9 9 9	9 9 9	9 9	9 9 9	9 9 9	9 9	9 9	

Stress Test ECG
1 normal
2 borderline
3 abnormal

1 Check with doctor before beginning exercise program

Lung Function FVC (L)	Lung Function FEV-1 (L)	Lung Function FEF25-75 (L)
0 0 0	0 0 0	0 0 0
1 1 1	1 1 1	1 1 1
2 2 2	2 2 2	2 2 2
3 3 3	3 3 3	3 3 3
4 4 4	4 4 4	4 4 4
5 5 5	5 5 5	5 5 5
6 6 6	6 6 6	6 6 6
7 7 7	7 7 7	7 7 7
8 8 8	8 8 8	8 8 8
9 9 9	9 9 9	9 9 9

Cholesterol Diet Plan
1 step 1
2 step 2
3 step 2+
4 Ornish

Exercise Intensity (mark only one)

Specified (fill in)
1 HR range
2 % HR max.
3 % HR reserve

% HR max
4 light 50-60
5 moderate 60-75
6 vigorous 70-90

% HR reserve
7 light 40-50
8 moderate 50-70
9 vigorous 70-85

Specified Intensity HR range/% HR max low	Specified Intensity HR range/% HR max high	Grip kg	Curl #	Push-ups #	Sit-ups #	Flex ins
0 0 0	0 0 0	0 0 0	0 0 0	0 0	0 0	0 0 0
1 1 1	1 1 1	1 1 1	1 1 1	1 1	1 1	1 1 1
2 2 2	2 2 2	2 2 2	2 2 2	2 2	2 2	2 2 2
3 3 3	3 3 3	3 3 3	3 3 3	3 3	3 3	3 3 3
4 4 4	4 4 4	4 4 4	4 4 4	4 4	4 4	4 4 4
5 5 5	5 5 5	5 5 5	5 5 5	5 5	5 5	5 5 5
6 6 6	6 6 6	6 6 6	6 6 6	6 6	6 6	6 6 6
7 7 7	7 7 7	7 7 7	7 7 7	7 7	7 7	7 7 7
8 8 8	8 8 8	8 8 8	8 8 8	8 8	8 8	8 8 8
9 9 9	9 9 9	9 9 9	9 9 9	9 9	9 9	9 9 9

Purpose & Explanation

The Personal Wellness Profile™ (PWP) is a measurement of one's current health status. It makes individuals aware of those health needs and lifestyle practices that determine personal well-being. Emphasis is on the factors we can actually control. Positive reinforcement of good health practices, along with recommendations for change when needed, is made for each major health area.

Scientific Basis for PWP™

PWP™ was developed by a team of health promotion specialists, including doctors, health educators, nutritionists, and exercise physiologists. Recommendations of risk reduction and health enhancement are drawn from established guidelines of leading health organizations and research, including:

American Cancer Society
American College of Sports Medicine
American Heart Association
Berkman and Breslow
Canadian Government
Department of Health and Human Services
Health Outcomes Institute
Johns Hopkins Medical Institutions
National Center for Health Statistics
National Committee for Quality Assurance
National Institutes of Health
National Mental Health Association
National Research Council
U.S. Department of Agriculture
U.S. Preventive Services Task Force
University of California at Berkeley
University of Michigan
World Health Organization

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WELLSOURCE® INC.
Health Assessment & Prevention Systems

Personal Wellness Profile

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ID # 000-00-0000 F47

Printed on:
Thursday, May 21, 1998

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Table Of Contents

This CONFIDENTIAL Personal Wellness Profile is presented to
you by the health caring people at Kaiser Permanente, Occupational Health.

Personal Wellness Profile - Overview

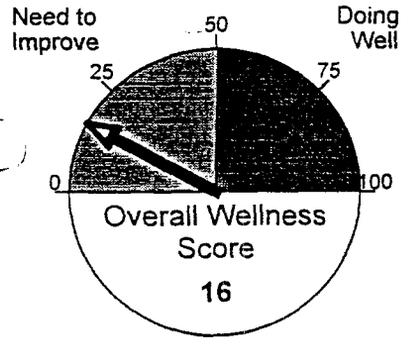
FORTY KPNW

Wellness Scores

Your scores in the major areas of wellness are shown on the right. Scores range from 0 to 100. A score of less than 50 shows need for improvement; 50 or above is in the recommended range. Specific information on each of these key areas are shown in the following reports.

Overall Wellness Score

The overall wellness score is based on the number of good health indicators and these seven major wellness scores.

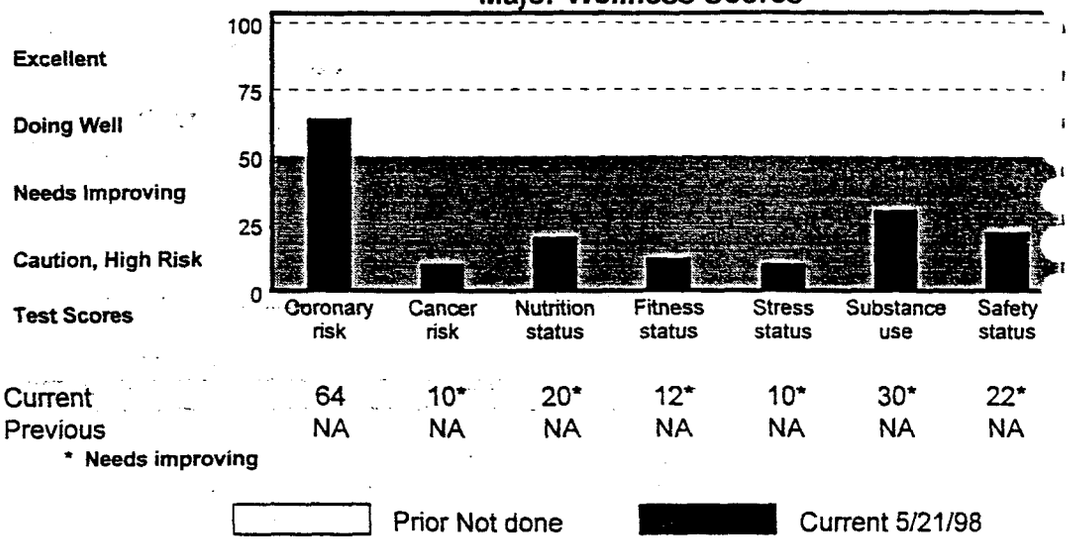


Your overall wellness score is 16, "Caution."

Good Health Indicators:
5 out of 15

- ☑ Low coronary risk
- ☐ No tobacco exposure
- ☐ Good cancer rating
- ☐ Wise alcohol use
- ☐ Good aerobic fitness
- ☐ Good nutrition
- ☐ Always wears seatbelts
- ☑ Good cholesterol level
- ☑ Happy most of the time
- ☑ Good blood pressure
- ☐ Good safety rating
- ☐ Good body composition
- ☐ 7-8 hours sleep per day
- ☐ Good stress rating
- ☑ Fewer than 5 sick days

Major Wellness Scores



	Coronary risk	Cancer risk	Nutrition status	Fitness status	Stress status	Substance use	Safety status
Current	64	10*	20*	12*	10*	30*	22*
Previous	NA	NA	NA	NA	NA	NA	NA

* Needs improving

Prior Not done Current 5/21/98

Recommendations

Your top 5 health needs or preventive actions are listed below. These are key factors needing attention to prevent serious health problems. Give these items top priority. Other recommendations and guidelines follow throughout this report.

1 **Weight Control:** A healthy weight can give you more energy and help you look an feel your best, while helping to prevent many serious health problems. For achievin and maintaining a healthy weight, see recommendations in other sections of the report.

2 **Physical Activity:** Every "body" needs regular physical activity such as walking, cycling, swimming, aerobics, or active sports. Regular exercise helps control excess weight, high blood pressure, high cholesterol, high blood sugar levels, and will reduc stress and help you relax.

3 **Improving Nutrition:** Good eating habits are basic to your health and can help prevent heart disease, high blood pressure, certain cancers, diabetes, and obesity. A low fat eating plan along with an increase in fruits, vegetables, and whole grains is best.

4 **Stress Reduction:** It is not possible to avoid all stress but there is a lot you can do to manage stress through increased physical activity, relaxation, planning and organization, problem solving, and improving relationships with others.

5 **Cancer Prevention:** Healthy eating, regular exercise, and other lifestyle factors wi greatly reduce your risk of getting many kinds of cancer. Have regular medical checkups and avoid smoking and other cancer causing behaviors.

<To change the text on these two lines, use the main menu item 'Configure - Sponsor phrases...' and modify the text in the 'Overview Information' box.>

Fitness - Overview

FORTY KPNW

Understanding Your Fitness Report

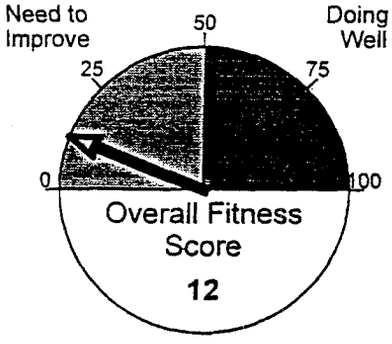
This report is to help you understand:

- How fit you currently are
- What areas may need improving
- How best to improve your fitness level

The indicators of fitness are listed on the graph to the right. You can quickly see how you are doing in each of the fitness areas. A fitness score of 50 or higher is needed for 'Good' fitness.
The rest of the report gives explanations and suggestions for improving your fitness level.

Overall Fitness Score

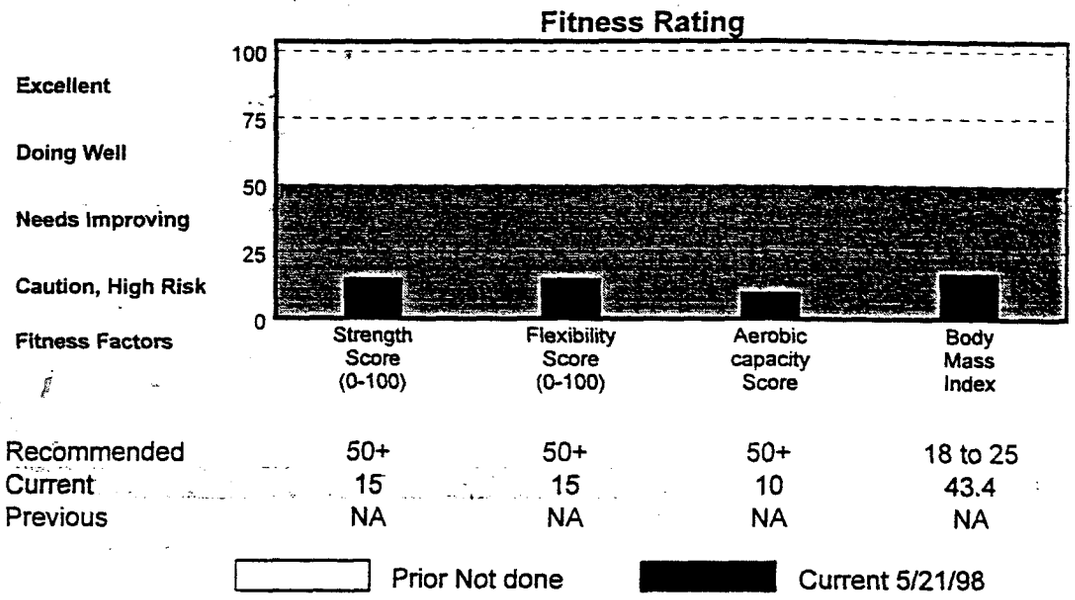
An average of the individual scores is shown in the graph below. Aerobics is weighted 50% and body comp. 25%.



Fitness rating scale

Excellent	75-100
Good	50-74
Need to improve	25-49
Caution	0-24

Your current overall fitness score is 12, "Caution."



Recommendations for Improving Fitness

Explanations and personal recommendations are listed below. Marked ✓ items need special attention. For further help and information, refer to the accompanying fitness guide and/or see a fitness trainer.

✓ **Abdominal strength/endurance** is important for maintaining good posture and protecting the back from strain or injury. Include abdominal strengthening exercises in your fitness program.

✓ **Upper body strength/endurance** exercises are needed to maintain muscle mass, bone mineral content, and strong ligaments and tendons. Without regular exercise they tend to atrophy (weaken). Do more strengthening exercises.

✓ **Flexibility** is important in maintaining full range of motion in joints and for preventing pulled muscles and injuries. Your results indicate a need for more stretching exercises in your fitness program.

✓ **Aerobic capacity** is a measure of cardiovascular fitness. Maintaining a healthy heart and circulation decreases risk of heart disease and increases longevity. You need to improve your aerobic capacity.

✓ **You are over** the weight recommended for good health. A healthy weight decreases the risk for high blood pressure, heart disease, stroke, diabetes, obesity and cancer. To achieve a healthy weight, get regular physical activity (30+ min per day) and choose low fat foods. If you need further help, talk to a nutritionist.

✓ **Caution** - Due to risks marked on your questionnaire, check with your physician before exercising.

Fitness - Exercise Guidelines

FORTY KPNW

Muscle Strength and Endurance

Doing Well ☐ Needs Improving ☑

Muscular strength and endurance are improved by using the overload principle (exercising at a higher level than your muscles are used to). Any overload will result improvement, but higher intensity effort will provide greater improvement. Start at a level that is easy for you to complete and progress gradually. General weight training principles are summarized below:

Activities: Dynamic weight resistance training and calisthenics. Choose 8-10 exercises that train the major muscle groups.

Intensity: Moderate to high resistance, allowing 8-12 repetitions of each activity. Start with 1 set of each exercise. For further improvement, increase gradually to 2-3 sets of each exercise.

Frequency: At least 2 days per week

Safety: Progress gradually as the exercise becomes easier.
Warm-up with easy lifts before making hard lifts.
Avoid excessive straining. Don't ho your breath. Breathe out with exertion.
Get instruction on technique from a fitness trainer if possible.
Work out with a partner.

Flexibility

Doing Well ☐ Needs Improving ☑

Muscles and joints become stiff and lose their range of motion with inactivity and agi You can maintain good joint mobility and improve flexibility with regular stretching exercises. Choose stretching exercises for the major areas of the body; lower back, hi region, the neck and shoulders, calves and backs of thighs. See guidelines below:

Warm-up Do stretching after the muscles are warmed up.

Technique Do a static stretch; slowly stretch a muscle to the point of mild discomfort then hold for 10-30 sec.

Repetitions 3 to 5 for each stretch

Frequency: At least 3 days per week

Safety: Don't over-stretch to the point of pain. Avoid bouncing movements

Avoid stretches that may worsen existing joint problems.

Body Composition

Doing Well ☐ Needs Improving ☑

Body Mass Index (BMI) is a number relating your weight (215 lbs) to your height (59 in). Research shows that people with a BMI of 19-24 live the longest. A high BMI is linked to heart disease and other chronic disease. An elevated BMI may not be a risk is due to a large muscle mass, as in weight lifters.

Body Mass Index: Your BMI is 43.4.

Your recommended weight is 94 - 124. This is based on a normal Body Mass Index of 19 - 25.

Waist/Hip Ratio (WHR) It is also important to know how fat is stored. Abdominal fat is a higher risk to health than fat deposited on the hips. The WHR is a measure of abdomina fat storage. A WHR less than 0.8 is recommended for women. Learn yo WHR.

Fitness - Aerobic Exercise Guidelines

Aerobic or Cardiovascular Fitness

Doing Well ☐ Needs Improving ☑

Aerobic exercises strengthen the heart and improve circulation. Examples of aerobic exercises are fitness walking, aerobic dance, bicycling, swimming, and active sports. Aerobic exercises challenge the heart and arteries to deliver oxygen to the muscles, causing an increased heart rate and heavier breathing.

Activities: Activities that challenge the cardiovascular system (increase heart rate and breathing). For example: fitness walking, jogging, bicycling, swimming, active sports

Intensity: Begin at an easy to moderate level. Don't go so hard you can't talk easily to another person while exercising. Check heart rate and stay within your target heart rate range.

Target heart rate (beats/min)
Recommended 86-104

See your health service provider for details.

Duration: At least 20-30 minutes per day. Work up to 30-60 minutes per day.

Frequency: At least 3 days per week. Work toward daily aerobic activity. Alternate easy with more vigorous exercise days.

Progression: When starting an exercise program, keep intensity moderate. As the exercise becomes easier over time, gradually increase to a more vigorous level for further improvement.

Safety: Get your doctor's clearance before beginning an exercise program if you have any health problems.

Aerobic Mile Activity List

Select a goal:

- ☐ 6 aerobic miles per week
- ☐ 10 aerobic miles per week
- ☐ 15 aerobic miles per week
- ☐ 20 aerobic miles per week
- ☐ ___ aerobic miles per week

Note: For positive changes in body composition and HDL cholesterol levels, complete at least 10-15 aerobic miles per week.

An 'Aerobic Mile' is the energy equivalent of jogging 1 mile. For example, 15 minutes of vigorous swimming is equal to the calories burned in running one mile. Select an aerobic mile goal from the list on the left. Then determine how many minutes are needed of each activity to achieve your weekly aerobic mile goal.

	Minutes of continuous, activity to = 1 aerobic mile		
Aerobic Activity	*Easy Pace*	*Moderate pace*	*Vigorous pace*
Running (11,9,8 min/mi pace)	11	9	8
Bicycling (10,14,16 mph)	15	12	11
Swimming	20	16	15
Racquetball	16	13	12
Hiking	22	18	16
Skating	17	14	12
Tennis	16	13	12
Walking (20,16,14 min/mi)	37	30	27

Note: At your present weight, one aerobic mile will burn 153 calories.

Making Fitness a Lifetime Commitment

Maintaining fitness for a lifetime is the goal. The following suggestions can help you achieve this goal and keep your exercise program fun and interesting.

Realistic goals Choose goals you know you can accomplish. You can revise them later if you desire.

Charting progress Write down your aerobic miles daily. Compare daily progress to your weekly goal.

Social support It helps to exercise with a spouse or friend. You can support and encourage each other.

Rewards When you reach specific milestones, reward yourself. Always be working toward a personal goal.

Heart Health - Overview

FORTY KPNW

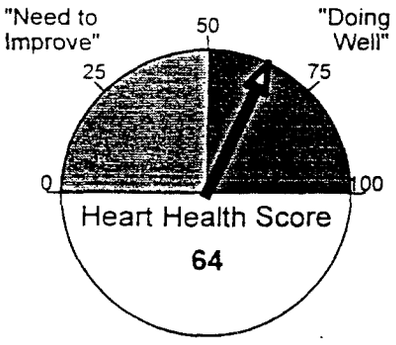
Your Heart Health Report

This report is to help you understand the key areas of your health profile which specifically affect your risk for coronary and circulatory disease.

The controllable risks for heart health are listed on the graph to the right. If improvement is needed, these are the areas on which you will need to focus. In addition to the controllable risks, there are non-controllable risks which are additionally listed under 'Heart Health Factors'. These include personal and family history of heart or circulatory problems, and your gender and age.

Overall Heart Health Score

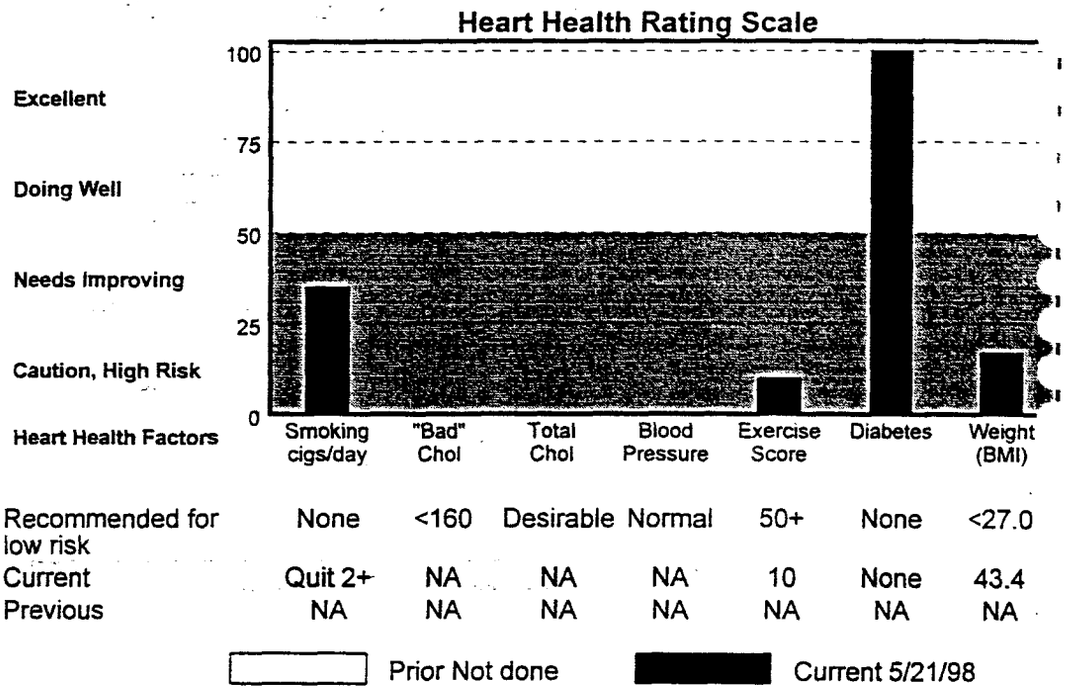
The overall Heart Health score is determined by the number of risk factors present.



Heart Health rating scale

Excellent	75-100
Good	50-74
Need to improve ...	25-49
Caution	0-24

Your current Heart Health score is 64, "Doing well."



Heart Health Factors	Smoking cigs/day	"Bad" Chol	Total Chol	Blood Pressure	Exercise Score	Diabetes	Weight (BMI)
Recommended for low risk	None	<160	Desirable	Normal	50+	None	<27.0
Current	Quit 2+	NA	NA	NA	10	None	43.4
Previous	NA	NA	NA	NA	NA	NA	NA

Prior Not done Current 5/21/98

Heart Health Factors

Factors associated with heart disease are listed below. Your risks are marked with a ✓. Give marked items special attention. Overall, you are at 'Low Risk' based on the criteria established by the National Cholesterol Education Program (NCEP).

- ○ **Personal history** of heart or circulatory problem.
- ○ **Family history** of early heart disease in a first degree relative.
- ✓ **Gender/Age.** Risk increases with age.
- ○ **Non-smoker.** Not smoking greatly reduces risk.
- ○ **High Blood Pressure.** Blood pressure of 140/90 or higher is considered high.
- ○ **High "Bad cholesterol"** A "Bad cholesterol" of 160+ indicates risk. "Bad cholesterol" is calculated as the difference between Total cholesterol and HDL.
- ○ **High Total cholesterol** A Total cholesterol of 200+ indicates risk.
- ○ **Diabetes** increases risk for heart disease.
- ✓ **Sedentary.** Inactivity is a risk. Be active 30 minutes, most days.
- ✓ **Weight** A Body Mass Index (BMI) over 27.0 is a heart risk.

Heart Health - Blood Tests

FORTY KPNW

Cholesterol Level

Doing Well ☐ Needs Improving ☐

A high total cholesterol level can clog arteries, causing a heart attack or stroke. On the other hand, HDL cholesterol is protective. HDL particles remove excess cholesterol, helping prevent blockage of arteries.

Your overall cholesterol risk is best determined by evaluating both "Bad" (LDL) and "Good" (HDL) cholesterol levels.

Your present cholesterol level was not recorded. For ideal risk, keep LDL cholesterol levels below 100 and HDL levels greater than 60.

Blood Test Results and Risk Status

	Your Results	Desirable	Borderline	High Risk
Total cholesterol	NA	less than 200	200 - 239	240+
LDL cholesterol	NA	less than 130	130 - 159	160+
HDL cholesterol	NA	40 or more	less than 40	less than 35
Risk ratio	NA	less than 4.0	4.0 - 4.9	5.0+
Triglycerides	NA	less than 200	200 - 399	400+
Glucose (fasting)	NA	less than 110	110 - 125	126+

To lower total or LDL cholesterol

- ✓ Limit fat intake, especially animal or saturated fat.
- ✓ Avoid high cholesterol foods, such as eggs or meat.
- ✓ Eat high fiber foods, such as oatmeal, brown rice, fruits, vegetables, and legumes (peas, beans, lentils).
- ✓ Achieve and maintain a healthy weight.

To raise HDL cholesterol

- ✓ Achieve and maintain a healthy weight.
- ✓ Get regular, aerobic exercise (walk, cycle, hike, swim, aerobics, active sports, jog) 10-15+ aerobic miles per week.
- • DO NOT SMOKE.
- • Note: women usually have higher HDL levels than men. Estrogen replacement therapy raises HDL levels in post-menopausal women.

Triglycerides

Your results: NA

Doing Well ☐ Needs Improving ☐

Triglyceride is a fancy name for fat in your blood. A triglyceride level less than 200 is recommended (less than 100 is ideal). Your triglyceride level was not recorded.

To lower Triglyceride levels

- ✓ Achieve and maintain a healthy weight.
- ✓ Get regular, aerobic exercise (walk, cycle, hike, swim, aerobics, active sports, jog) 30 min. or more (preferably) daily. ***Be sure to get your doctor's guidance before starting any exercise program if you have any health problem.***
- • Limit intake of sugar and desserts.
- ✓ Avoid or limit alcohol intake.

Glucose

Your results: NA

Doing Well ☐ Needs Improving ☐

A fasting blood glucose level of 110 or above may indicate a glucose tolerance problem, increasing your risk of diabetes. A fasting glucose level of 126+ indicates high risk. Your glucose level was not recorded for evaluation, and you indicate no personal history of diabetes.

To lower Glucose levels

- ✓ Achieve and maintain a healthy weight.
- ✓ Get regular, aerobic exercise (walk, cycle, hike, swim, aerobics, active sports, jog) 30 min. or more (preferably) daily. ***Be sure to get your doctor's guidance before starting any exercise program if you have any health problem.***
- • Limit intake of sugar and desserts.
- ✓ Avoid or limit alcohol intake.

Heart Health - Reducing Risk

FORTY KPNW

Smoking

Your results: Quit 2+

Doing Well ☑ Needs Improving ☐

Smoking damages the heart. It decreases HDL levels, increases the likelihood of a bl clot, and damages the artery walls, causing cholesterol to be deposited, clogging the arteries. By not smoking you are practicing preventive medicine. Also try to avoid smoky environments. Second-hand smoke can also increase your risk.

Stopping smoking was a positive step towards better health! It reduces your risk for lung disease, cancer, and heart disease. After stopping for 10 years, your risk is near the same as a nonsmoker. Maintain your resolve to be smoke free!

Blood Pressure

Your results: NA

Doing Well ☐ Needs Improving ☐

Keeping blood pressure low is protective to the heart and arteries. A pressure of 120/ or lower is ideal. Pressures of 140/90 or above are considered high blood pressure an will increase your risk of heart attack and stroke. Your clinical blood pressure was nc recorded.

How to lower your blood pressure:

- ✓ Achieve/maintain a healthy weight. Even a weight loss of 10 lbs can do wonders.
- ✓ Get regular, moderate, physical activity such as walking.
- ✓ Eat foods low in fat, high in fiber, and adequate in calcium and potassium.
- ✓ Avoid or limit alcohol intake. Alcohol can increase blood pressure.
- Limit intake of salt and salty foods.
- ✓ Keep stress moderate, get adequate sleep (7-8 hrs daily), and take relaxation breaks.

Physical Activity

Your results: Score - 10

Doing Well ☐ Needs Improving ☑

Physical activity is protective to the heart and circulation. Regular aerobic activity improves the way the body uses fats, raises HDL levels, helps lower blood pressure, helps control/prevent high blood sugar levels, decreases clotting tendency and helps control/prevent excess weight. Exercise also strengthens the heart so it works more efficiently. Consider regular exercise as good preventive medicine.

How to exercise for heart health:

Frequency - 3-4 times/wk minimum, daily if possible
Intensity - Recommended Exer. heart rate: 86-104
Time - 20-30 minutes minimum, 30-60 min optimum

- Start at easy level, progress gradually.
- Get doctor's guidance first if health problems exist or age 40+ and not used to vigorous activity.

Examples:

- Walk, hike, climb hills
- Low impact aerobics
- Bike or stationary cycle
- Active gardening (mowi digging, raking leaves)
- Active sports

Body Weight

Your results: BMI 43.4

Doing Well ☐ Needs Improving ☑

Your Body Mass Index (BMI), a measure of your weight (215 lbs) in relation to your height (59 in), is above the upper limit designating overweight (a BMI of 27.0 or 134 lbs for persons your height). Excess body fat increases risk for high blood pressure, h cholesterol and diabetes. Maintaining a healthy weight is protective to the heart and arteries.

How to lose weight:

- Dieting doesn't work. Learn to eat healthy lowfat meals and avoid late snacks.
- Be active; try to get 30+ minutes of moderate to vigorous physical activity daily.
- Avoid excessive stress, get adequate rest, and take time for yourself.

Nutrition - Overview

FORTY KPNW

Understanding Your Report

The purpose of this report is to help you better understand:

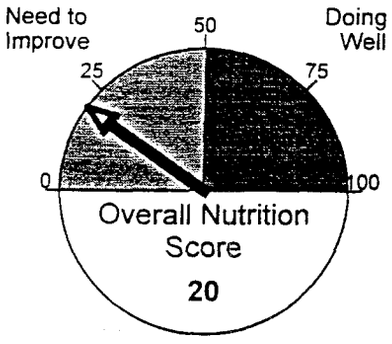
- Your current eating habits,
- Any health risks caused by poor nutrition, and
- How you can improve your eating habits and your health.

Five indicators of good nutrition are listed on the graph to the right. You can quickly see how you are doing in each of these five areas.

The rest of the report gives explanations and suggestions for improving your nutritional status.

Overall Nutrition Score

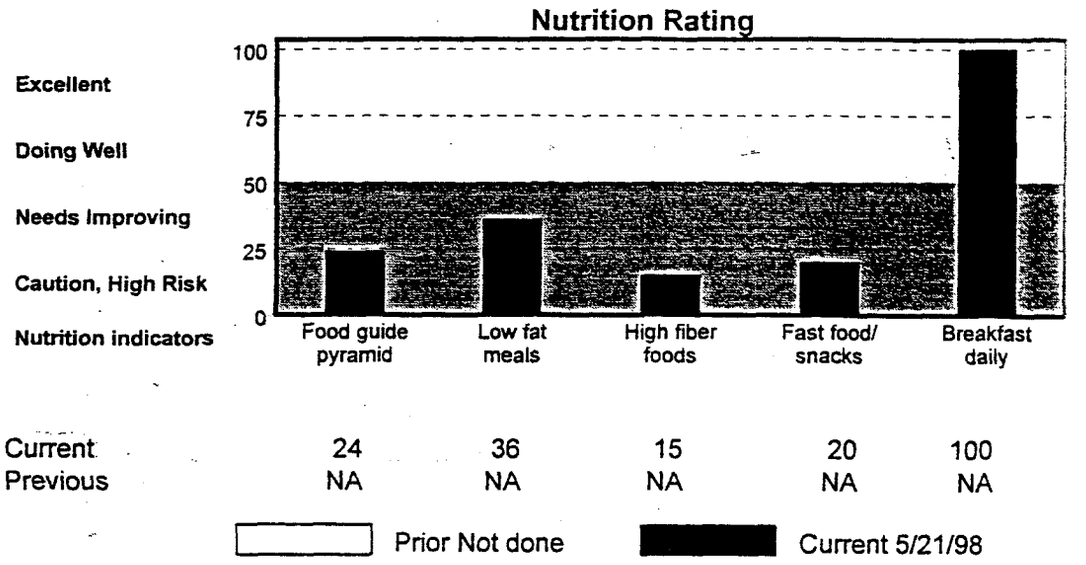
Your overall score is based on your current eating habits. A score over 50 is desirable.



Nutrition rating scale

Excellent	75-100
Good	50-74
Need to improve	25-49
Caution	0-24

Your current overall nutrition score is 20, "Caution."



Recommendations Marked ✓ items show need for improvement.

✓ **Food pyramid score -** You did not meet all of the guidelines in the food guide pyramid. Review the minimum recommended number of servings for each food group to help assure your nutrition is balanced and adequate. See the rest of the report for more information and how to make improvements.

✓ **Low fat eating -** Limit foods high in fat, especially animal or saturated fats. They increase the risk of obesity, high blood pressure, heart disease, stroke, and diabetes. Use fat free or low-fat milk and dairy products. If you eat meat, limit the amount and choose lean cuts, skinless chicken, and fish. Also limit high fat baked goods, fried foods, salad dressings, butter, and fats and oils used in cooking.

✓ **High fiber foods -** are low in fat and help protect against obesity, high blood pressure, heart disease, stroke, and certain cancers. Examples are: fruit, vegetables, potatoes, peas and beans, whole grain breads and cereals. Eat more of these foods.

Breakfast - Continue eating breakfast for body and mind to perform their best. People who skip breakfast have more accidents, don't learn as well, usually snack on less nourishing food, and don't live as long as those who eat breakfast daily.

✓ **Fast foods/snacking -** Most fast foods and snacks are high in fat and calories and low in nutrition. Limit typical snacks such as chips, pastry, and soft drink. If you snack, choose fresh fruits, veggies, breads, and other healthy choices.

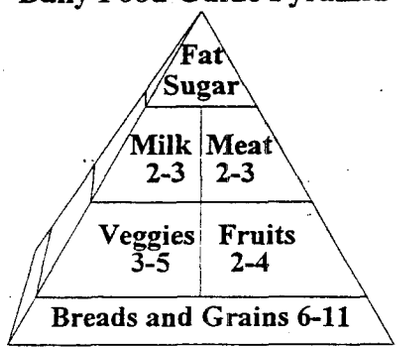
✓ **Other nutritional recommendations:**
None. Review the rest of this report and the accompanying nutrition educational materials for further information.

Nutrition - Food Guide

FORTY KPNW

The USDA and USDHHS have developed a national food guidance system, the "Food Guide Pyramid." It provides a daily eating plan, summarized below. It can help you evaluate your current eating habits and point ways to better nutrition.

Daily Food Guide Pyramid



The major portion of your diet should come from foods near the foundation of the pyramid. Limit foods near the top.

Bread Group	0.0 serv/day	6-11	5.1	1 slice of bread 1 oz. dry cereal 1/2 C ckd rice, pasta
Vegetables	1.0 serv/day	3-5	2.0	1 C raw vegetables 1/2 C ckd or chopped 3/4 C veg. juice
Fruits	0.0 serv/day	2-4	1.0	1 medium fruit 1/2 C ckd or chopped 3/4 C fruit juice
Milk group	1.0 serv/day	2-3	1.3	1 C milk or yogurt 1.5 oz. natural cheese 2 oz. process cheese
Meat/protein foods	0.0 serv/day	2-3	2.2	2-3 oz. cooked meat 1 egg, 3 oz. tofu 1 C ckd beans
Fats, oils	0.0 serv/day	1-2 serv/day	3.5	Oil, butter 1T, salad dressing or cream 2T
Sweets	1.0 serv/day	1-2 serv/day	3.5	1 cookie, 1/2 C sherbet soft drink, 1T jam

† Recommended servings: The lower range is for older adults or sedentary women. The upper range is for teenage boys, active men and very active women. Children and other persons fall somewhere in the middle of the range.

Breads and Cereals

Doing Well ☐ Needs Improving ☑

Choose whole-grain breads and cereals. Grains provide complex carbohydrates and are good sources of fiber, vitamins, minerals, and are low in fat. Grain products should provide the largest share of your food calories.

Vegetables

Doing Well ☐ Needs Improving ☑

Vegetables are mostly fat free, very low in calories, and protective against heart disease and cancer. Dark, leafy green vegetables are especially nutritious. Eat 3-5 servings daily.

Fruits

Doing Well ☐ Needs Improving ☑

Fruits add flavor and variety to meals, are low in fat and calories, and are protective against heart disease and cancer. Eat 2-4 servings daily, including fruits high in vitamin C (e.g. citrus, melons, berries).

Milk Group

Doing Well ☐ Needs Improving ☑

Choose calcium rich foods such as non-fat or low-fat milk, yogurt, and cheeses. A low calcium intake can contribute to weak, brittle bones. If you don't drink milk, find an adequate replacement. Two servings per day are recommended.

Protein Group

Doing Well ☐ Needs Improving ☑

Eat 2-3 servings per day. Choose from low fat meats (lean cuts, skinless fowl, and fish) legumes (peas, beans, garbonzoes, lentils, split peas), tofu, and meat alternates. Vegetarian proteins are low in fat, cholesterol free, and are high in fiber.

Fat & Sugar Group

Doing Well ☑ Needs Improving ☐

Congratulations! Continue to go easy on foods with added fats and sugar, and rich desserts that are high in calories and low in nutrients. Eat sparingly of typical desserts (cookies, cake, pastry, pies, ice cream), especially if you're overweight. You can eat more low calorie desserts; fruit salad, non-fat frozen yogurt, berries, and melons.

Body Composition - Overview

FORTY KPNW

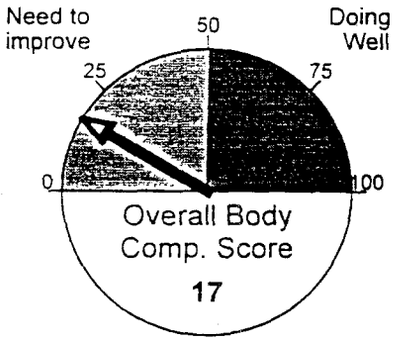
A Healthy Weight

Research has found that a body weight within the desired range for a person's height is predictive for health and longevity. Your recommended weight is based on this relationship. By keeping weight in control you help prevent high blood pressure, heart disease, stroke, and certain cancers.

Your body composition measurements are shown in the graph on the right. Each factor is rated from **"Excellent** to **High Risk"**. Your overall risk is shown in the circle graph below and is rated from 0 to 100. A high score is desirable.

Overall Body Comp. Score

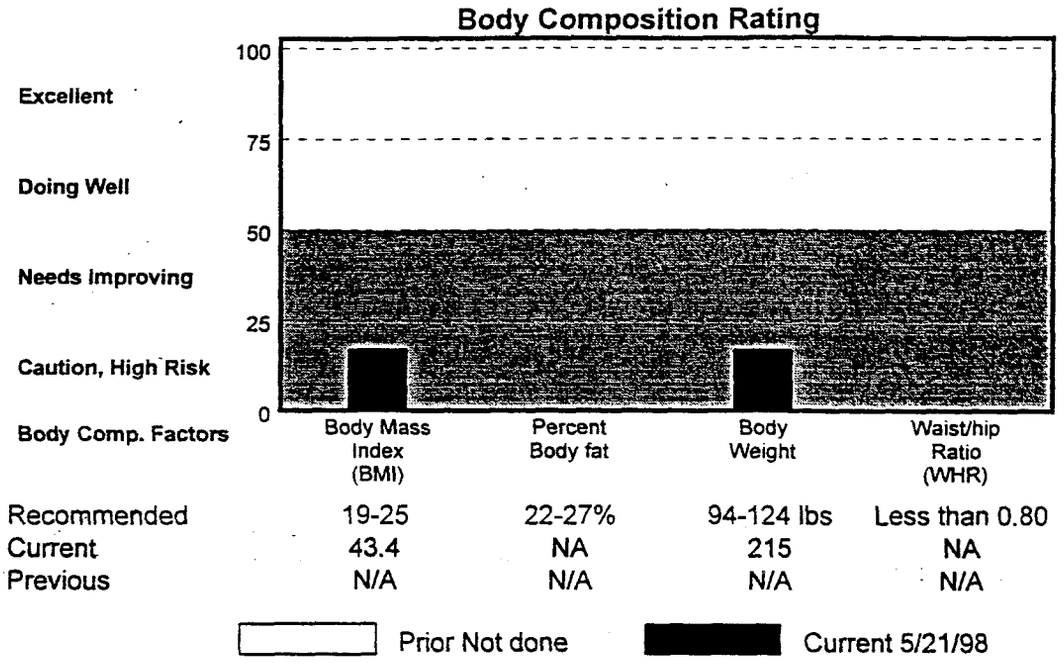
Your overall score is a weighted average of the individual scores shown in the graph above.



Overall score rating scale

Excellent	75-100
Doing Well	50-74
Need to improve	25-49
Caution (high risk)	0-24

Your current overall body comp. score is 17, "Caution."



	Body Mass Index (BMI)	Percent Body fat	Body Weight	Waist/hip Ratio (WHR)
Recommended	19-25	22-27%	94-124 lbs	Less than 0.80
Current	43.4	NA	215	NA
Previous	N/A	N/A	N/A	N/A

Prior Not done Current 5/21/98

Evaluation/Recommendations

Marked ✓ items show personal risk. For further information, refer to the accompanying educational guide and/or talk to your health counselor.

✓ **Body mass index (BMI)** BMI is a number relating your weight (215 lbs) to your height (59 in). It is often used in health studies. Research indicates that people with a BMI of 19-24 live the longest. Your current BMI is 43.4.

A BMI of 27.0 or higher, for women, is linked to increased risks for heart disease, diabetes, high blood pressure, stroke, and arthritis. A high BMI, however, may not be a risk if it's due to high muscle mass. This is common in bodybuilders.

✓ **Body weight** Use the chart below to help you evaluate your present weight (all recommended values based on persons your height and gender):

- Recommended weight (based on BMI of 19-25) = 94-124 lbs.
  Note: thin build persons should be near lower range, large frame/muscular build near top of range, and medium build near middle of range.
- Overweight standard (BMI of 27.0 or higher) = 134 lbs or higher.
- Your present weight = 215. Consider a weight management program.

✓ **Waist/Hip ratio (WHR)** A WHR measurement shows how fat is distributed on the body. A high WHR (greater than 0.80 for women) is linked to increased risk of diabetes, heart disease, and certain cancers. To determine your WHR, measure your waist at the level of the naval, and your hips where they are the largest. Then, divide your waist measurement by your hip measurement.

Substance Use - Overview

FORTY KPNW

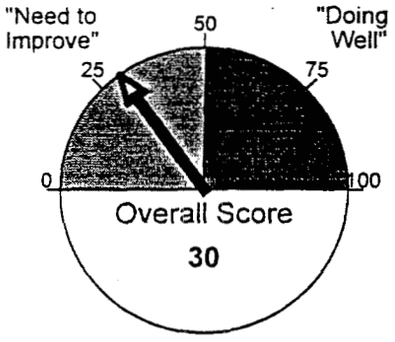
Understanding Your Substance Use Report

This profile is based on your answers to the Alcohol, Drugs and Smoking questions. Examine your profile and review the recommendations regarding careful use or avoidance of certain chemical substances. If needed, get help from your physician or health counselor in making lifestyle changes.

Areas of major concern are: Heavy use of alcohol, tobacco use, exposure to second-hand smoke, high caffeine intake, use of mood altering drugs, and drug interactions.

Overall Substance Use Score

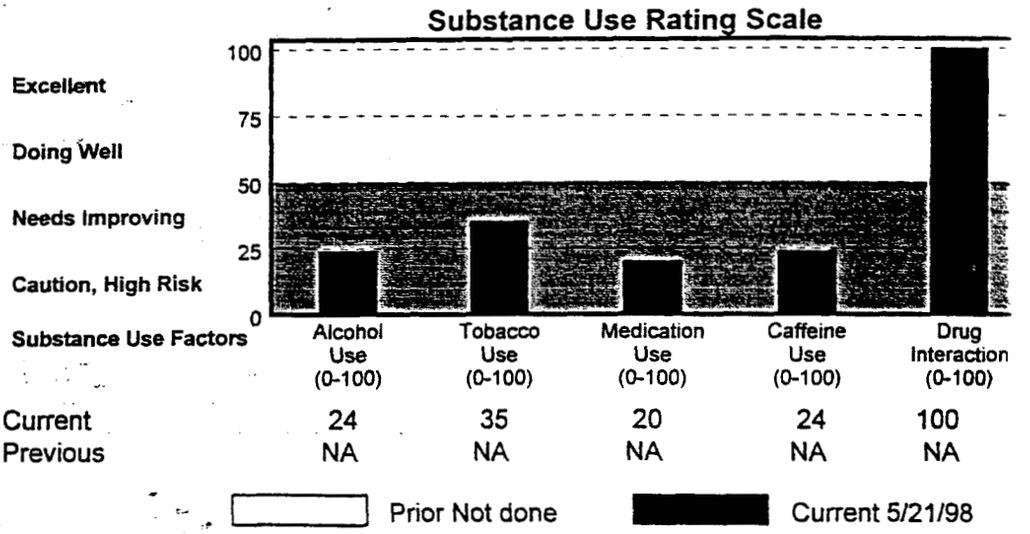
The overall substance use score is a weighted average of the individual scores shown in the graph.



Overall score rating scale

Excellent	75-100
Doing Well	50-74
Need to improve	25-49
Caution (high risk)	0-24

Your current overall substance use score is 30, "Needs Improving."



Recommendations

The following recommendations are guidelines from leading national health organizations. Items marked ✓ show need for special attention.

✓ **Alcohol** - Alcohol use is linked to liver disease, certain cancers, accidents, addictic social problems, and is the second primary cause of hospitalization. The USDA Dietary Guidelines on alcohol state that if an adult drinks, do so in moderation, it should be no more than 1 drink per day, with meals, and when consumption does n put them or others at risk.

Some people should not drink: women who are pregnant or trying to conceive, people who plan to drive or operate equipment, people taking medication, those wl can't keep their drinking moderate, and children and adolescents.

✓ **Tobacco** - Smokeless tobacco is addicting and causes serious risk for mouth and throat cancers. Give serious thought to being tobacco free.

✓ **Medications** - Medications are needed at times but if misused can cause serious problems. Taking drugs on a regular basis to relax, sleep, or alter your mood, can lead to a serious habit or dependency. Avoid street drugs and use all other medications as directed by your doctor.

✓ **Caffeine** - Caffeine free drinks are best for your health. Excessive caffeine intake has been associated with sleep disturbances and nervousness. Limit use of caffeinated drinks such as coffee, tea, and colas, to less than four per day.

Drug Interactions - Continue to prevent dangerous drug interactions when gettin new medicines by always informing your doctor of all medicines you are taking an avoid alcohol while taking them.

Stress/Coping - Overview

FORTY KPNW

Understanding Your Stress Report

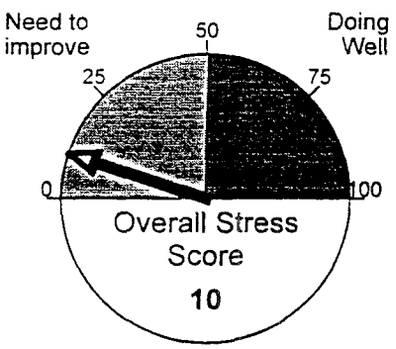
The purpose of this report is to help you better understand:

- How you are coping with stress
- If signs of excess stress are present
- And how you can improve your coping ability

Four indicators of stress and coping are listed on the graph to the right. You can quickly see how you are doing in each of these areas. The rest of the report gives explanations and suggestions for improving your coping ability.

Overall Stress Score

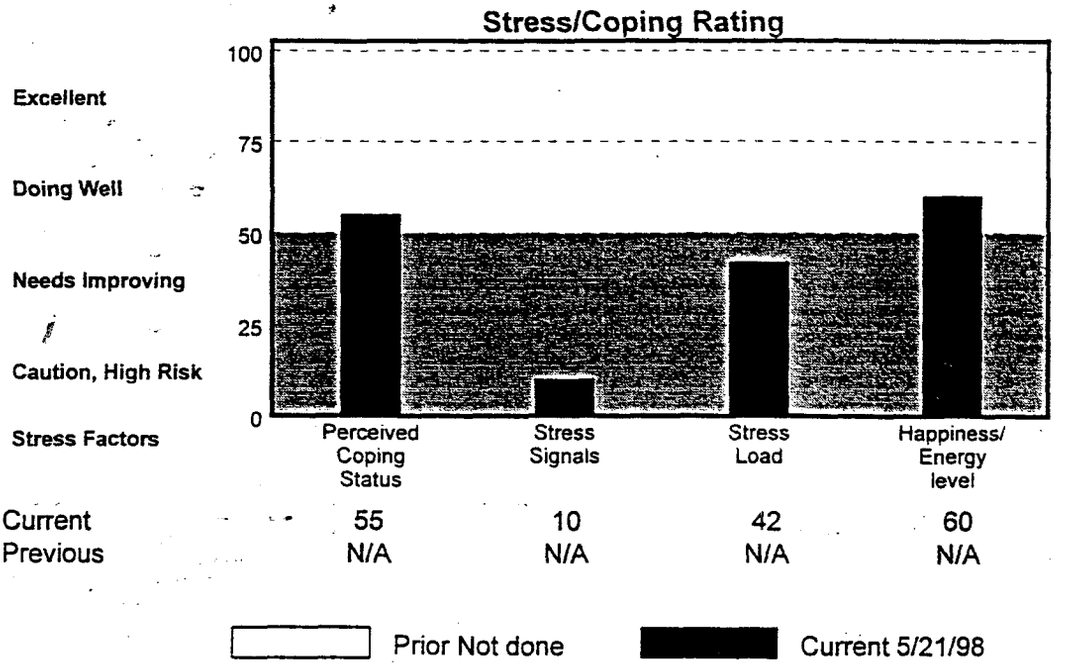
Your overall stress score is based on the average of the major stress ratings and specific stress indicators.



Overall score rating scale

Excellent	75-100
Doing Well	50-74
Need to improve	25-49
Caution (high risk)	0-24

Your current overall stress score is 10, "Caution."



Recommendations for Coping with Stress

The following explanations and recommendations can help you see where to make improvements. Items marked ✓ show need for special attention. For further help and information, refer to the accompanying stress management guide and/or a counselor.

Perceived coping status - You feel confident that you are handling stress in your every day life very well. That's great! Maintain your good coping status by balancing life's demands with adequate time for rest and recreation.

✓ **Stress signals** - Stress can gradually build up until it becomes difficult to cope. Be aware of stress signals such as: constant worry, low energy, and lack of enjoyment in life. Take action to reduce stress. Get help from an understanding friend or counselor if needed.

✓ **Stress load** - There are numerous factors in life that cause stress. You indicate several stressors in your life. Take the time to develop good relationships, solve problems, and get help when needed. Attend to stressful situations before they affect your health.

Overall happiness/energy level - Having a positive attitude and confidence in yourself is a healthy approach to life. Both physical and emotional health are related to good stress management. Keep up the positive approach to life!

Coping with life is easier when you get adequate rest, daily physical activity, and take time to relax (listen to music, walk in the park, talk to a friend, enjoy a hobby).

✓ You marked "recently thought about ending my life." Get help immediately, from your doctor, counselor, or friend. Do not wait.

Safety - Overview

FORTY KPNW

Understanding Your Safety Report

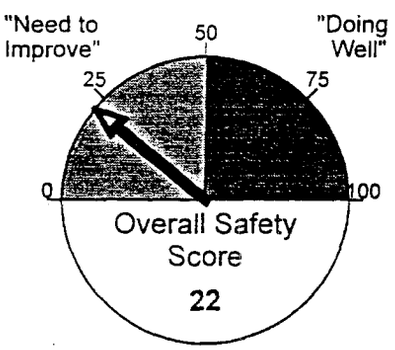
This profile is based on your answers to the safety questions. Many factors influence our health on a daily basis. Habits that promote a safe environment may have the greatest immediate impact on your quality of life. Why? Because-

- Accidents are a leading cause of death and disability.
- Accidents are a major cause of lost work time.

This profile rates your responses to major safety issues. Recommendations are provided to help you in making good safety related decisions.

Overall Safety Score

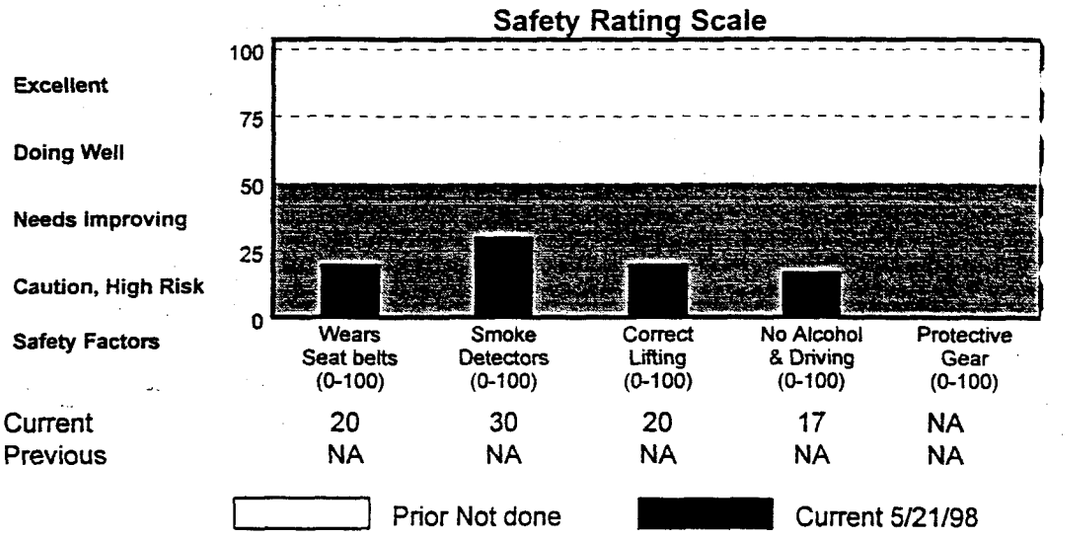
The overall safety score is based on the number of good safety factors appearing in the safety rating scale.



Safety Rating scale

Excellent	75-100
Doing Well	50-74
Needs Improving	25-49
Caution, High risk	0-24

Your current overall safety score is 22, "Caution."



Recommendations for Improving Safety

The following explanations and recommendations can help you see where to make improvements. Items marked ✓ show need for special attention.

✓ **Wear Seat Belts** - Wearing seat belts reduces risk of serious injury and death. In many states it's the law. Make a practice to always belt up.

✓ **Use Smoke Detectors** - Smoke detectors have saved thousands of lives. Be sure you have working smoke detectors in all sleeping areas of your home. Check them at least once a month. Most deaths from home fires involve houses without working smoke detectors.

✓ **Do Correct Lifting** - Always use correct lifting technique to protect your back. When lifting heavy objects, bend and lift with your legs, not your back. Keep your back straight, maintaining the normal curve. Hold the heavy object close to your body. If you need to turn, use your legs. Don't twist your back while lifting.

✓ **No Alcohol and Driving** - Drinking and driving kills over 20,000 people a year in North America alone. If you do drink, never drink and drive. It takes the liver about one hour to clear the alcohol from one drink out of the blood. Allow an hour before driving for every drink, or call a cab. Look out for your friends who may drink and encourage them to do the same. You may save the life of a friend.

Health Age - Overview

FORTY KPNW

Health Age

The effect of health practices on longevity is demonstrated by a 15 year study of more than 6,900 people. Researchers found 7 basic health habits that were good predictors of how long people lived.

Persons following 6 or 7 of the good health practices lived 7 to 12 years longer than those following fewer than 4.

Your health practices are compared to this study to determine how healthy you are and project your "Health Age."

Good health Practices Rating (0-7)

Health Age - Your health age is 50.7. This is your "true body age" based on present health practices.

Achievable age - Your achievable age is 42.2. This means you could add 8.5 years to your life expectancy.

Review the health practices listed on the right for ways to improve your health. Marked items ✓ need special attention.

Doing Well	Need to Improve	Good Health Practices
✓		Not smoking
	✓	Regular, aerobic exercise, at least 30 min, 3+ times/week
	✓	Alcohol, none or moderate use
	✓	Adequate sleep, 7-8 hours per night, most nights
	✓	Recommended desirable weight, 94-124, based on BMI.
✓		Eat a good breakfast every morning, or most mornings
	✓	Avoid frequent snacking on typical snacks

Recommendations: Marked "✓" items need improving

Smoking - Congratulations on being a non-smoker! Non-smokers, on the average, live 10-12 years longer than those who continue to smoke. Politely encourage family and friends not to smoke, as well.

✓ **Activity** - Every body needs regular physical activity: brisk walking, cycling, swimming, aerobics, or active sports. At least 30 minutes of moderate aerobic activity, 3 or more times per week is needed for optimum health.

✓ **Alcohol** - Drinking can lead to serious health problems: liver disease, cancer, high blood pressure, accidents, and alcohol dependency. If you choose to drink, do so in moderation and don't drive after drinking.

✓ **Sleep** - You need more sleep. People who get 7-8 hours of sleep daily have lower death rates than those who sleep less. Adequate rest improves physical and emotional health.

✓ **Weight** - Your reported weight is above the desirable range. A healthy weight can help you look and feel your best. Achieve a healthy weight, eat low fat foods, be physically active, and avoid late night meals.

Breakfast - Continue eating breakfast! People who eat breakfast daily live longer than those who don't. Healthy breakfast choices include: fruit and fruit juices, whole-grain breads and cereals, and low fat milk.

✓ **Snacking** - Frequent snacking on "junk foods:" chips, pastry, colas, and other high fat/high calorie foods, provides excess fat, calories, salt, and sugar, but little nutrition. If you snack, choose fresh fruits and veggies.

Cancer Risk - Overview

FORTY KPNW

Reducing Cancer Risks

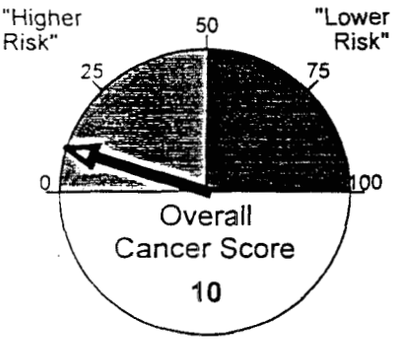
- Become aware of any cancer risks you may have.
- Learn how to change the most important risk factors, and
- Learn prevention guidelines and early detection.

Cancer Risk Categories:
Family history
Dietary factors
Smoking status
Other life-style factors

These categories are shown to the right and are rated from **"Excellent"** to **"Caution"**. Your overall cancer risk is shown in the circle graph below. A score of 50 or higher is desirable.

Overall Cancer Score

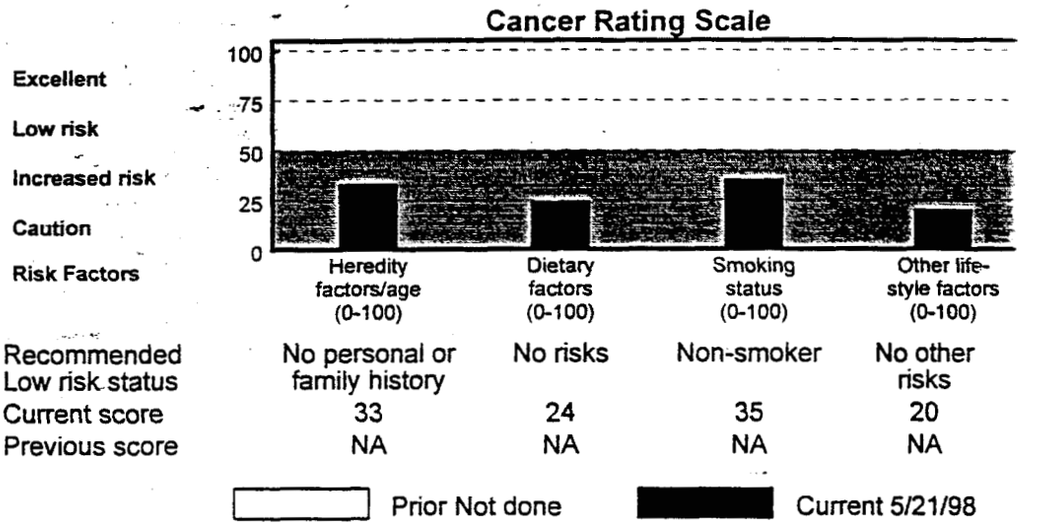
Your overall score is based on the number and importance of cancer risk factors present.



Cancer Risk Rating Scale

Excellent	75-100
Low Risk	50-74
Increased Risk	25-49
Caution	0-24

Your current overall cancer score is 10, "Caution."



Recommendations Marked items ✓ need improving or attention.

✓ **Hereditary factors and age**
- ☑ You report a family history of colorectal cancer, breast cancer and ovarian canc
- ☑ Age is a factor we cannot control. Be alert to cancer prevention issues.
- ☑ You report a personal history of bowel polyps, skin cancer and other cancer.

✓ **Dietary factors**
- ☑ Foods rich in dietary fiber, such as whole grains, fruits and vegetables, protect against colon cancer and possibly breast cancer. Look for ways to include more these foods in your diet.
- ☑ Dietary fat has been related to increased risk of colon cancer; a common cancer Choose low fat foods and reduce added fats, such as butter or margarine with yo meals.
- ☑ Fruits and vegetables contain many protective elements called phytonutrients. H at least 5 fruits and vegetables daily.

✓ **Smoking**
- ☐ Remain a non-smoker. The longer you do, the lower your risk for the many cancers caused from using tobacco.
- ☑ Use of snuff or chewing tobacco greatly increases your risk of oral cancer.

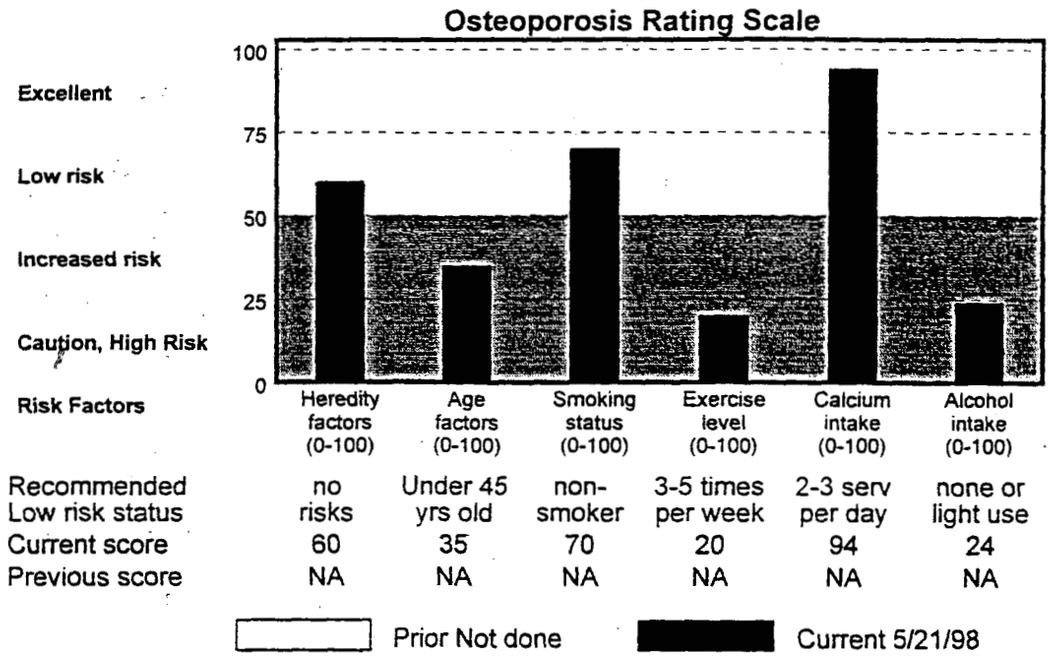
✓ **Other lifestyle factors**
- ☑ Alcohol is a cancer promoter. Limit intake to no more than 1 any one day.
- ☑ Exposure to certain viruses transmitted in sexual contact increases risk. Follow "safe" sexual practices and avoid multiple sex partners.
- ☑ Regular exercise has been shown to reduce cancer death even with other risks present. Begin a regular activity or exercise routine, 3 or more times per week.
- ☐ Sun/ultraviolet exposure can lead to skin cancer. Continue to wear protective clothing and sunblock when outside for extended periods of time.
- ☑ Cancer Warning Signs - see Medical Follow-Up section.
- ☑ Perform cancer screening exams as outlined in Medical Follow-Up / Preventive Exams section.
- ☑ Body weight score is outside of desired range. This increases your risk. Choose lifestyle practices that help improve your body composition.

This report is designed to help you:

- Understand osteoporosis
- Identify risks you may have
- Determine how to prevent osteoporosis from developing

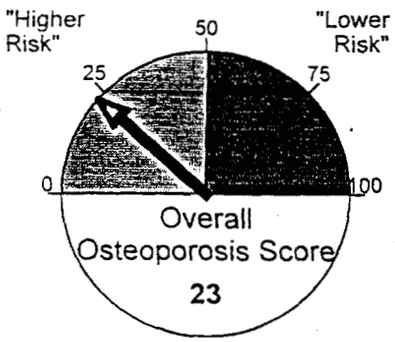
The risk factors for osteoporosis are listed on the graph to the right and are rated from **"Excellent"** to **"High risk"**. Your overall risk is shown in the circle graph below and is rated from 0 to 100; a high score is desirable. A score of 50 or higher is needed to achieve a rating of "Low Risk."

The rest of the report gives explanations and suggestions for improving and/or maintaining bone strength.



Osteoporosis Score

Your osteoporosis score is based on the number and importance of risk factors present.



Osteoporosis rating scale

Excellent	75-100
Low Risk	50-74
Increased Risk	25-49
Caution (high risk)	0-24

Your current overall score for osteoporosis is 23, "Caution (high risk)."

Recommendations for Improving Bone Health

Marked items ✓ show personal risk. For further information, refer to the accompanying educational guide and/or talk to your doctor.

Hereditary factors - There are four hereditary factors that affect risk:
Women are at higher risk (4 out of 5 people with osteoporosis are women).
A family history of osteoporosis puts you at higher risk.
Small boned persons are at higher risk.
Caucasian and Asian women are at higher risk than other races.

✓ **Age/menopause** - Age is the most important determinant of bone density. The older you are, the higher your risk. Peak bone density is between 25-35 years of age. Menopause increases bone loss, especially the first few years after menopause. Being excessively lean increases risk, especially if not menstruating.

Smoking - Congratulations for not smoking. Smoking can be toxic to bone cells and can reduce absorption of calcium.

✓ **Inactivity** accelerates bone loss. On the other hand, weight bearing exercises help maintain strong bones and increase bone density. Examples include: aerobics, walking, jogging, dancing, weight training, and active sports.

Dietary factors - Adequate calcium is essential for strong bones; 1,000 mg of calcium per day is recommended. Eat 2-3 servings of high calcium foods daily, e.g. low-fat milk, yogurt, cheese, broccoli, greens, and firm tofu. Get adequate sunshine or vitamin D in fortified milk or in a supplement. Keep intake of protein moderate. High intakes cause calcium loss in the urine.

✓ **Alcohol** - Because alcohol affects bone formation, limit intake to recommended levels.

Medical Follow-Up

FORTY KPNW

Symptoms of Medical Problems

The following items (identified from your symptoms) are medical problems that should be discussed with your physician:

- ☑Chest pain or discomfort, or frequent palpitations or fluttering in the heart
- ☑Unusual shortness of breath
- ☑Unexplained dizziness or fainting
- ☑Ankle edema (swelling from retained fluids)
- ☑Temporary sensation of numbness or tingling, paralysis, vision problem, or lightheadedness
- ☑Significant, unexplained weight loss of 10 or more pounds
- ☑I've recently thought about ending my life. Get help immediately.

Screening Results

The following test results are in the high risk area and need further evaluation and attention by your physician.

You have no high risk areas that can be associated to any test results you have listed on your questionnaire.

Preventive Exams

The following exams are recommended for persons your age and gender. Checked ☑ items need attention.

Note: Persons with certain conditions may need more frequent exams. Follow your doctor's advice.

- ☑Physical exam, every 1-3 years, yearly after age 65
- ☑Cholesterol check, every 1-3 years
- ☑Blood pressure check, every 1-2 years
- ☑Dental exams, regularly
- ☐Vision screening, as needed
- ☐Hearing screen, periodically as needed
- ☑Monthly self breast exam
- ☑Mammogram, every 1-2 years with annual clinical breast exam
- ☑PAP smear, every 1-3 years
- ☑Immunizations, Rubella, check with MD

5 Leading Causes of Death, Persons 25-64

If you know your leading health hazards, take steps to minimize your risk.)

1. Cancer
2. Heart disease
3. Motor vehicle and other accidents
4. Human immunodeficiency virus (HIV) infection (AIDS)
5. Suicide and homicide

MALE LAW ENFORCEMENT OFFICERS' AND THEIR SPOUSES PERCEPTIONS TO POST-SHOOTING REACTIONS

The purpose of the study was to examine what symptoms spouses perceive in the officer following a critical incident and how close those perceptions are to the officer's self-report. Because it is believed that law enforcement officers tend to deny feelings and symptoms, the question was -- would spouses report more symptoms than officers?

A 37-item questionnaire was prepared for 30 married couples, the questionnaire had items describing stress symptoms typicaliy experienced after a critical incident. It was divided into six scales:

The Blunted Affect and Withdrawal Scale assessed the expression of feelings within the family and communication.

Th Depression Scale assessed feelings of sadness and disappointment.

The Anger and Aggression Scale assessed over expression of rage within the family.

The Anxiety Scale assessed tension and worry.

The Sexual Function Scale assessed interest in sexual activity.

The Coping Mechanisms Scale assessed overindulgence of food, alcohol or non-presciption drugs.

The group comparisons showed that the officers and spouses viewed the effects of the critical incident similarly. However, if the mean averages are looked at for just the spouses responses, it shows a consistent tendency for the wives to report more symptoms on every scale. This implies that although the officers reported little distress, their wives perceived them experiencing considerable distress. The research indicates that the spouses not only experience their own fears and anxieties but worry about their husbands'. As a result the spouses perceive greater stress than the officers experience.

Future research to take this a step further is to do the same comparisons on how the officer perceives the spouse's reaction to critical incidents.

05-11-98

HOME

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Feedback

Group offers insight into unique world of police work

The newly formed P.P.B. Roses helps spouses of Portland officers cope with the job's strains, stresses and dangers

By Maxine Bernstein of The Oregonian staff

The pain Heidi Nice felt when Portland police Officer Thomas Jeffries was killed in a shooting was com pounded when her husband, a fellow officer, sought the support of his co-workers and instead of her.

õwindowl;1300,3400,4."He didn't want to sit with me at the funeral. He wanted to sit with other officers," she said. "For the first time, Kyle didn't let me be part of his job. I realized I needed to grieve with someone, too."

Liz Schober, the wife of another Port land officer, said the stress from his career nearly destroyed their marriage. She said her husband, Eric, would come home from his police shift grumpy and callous. At the time, she took it per sonally, not realizing other spouses of offi cers were dealing with similar problems.

The experiences of Nice and Schober were among the cata lysts that led to the creation of a new sup port group for spouses and families of Port land cops. The two women are among seven spouses who recently started P.P.B. Roses, or Portland Police Bureau Rein forcing Officers' Spouses through Education and Sup port.

"The police bureau has always talked about it being a big family. But it's always been just the police officers

who are part of that," said Alice Edgecomb, whose husband, Andy, has been a Portland officer for five years. "We're just trying to include the entire family and let them all know we're in this together. We decided that we needed support every day -- not only in tragedies."

Throughout the country, similar groups are popping up through informal gatherings, and spouses of police are swapping information via the Internet on everything from police benefits to survival tips for the "rookie spouse."

Nancy Ford, the wife of an officer in Vancouver, Wash., set up her own Web page, called Partners Off Duty. Lisa Clark of Tecumseh, Mich., writes a bimonthly newsletter on the Web called "Beside the Badge." And Sue Woods of Texas edits a newsletter, "Spouses of Police Officers -- Helping Law Enforcement Families Succeed."

"If a police officer doesn't have a healthy family life, it will affect their job performance," Ford said. "So, this is not only to help the family but the officer as well."

The unique strains, stresses and dangers of a law enforcement career and how they affect the officer's family are not fully understood by people with no ties to public safety work, police psychologist Alexis Artwohlsaid.

The new support group will enable spouses to gripe collectively about officers' long hours, night shifts and middle-of-the-night emergency call-backs. More important, it will provide them with some solace that they are not alone in coping with these challenges.

"There's a lot to deal with when you're married to a police officer," said Robin Georgioff, the wife of Portland officer Mark Georgioff. "This just lets people see there's a lot of other spouses out there facing some of the same difficulties and joys."

The pains and pitfalls of police work were not a topic that police historically spoke openly about, said Officer Robert King, who runs the Portland police Employee Assistance Program.

Some police departments set up their own spousal support groups as they began to recognize the need to provide support for officers, not only on the job but in

their home lives, King said.

In Portland, police auxiliary groups existed in the past, but they were largely social organizations. About three years ago, the bureau eliminated its full-time police chaplain and about a year ago began an Employee Assistance Program. With King's guidance, the bureau has started offering an "emotional survival" course for officers, which will extend to spouses and relatives within the next year.

It was during a candlelight vigil for slain officer Jeffries in the fall that the idea for P.P.B. Roses was born. John Elms, a Portland police chaplain volunteer, said a number of officers' spouses disturbed by the death approached him at the vigil, seeking some guidance. He suggested they form a support group. Seven women began meeting in the fall and held their first event in late April, bringing in Artwohl to talk about "everything police couples wanted to know about stress but were afraid to ask."

Georgioff, who hardly knew Jeffries, said she was surprised by how deeply his death disturbed her. His death was followed six months later by the fatal shooting of Officer Colleen Waibel.

"Tom's death just totally shattered any sense of security I had. That was the first time in my husband's career that I realized my husband could die," she said. "Now, every night before I go to bed, I check to see if the ringer on the phone is on. I never did that before."

P.P.B. Roses is not only for wives but for husbands of women officers, significant others, relatives and the officers themselves. The group plans to hold regular meetings, invite guest speakers and hold social gatherings as well.

Eric Schober, a Portland officer for nine years, said he welcomes the new group and is pleased his wife is involved.

"There hasn't been a lot of communication with officers or their spouses about what this occupation is like. It's a very consuming job," he said.

Schober separated from his wife for a year, largely because of fallout from his job.

"I changed. How we related to each other changed," he said. "The last thing I wanted to do after dealing with problems all day long was talk out problems with my wife and end up in another stressful situation. I just wanted to relax when I came home."

Some officers tend to view "everybody as the bad guy," including their spouse at the end of a work day, Artwohl said. Some officers experience an "adrenalin dump," finding life at home a disappointing bore after leaving the fast-paced street action on the job.

Liz Schober said she noticed all these signs in Eric.

"If we would have had some education on this, it could have helped me to understand why he was acting the way he was and maybe not take it so personally," she said.

The Schobers are back together but feel they have much more to learn and share with other police couples.

"This is probably something that was needed a long time ago," Eric Schober said.

Mark Georgioff, a Portland cop for 4 years, agrees.

"Ten years ago, this probably would never have happened," he said. "There was too much pride, too much internalization to admit that it was needed."

The P.P.B. Roses will mark National Police Awareness Week by sponsoring a candlelight vigil at 8 p.m. Tuesday at the Police Memorial in Portland to honor city officers who have fallen in the line of duty. The memorial is at 1400 S.W. Front Ave.

Maxine Bernstein covers the Portland Police Bureau for The Oregonian's Crime, Justice and Public Safety Team. She can be reached by phone at 221-8212, by mail at 1320 S.W. Broadway, Portland, Ore. 97201, or by e-mail at maxinebernstein@news.oregonian.com

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CISM Conference in Chelan, Washington Nov 4 - 7, 1999

Basic CISM

- Pre incident education
- On scene support teams
- Peer support (individual consults)
- Defusing
- Demobilization
- CISD
- Specialty debriefs (any group that considers themselves different from the rank and file ie START)
- Family support/interventions
- Follow-up services - EAP
- Mental health referral services
- Community assistance

CISM must be comprehensive

Not a stand alone
Utilize peers along with an EAP program
All volunteers should be from the same culture

Defusing Model - small group rapid intervention within hours of incident

- Introduction - purpose, guidelines, what will happen
- Exploration - describing what happened, assessing for additional intervention
- Information - summarize, normalize, educate

Never held on scene, neutral location, conducted by CISM peers, no MHP necessary

Debriefing Model - held 24 - 72 hours after incident - often used for larger incidents with more participants

- Introduction - set the tone, guidelines, what to expect
- Fact - ask what happened (what did they see, hear, smell)
- Thought - what was your first thought
- Reaction - what was the worst part
- Symptom - what are you experiencing

- Teaching - explaining what is happening specific to the symptoms described and how to care for self
- Re-entry - summarizing "You are normal people, with normal reactions to an abnormal event"

Defusing are done 6:1 Debriefing

Demobilization - held immediately after an incident-sets of defusing and followed up with CISD

Law Enforcement Suicide

Lt. Dell Hackett Lane County Sheriff's Office

- Officers 8x more likely than the public
- 150 LODD/300 suicides a year
- twice private sector

Oregon academy
- 40 hours of vehicle
- 40 hours of firearms
- 4 hours of CIS awareness

Management - Sergeants get 8 hours
- Management needs to be trained to watch for the signs leading to stress
- The culture contributes to it ... stuff it, tough it, get a grip, get drunk
  - Co workers and agencies response often afterwards is
  - I never knew
  - I should have seen it
  - Guilt - remorse - suffering
  - Can be overwhelming for the department

Warning signs and risk factors

- Clinical depression
- Drug/alcohol abuse
- Negative change in behavior
- Change in sleep patterns
- Feeling of helplessness
- Decreased appetite
- Previous attempts/family members
- Guilt, shame, self hate
- Overwhelming sadness (crying)
- Fear of losing control
- Verbalizing suicide thoughts
- Giving away personal possessions
- Excessive focus on suicide
- Take unnecessary risks - out of character

Watch officers on internal investigations for suicide
Get them in touch with MHP or chaplain

CISM for air crews

Association of Air Medical Services agencies in air transport

Usually dealing with the sickest of the sick/neonatal/peds
Unique environmental factors - noise, vibrations of aircraft
LODD's have gone up with more air accidents

Debriefing the Debriefers

Dennis Potter MSW and Paul LeBurteaux PHd

Developed Debriefing the debriefers to help with burn out of participants

Why do it?

1. Prevention
   - Vicarious traumatization
   - Cumulative stress
   - Critical self judgement

2. Teaching
   - To practice what we teach
   - To improve

Goals

Increase effectiveness, longevity, learning
Decrease personal reactions, take care of self, monitoring team reactions

Timing

- Should be done as a normal part of team's SOP's
- Be done before going home
- Depends on the scale of event - the larger the longer out it should be done to have time to process

Phases

- Review - intro/fact/thought How did it go? What happened?
- Response - reaction/symptom What did you say you wish you hadn't?
- Remind - teach/reentry What are you going to do to take care of self?

Appendix C

Stress Training for the Officers and Family

Contents

1. Request for Proposal for training on stress risk factors and protective factors for municipal police officers and their families October 1999

2. LPD Stress Training and Critical Incident Stress Management, February 2000

3. Magellan stress training curriculum

LPG Stress Prevention and Treatment Taskforce

Longview, Washington
Det. Jeff Davis, LPG, Administrator

Jeanne Harris, facilitator

Request for proposal
for training on stress risk factors and protective factors
for municipal police officers and their families
October 1999

Background information

In 1997 the Longview Police Guild applied for and received a federal grant from the National Institute of Justice Corrections and Law Enforcement Family Support Program (CLEFS). The purpose of the grant is to develop a comprehensive stress prevention and treatment program to meet the needs of the Longview Police Department officers and their families. The grant enables a taskforce made up of volunteer members from the Guild, LPD officers, their families and management, City of Longview staff, insurance carriers and service providers to meet to do several things;

- Assess the needs of the officers and their families
- Provide training to the officers and their families regarding stress risk and protective factors
- Review the current policies and practices of each participating group
- Assess the organizational culture of the LPD
- Review current stress program services

Based on the information gathered the task force will design a new stress prevention and treatment program and a plan for implementing the program to insure its creation.

It is the goal of this task force to collect as much information as possible to develop a comprehensive plan for preventing and treating job-related stress in criminal justice environments. It is anticipated by the grant provider that this plan can and will be used by other jurisdictions or peripheral industries hoping to accomplish the same goal.

An important outcome of this grant is to provide a training session with officers and their families about stress in the policing industry. This training session should include the risk factors (the cause and effect) and the protective factors (awareness, prevention and treatment) for officers and their families.

Scope of Work for this RFP

- *Develop one eight hour training session to be delivered twice for a total of 16 hours of training; time frames for delivery to be determined as they need to be convenient for police officers, staff and family.* Days for training to be scheduled, it may be necessary for the trainer to be available on a Saturday.
- Training should include interactive work with the participants
- Training to be delivered in Longview, Washington in January 1999
- Training to consist of information addressing:
    - What is stress?

Jeanne Harris, facilitator Phone 360.896.0422 Email jeanne@pacifier.com Website www.jeanneharris.com

- What are the risk factors for officers?
- What are the risk factors for the families of officers including adolescents?
- What are the protective factors for officers?
- What are the protective factors for the families of officers including adolescents?

Include solid, hands on, take home information that the officers and families can use to identify and start to work on the reduction of stress factors in their personal and professional lives. Example, a piece on marriage and/or relationship – gender differences, what they are and how to cope with them.

- Trainer will coordinate with the evaluator of the grant to complete pre-training assessment of knowledge regarding stress and post-training assessment.

- Trainer will develop curriculum specific to police officers if necessary.

Cost

Prepare and deliver a budget that includes training, any additional curriculum development as needed, travel and all other expenses. Hand out material will be copied at the expense of the Longview Police Department for the training sessions.

Requirements for Response to RFP

Include:

1. Letter of introduction to include why you are interested and why you are qualified and that you are available
2. Documentation of credentials including licenses held, education, similar projects and experience
3. Three reference letters
4. Outline of the proposed training session
5. Budget

Additional information may be requested.

This RFP must be received no later than November 26, 1999 at 5:00 PM

Send to:

Facilitation Resources
Jeanne Harris, facilitator
14511 NE 49th Cir
Vancouver Wa 98682

Any questions regarding this RFP please contact: Facilitation Resources, Jeanne Harris at 360.896.0422 or email at jeanne@pacifier.com

Longview Police Department

Stress Training
And
Critical Incident Stress Management

February 2000

Traumatic
Stress
Reference
Material

Material compiled and presented by
Denney Kelley

COPS- officers killed will help at.

Stress Continuum

General Stress	Cumulative Stress	Critical Incident Stress	Posttraumatic Stress Disorder
Inescapable	Build-up of general stress	Caused by traumatic event	Requires 30+ days of symptoms post-incident, including: 1. Intrusion 2. Avoidance 3. Arousal
Normal	Destructive over time	Normal	Debilitating
Distress	Burnout	Painful/upsetting but normal	PTSD

Note: No amount of cumulative stress will result in Critical Incident Stress or PTSD.

Defining Critical Incidents

Solomon: Any situation that results in an overwhelming sense of vulnerability or loss of control.

Mitchell: Any situation faced by emergency service personnel that causes them to experience unusual strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later.

Fay: An event which challenges ones world view and produces a temporary state of psychological unbalance and emotional turmoil. (Mitchell)

Critical Incident Stress Information Sheet

You have experienced a traumatic event or a critical incident (any incident that causes someone to experience unusually strong emotional reactions which have the potential to interfere with their ability to function). Even though the event may be over, you may now be experiencing or may experience later, some strong emotional or physical reactions. It is very commons, in fact quite *normal*, for people to experience emotional aftershocks when they have passed through a horrible event.

Sometimes the emotional aftershocks (or stress reactions) appear immediately after the traumatic event. Sometimes they may appear a few hours or a few days later. And, in some cases, weeks or months may pass before the stress reactions appear.

The signs and symptoms of a stress reaction may last a few days, a few weeks or a few months and occasionally longer, depending on the severity of the traumatic event. With understanding and the support of loved ones, the stress reactions usually pass more quickly. Occasionally, the traumatic event is so painful that professional assistance from a counselor may be necessary. This does not imply craziness or weakness. It simply indicates that the particular event was just too powerful for the person to manage by him or herself.

Here are some common signs and signals of a stress reaction:

Physical*	Cognitive	Emotional	Behavioral
Chills	Confusion	Fear	Withdrawal
Thirst	Nightmares	Guilt	Antisocial acts
Fatigue	Uncertainty	Grief	Inability to rest
Nausea	Hypervigilance	Panic	Intensified pacin
Fainting	Suspiciousness	Denial	Erratic movemer
Twitches	Intrusive images	Anxiety	Change in social activity
Vomiting	Blaming someone	Agitation	
Dizziness	Poor problem solving	Irritability	Change in speec patterns
Weakness	Poor abstract thinking	Depression	
Chest pain	Poor attention/ decision making	Intense anger	Loss or increase of appetite
Headaches		Apprehension	
Elevated BP	Poor concentration/ memory	Emotional shock	Hyperalert to environment
Rapid heart rate		Emotional outbursts	
Muscle tremors	Disorientation of time, place or person	Feeling overwhelmed	Increased alcohc consumption
Shock symptoms		Loss of emotional control	
Grinding of teeth	Difficulty identifying objects or people	Inappropriate emotional response	Change in usual communication
Visual difficulties			
Profuse sweating	Heightened or lowered alertness		
Difficulty breathing	Increased or decreased awareness of surroundings		

Any of these symptoms may indicate the need for medical evaluation.

BIO-CHEMISTRY OF TRAUMATIC STRESS

1. Assessing a situation as life threatening results in a massive release of hormones. The purpose of this "chemical dump" is to permit a person to function at absolute peak efficiency for a brief period of time.

2. The amount of hormones released amounts to essentially an "overdose." The trade off nature has made is in favor of short-term effects from this overdose in exchange for the heightened abilities necessary for immediate survival.

3. These chemicals remain active in the body for up to two weeks and cause many of the symptoms associated with trauma.

4. Every detail associated with a life threatening incident is permanently etched into the memory but because of the effects of the stress hormones, these memories may be "filed" incorrectly.

5. This "misfiling" may cause gaps in what you recall, flashbacks, nightmares, or anxiety experienced seemingly at random. These are normal reactions to abnormal circumstances.

6. Physical exercise on a regular basis beginning within 24 hours of the traumatic incident and continuing on a daily basis can help "burn off" the hormones causing the symptoms.

7. Consumption of caffeine immediately after a traumatic incident and/or consumption of alcohol within a period of 72 hours after a traumatic event can make the symptoms worse.

NORMAL TRAUMATIC STRESS REACTIONS

1. <u>During the Incident</u>

   - Sensory acuity heightened and focused (tunnel vision 67%).
   - Functioning on "auto pilot," training kicks in.
   - Time distortion, slow (67%) or fast (16%) motion.
   - Depersonalization.
   - Auditory distortion, diminished (51%) or increased (18%) sound.
   - Rate of respiration increases.
   - Non-essential bodily functions shut down.
   - Pulse and blood pressure increase.
   - Hormonal release including adrenaline, cortisol and thyroxine.

2. <u>Immediately Following the Event</u>

   - Stress hormones continue at elevated levels.
   - Hyper vigilance.
   - Difficulty tracking.
   - Headache.
   - Nausea, vomiting, diarrhea.
   - Agitation.
   - Anger at what happened.
   - Exaggerated startle reflex, "jumpy."
   - Muscle tremors.
   - Feeling unusually cold or warm.
   - Hyperventilation/lightheaded feeling.
   - Profuse sweating.

Note: Many officers report that they do not feel the full impact of the incident until two or three days afterwards.

3. 72 Hours to 30 Days Post Incident

- Sleep/Appetite Disturbances.
- Agitation.
- Irritability/Anger Outbursts.
- Hyper vigilance.
- Difficulty concentrating.
- Headaches/nausea/other physical complaints.
- Mood swings.
- Shame/guilt.
- Preoccupation with the incident.
- Unusual feelings of vulnerability.
- Recurrent/intrusive/distressing memories.
- Nightmares.
- Flashbacks.
- Anxiety when exposed to events that resemble or symbolize the incident.
- Feeling like an outsider or distant from others.
- "What's the use" attitude or resignation to early death.
- Restricted range of emotions.
- Escapist or numbing behaviors.
- Depressed immunity/increased susceptibility to illness.

ABNORMAL TRAUMATIC STRESS REACTIONS

1. The persistence of any normal symptom(s) beyond a period of 30 days.

2. The presence of any symptom(s) to such a degree that normal social or occupational functioning is impaired.

3. Suicidal ideation.

4. A marked increase in the consumption of alcohol or other drugs.

5. Increased risk taking to the point of foolhardiness.

6. Episodes of domestic violence.

7. Obsessive second guessing.

THE THREE FACTORS WHICH PREDICT THE SEVERITY OF TRAUMA REACTIONS

1. Prior History of the Individual

   - Individuals with prior unresolved traumas and problems maybe more susceptible to psychological injury.

2. The Perceived Severity of the Trauma

   - Sudden, unexpected.
   - Person experiences vulnerability.
   - Person experiences loss of control.
   - Outcome.
   - Degree of injury, threat, death to self and others.

3. Nature of the Recovery Environment (what happens to person afterward)

   - Treatment by agency.
   - Peer support.
   - Command staff support.
   - Support from friends and family.
   - Psychological debriefing and treatment.
   - Public support.

Of the above three factors, No. 3, the Nature of the Recovery Environment, is the most important. How a person is treated afterward usually makes the biggest difference in how quickly they recover.

PRIMARY FACTORS IN RECOVERY FROM STRESS AND TRAUMA

1. Self-Care

   - Healthy lifestyle choices.
   - Social/emotional support network of friends, peers, family.
   - Proactive in solving own problems (educate self about problems and coping strategies, seek help when needed, avoid victim mentality).
   - Spiritual foundation (not necessarily religious) that provides values, meaning, and purpose to life.

2. Peer Support

   - Peer support and counseling training.
   - Traumatic incident support team.
   - Alcohol recovery support team.
   - Peer adviser team.
   - Disabled officer support team.
   - Significant other support team.

3. Good Supervision and Administrative Support

   - Commitment to physical and emotional welfare of employees.
   - Training in supervision skills and mental health issues.
   - Administrative support for good supervision.
   - Good role modeling by supervisors.
   - Innovative program development.
   - Willingness to confront problems.
   - **People are First.**

4. Mental Health Professionals

- Training for employees and supervisors.
- Clinical supervision in peer support issues.
- Traumatic incident debriefings.
- Psychotherapy.
- Consultation as problems arise.
- Psychological evaluations.

Stress, Traumatic Stress and Critical Incident Stress Management

Portland Police Bureau
TIC Team

Presented by

Magellan-Portland Employee Assistance Program

Stress is…..

1. A specific set of physical changes…

2. …which occur in reaction to the perception of a threat…

3. …and which prepare the body for running if possible or fighting if necessary.

4. Stress is a survival mechanism.

Traumatic Stress is…

1. An extreme shock to the body, both mentally and physically…

2. …caused by a massive hormonal dump…

3. …in response to an event of such magnitude that there is no way to prepare for it.

4. Typically, traumatic events involve a threat to one's own life or physical integrity, or…

5. …a similar threat to a close friend or loved one.

6. No amount of "regular" stress, no matter how great or how prolonged, will result in a traumatic stress reaction.

Stress Continuum

General Stress	Build-up of general stress	Caused by traumatic event	including:
Inescapable			1. Intrusion 2. Avoidance 3. Arousal
	Destructive over time	Normal	Debilitating
Normal	Burnout	Painful/upsetting but normal	PTSD
Distress	Critical Incident Stress	Posttraumatic Stress Disorder	
Cumulative Stress		Requires 30+ days ot symptoms post-incident,	

Note: No amount of cumulative stress will result in Critical Incident Stress or PTSD.

Law Enforcement Personnel:
Potentially Traumatizing Events

1. High speed traffic accident while in pursuit or responding to call/ struck by vehicle.
2. Multiple "bad calls" within brief period of time.
3. Intensely adverse media exposure.
4. Multiple homicides within a community.
5. Body part recovery.
6. Equipment malfunction at critical moment.
7. Serious injury to or death of a child.
8. Suicide of family member or co-worker.
9. Officer-involved shooting.
10. Inadequate resources to respond to major disaster.
11. Overpowered or held hostage.
12. Line of duty death.

Normal
Traumatic Stress Reactions

1. <u>During the Incident</u>:

   - Sensory acuity heightened and focused (tunnel vision 67%)
   - Functioning on "auto pilot," training kicks in.
   - Time distortion, slow (67%) or fast (16%) motion.
   - Depersonalization.
   - Auditory distortion, diminished (51%) or increased (18%) sound.
   - Rate of respiration increases.
   - Non-essential bodily functions shut down.
   - Pulse and blood pressure increase.
   - Hormonal dump including adrenaline, cortisol and thyroxin.

2. <u>Immediately Following the Event</u>:
   - Stress hormones continue at elevated levels.
   - Hypervigilance.
   - Difficulty tracking.
   - Headache.
   - Nausea, vomiting, diarrhea.
   - Agitation.
   - Anger at what happened.
   - Exaggerated startle reflex, "jumpy."

Normal
Traumatic Stress Reactions
(Continued)

Note: Many officers report that they do not feel the full impact of the incident until 2 or 3 days afterwards.

3. <u>72 Hours to 30 Days Post-Incident</u>:

- Sleep/appetite disturbances.
- Agitation.
- Irritability/anger outbursts.
- Hypervigilance.
- Difficulty concentrating.
- Headaches/nausea/other physical complaints.
- Mood swings.
- Shame/guilt.
- Preoccupation with the incident.
- Unusual feelings of vulnerability.
- Recurrent/intrusive/distressing memories.
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3. Suicidal ideation.

4. A marked increased in the consumption of alcohol or other drugs.

5. Increased risk-taking to the point of foolhardiness.

6. Episodes of domestic violence.

7. Obsessive second-guessing.

Bio-Chemistry of Traumatic Stress

<u>Involuntary</u> chemical reactions in the brain and body account for the symptoms of traumatic stress.

1. Hormones associated with the stress reaction include:

   A. Epinephrine.

   B. Cortisol.

   C. Aldosterone.

   D. Thyroxin.

2. Parts of the brain associated with the stress reaction include:

   A. The amygdala.

   B. The hippocampus.

3. The Amygdala:

   A. Stimulates life-saving functions in the brain.

   B. Avoids near-death experiences.

4. Amygdala function results in:

   A. Intense and immediate reactions.

   C. Permanent memory.

Bio-Chemistry of Traumatic Stress

(Continued)

5. The Hippocampus:

   A. Files memories.

   B. Unconsciously scans environment for the unexpected.

6. The Hippocampus is sensitive to the stress hormone cortisol.

   A. Low doses of cortisol enhance memory categorization.

   B. High doses repress memory categorization.

7. In a life-threatening situation:

   A. Everything that happens is burned into your memory.

   B. These memories may not be filed correctly, resulting in:

      - Gaps in what you can recall.
      - Flashbacks.
      - Anxiety experienced seemingly at random.

8. REM sleep, often associated with dreaming, is a time when "misfiled" memories are sorted out.

   A. Nightmares may actually be useful in this process.

   C. Eye Movement Desensitization Reprocessing (EMDR) may help the process.

Dynamics of a Critical Incident

1. **"Here Comes Trouble."**

   First indication that something unusual is about to happen. May be a gut feeling.

2. **"Oh, Shit!"**

   First awareness of vulnerability. May feel weak, afraid, or out of control.

3. **"Survival Mode."**

   Danger is assessed on the basis of our ability to respond effectively. A plan is consciously or unconsciously developed. Training kicks in. We begin to react and may begin to feel more balanced and in control.

4. **"Here Goes Nothing."**

   The point of no return. We are committed to a course of action. Our minds are focused and tremendous strength is mobilized.

5. **"Action."**

   We act, guided by our training and motivated by our desire to survive.

Peer Support Checklist

DO:

- ❑ Remember confidentiality.
- ❑ Respond in person as quickly as possible. Be prepared to spend some time with him/her.
- ❑ Get the officer some distance from the immediate scene.
- ❑ Let the officer determine how much contact s/he wants to have with you; however, *never leave an officer alone if you have concerns about his/her state of mind.*
- ❑ Remind the officer that his/her physical, sensory, emotional, and thinking symptoms are normal.
- ❑ Assist the officer in contacting his/her family.
- ❑ Offer to stay with or help the officer locate a suitable friend to stay with overnight for a day or two.
- ❑ Ask questions that show your concern such as, "How are you doing?" or "What can I do for your family?"
- ❑ Be careful about making statements to the effect of, "I'm glad to see you're OK." It is better to say, "I'm glad to see you weren't injured" or "I'm sorry you had to go through that."
- ❑ If the officer has been injured, let him/her know that help is on the way and that you will see to it that s/he gets the best care available.
- ❑ Listen non-judgmentally. Listening is doing something.

Peer Support Checklist

(Continued)

DO:

- ❑ Explain to the officer what will happen administratively so the officer will not see the investigation as a personal attack. Wait until the officer can absorb new information.
- ❑ Be prepared to repeat instructions and information.
- ❑ Arrange for a high-ranking officer to communicate concern and support in a face-to-face manner. Include the officer's family.
- ❑ Suggest the officer use an answering machine to screen his/her phone calls for a period of days.
- ❑ Encourage the officer to use available administrative leave.
- ❑ Know your limits. Support the officer to get professional help when necessary.

Peer Support Checklist

(Continued)

DO NOT:

- ❑ Take your responsibility lightly or pressure yourself to do all the right things.
- ❑ Accept at face value the statement that "everything is OK." Spend some time with the officer and make your own assessment. Look for:

  * The ability to concentrate.
  * The ability to engage in problem-solving type thinking.
  * The absence of self-recrimination.
  * The absence of depression.

- ❑ Ask for an account of the incident. Let the officer talk about whatever s/he wants. If the officer is silent, your presence is still important.
- ❑ Spend much time describing similar incidents you have experienced.
- ❑ Tell the officer s/he did the right thing. Especially if you don't know what s/he did. This can be very offensive. If you must address this issue, let the officer know you trust his/her judgment.
- ❑ Congratulate the officer; make jokes about his/her "marksmanship", or refer to him/her as "killer", "bad ass", etc.
- ❑ Make critical comments about the officer's performance, even if you find it questionable. If you cannot be supportive, request that another officer be assigned in your place.
- ❑ Suggest the officer consume caffeinated or alcoholic beverages. Water and fruit juice are recommended.
- ❑ Fail to stay in contact with the officer, even if you are only "checking in."

Peer Support Checklist

(Continued)

DO NOT:

- ❑ Refer to officers who are experiencing lasting symptoms as "mentals" or other negative terms. Doing so makes it less acceptable for officers who need professional help to get it.

- ❑ Fail to encourage officers to seek professional help if you see that they are bothered by symptoms for longer than a month.

When Trauma Happens to You

Note: Read this right now. Keep it handy. Review it. Know it. You will have trouble absorbing this information if you read it for the first time after an incident.

1. You are the least objective person who can evaluate your condition and/or immediate needs. Rely on your TIC Team advisor, your family, and your friends.

2. You will experience a range of physical, emotional and sensory symptoms as well as uncharacteristic thoughts. These will seem strange but they are normal. You are not going crazy.

3. Avoid consuming caffeine, tobacco or alcohol.

   A. Caffeine and tobacco are stimulants which are now thought to trigger PTSD formation.

   B. Alcohol is a depressant which inhibits the memory integration process.

4. Eat healthy meals even if you are not hungry.

5. Don't isolate yourself. Talk it out. Stay in touch with your support system including your TIC Team advisor. Talking helps to:

   * Reduce physical and emotional symptoms.
   * Place the event in perspective.
   * Eliminate second-guessing.

6. Avoid making any decisions until you feel better.

When Trauma Happens to You
(Continued)

7. Understand that how you deal with an event is more important for your mental health than was the event itself.

   A. Second-guessing.

   B. Guilt.

      * Responsibility guilt.
      * Survivor guilt.

   C. Anger.

   D. If you find that you are struggling with physical or emotional symptoms beyond 30 days post-incident, consider seeking confidential professional help.

8. Get plenty of exercise.

9. Don't focus your energy all in one area. You will need to strike a balance between work, play, spiritual pursuits (religious or otherwise), social and family interaction.

10. Take some time off work.

11. Keep your sense of humor.

Critical Incident Stress Debriefing

Critical Incident Stress Debriefing is:

A structured group process....

which is both psychological and educational in nature, and...

which mitigates the impact of a traumatic event...

by accelerating the recovery process experienced by normal people to abnormal events.

CISD is only one element of a sound Critical Incident Stress Management Program. Other components include:

- Pre-incident traumatic stress training
- Continuing stress management education
- Administrator and supervisor stress education and support programs
- Family support services
- Professional employee assistance counseling
- Specialty debriefings: informational, mutual aid, community
- On-scene support services
- Disaster intervention services: demobilizations, de-escalations
- Defusings
- Follow-up services after critical incident interventions
- Chaplain services
- Psychotherapy

Critical Incident Stress Debriefing

(Continued)

Critical Incident Debriefing is not:

1. Psychotherapy.
2. A critique of anyone's performance.
3. Part of an investigative process.
4. A fitness-for-duty evaluation.
5. A tactical debriefing.
6. Time for telling war stories, acting our interpersonal conflicts, or engaging in "ain't it awful" complaining.
7. Designed to remove all symptoms present.

Key Elements of CISD

The following conditions should be met for CISD to be effective:

1. Group leaders should be specifically trained and skilled in the process of CISD.

2. There should be at least 2 group leaders: one law enforcement professional and one mental health professional.

3. Group participants should be those individuals who were directly involved in the traumatic incident.

4. Groups should not include:

   A. The simply curious.
   B. Administrative personnel unless part of the incident.
   C. Student observers (they can be trained elsewhere).

5. Including of ancillary personnel will alter the dynamics of the group and will result in diminished results.

6. The ideal group size is 8 to 12 people. Effective debriefing can be done with groups as large as 20.

7. In all but exceptional circumstances, groups should include participants from only one service branch. Police should be debriefed separately from fire personnel.

Key Elements of CISD

(Continued)

8. CISD should be held in a comfortable location free from interruptions.

   A. Group participants should decide where they want the group held.

   B. CISD should not be started until all participants have arrived.

   C. There are no scheduled breaks during the CISD.

   D. All participants should plan to remain until the CISD is complete.

   E. CISDs generally require 2 to 3 hours to complete.

9. Interpersonal conflicts between participants which may explode during the CISD should be mediated in advance.

10. Confidentiality is critical. No person who cannot commit him/herself to confidentiality should be permitted to participate.

    A. No notes are to be taken.

    B. No recording devices are permitted.

    C. Members of the media are to be strictly excluded.

The Stages of CISD

Stage	Objectives
1. Introduction	To introduce intervention team members, explain the process, and establish ground rules.
2. Fact	To recreate the traumatic event through descriptions of each participant's experiences.
3. Thought	To allow participants to describe their thoughts during the event and to transition to the reaction stage.
4. Reaction	To identify the most traumatic aspect of the event for each participant, and to identify each person's emotional reactions.
5. Symptom	To identify personal symptoms of distress and transition to the educational level.
6. Teaching	To educate regarding normal reactions and adaptive coping mechanisms. To provide a cognitive anchor for developing perspective, learning from experience, and re-sorting "misfiled" memory data.
7. Re-entry	To clarify ambiguities and prepare for closing.

Why CISD Works

1. Early Intervention

   CISD provides an early intervention which prevents traumatic memories which are distorted and over-generalized from becoming rigid and resistant to change.

2. Catharsis

   CISD provides a safe, supportive, and structured environment for emotions to be vented. Discussing traumatic events reduces stress arousal and improves immune functioning.

3. Opportunity to Verbalize Trauma

   CISD permits participants to express, explore, and better understand specific traumas, fears and regrets.

4. Structure

   CISD provides a structure which, when superimposed on the chaotic memories, emotions and symptoms of trauma, helps reduce their intensity.

5. Group Support

   CISD provides an opportunity for participants to receive support from the group, including information about the trauma which could not be known to all who experienced it, insight that one was not alone in experiencing symptoms, as well as constructive coping suggestions. The group format also permits participants to generate feelings of hope.

Why CISD Works

(Continued)

6. Peer Support

Although mental health professionals oversee the CISD process, it is a peer-driven process. Working together with professional peers who "have been there" themselves gives the process unique strength.

7. Follow-Up

CISD provides an opportunity to follow-up with persons who have been through traumatic events to better ensure the likelihood of rapid and total recovery.

REACTIONS THAT ARE COMMON IN PEOPLE EXPERIENCING A TRAUMATIC EVENT

PHYSICAL	EMOTIONAL	COGNITIVE (THINKING)
nausea	anxiety/fear	impaired judgment and thinking
sweating	grief	difficulty in making decisions
dizziness	lost/isolated	short-term memory problems
headaches	withdraw	repeated memories of the incident
hyperventilation	anger	forgetfulness
sleeping problems	overwhelmed	poor attention/concentration
stomach discomfort		

People who have been through a traumatic event, such as a shooting, a robbery or a trauma resulting in death or injury, report having a variety of experiences. These include:

FEAR
They may be afraid of being in public, returning to the scene, or being re-victimized.

HYPERALERTNESS
They find that they startle easily: they "jump" when suddenly approached by coworkers or the public, or when they hear loud sounds, particularly noises which remind them of the event.

GUILT
They feel that they could have done something differently; they wonder if they could have prevented the incident, or if they did not do something they feel they should have done. They replay the situation over and over again.

ANGER
They are enraged that their life has been disrupted and that they no longer feel safe or in control. They are angry that their families might be endangered.

ISOLATION
They feel that they are the only ones who are having reactions to the event; they experience feeling isolated from family and friends who they feel cannot understand

These persons also describe a number of other behaviors that are common after a trauma:

- paranoia about their own and their family's safety;
- irritability, which may be directed at their family or friends;
- loss of motivation - feeling blue or depressed;
- increased absenteeism;
- obsession with the event, i.e., seeing the intruder while they're shopping; re-running the incident in their minds;
- apathy;
- chronic fatigue;
- increased drug/alcohol use;
- reliving the trauma and their feelings of vulnerability and helplessness when they hear of other events through TV, news, articles, etc.

CAPE Employee Assistance Program
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COPING WITH THE AFTERMATH OF TRAUMA

Awareness and understanding are crucial in beginning to deal effectively with this event in your life. You can begin by being aware that you WILL react to some degree, perhaps in some of the ways we've discussed. Remember that your reactions are normal.

1. You may find that you react to sights, sounds, smells, and textures that were present at the time of the incident.

2. Sometimes, being exposed to a traumatic event may trigger memories of past events in your life which were also traumatic or which involved loss or loss of control. Perhaps you have been in a trauma before, have been an assault victim, or have lost someone in death. You may find yourself reacting anew to feelings about these earlier events.

3. Feelings of vulnerability and helplessness are frequent after traumatic incidents. One of the first things to pay attention to is your need to feel safe again. For a short time, take any precaution which will make you feel safer. Some examples might include:
   - Having someone drive you to work and pick you up at the end of the day.
   - Following procedures that will protect you from as much risk as possible while at work.
   - Installing new locks at home, security lighting for your home, walking your children to and from school or the bus.
   - Making your daily schedule as predictable and routine as possible for a while to return some control and stability to your life.
   - Taking care of yourself physically. Consciously being aware of good nutrition and getting adequate sleep. Do not use drugs or alcohol for relief.
   - Continuing to do the things you enjoy doing.

   In taking measures such as these, you are not only making yourself and your family safer, you are restoring some sense of being in control. We suggest that you continue to do what it takes to feel safe for as long as you need to.

RECOVERING FROM TRAUMA

Be aware of your support systems. They will be playing a very important part in helping you to resume your normal functioning after the incident.

Typically, people find these three levels of support:

1. The most important system for you may be your ***peers*** at work. Very possibly, these people have gone through the trauma with you and know how you feel. Use each other to talk about your feelings and support each other.

2. The next level of support may be your ***family.*** They will need to know what is happening with you and what to expect. They will react to your experience, but may not have the information needed to deal with it as you do. Please remember that children are very perceptive. Don't underestimate their ability to understand and deal with life's traumas.

3. The third level of support may come from the ***community***. You may find this support in friends, counselors, the clergy, or other significant people in your life.

You may find yourself withdrawing from these support systems, and sometimes misdirecting your anger at them. It is very important to use them for talking and communicating.

Here is a general strategy which may help you de-brief the experience of your victimization with your support groups:

1. Find a person (family member, friend, EAP counselor, clergy member, social group, etc.) with whom you are comfortable. Feel sure they are receptive and non-judgmental.

2. SHARE with them what you saw, heard, touched, smelled, etc. (The purpose is to bring what you experienced back to the surface, to re-create the experience. This will allow you to deal with the situation as you remember it, not as you fantasize it.)

3. After you have re-created the incident, try and attach the feelings you experienced. You may react to some parts of the incident which others may not react to, and vice versa. The reactions to associated feelings are important to acknowledge and deal with.

4. As you express your feelings, understand that these feelings are normal reactions to an abnormal situation. They also may be connected to past traumas you have never dealt with.

5. Continue talking (over a period of time) for as long as it takes for you to get to the associated feelings.

6. As the process continues, share what has been happening to you since the incident, i.e., nightmares, irritability, and any other changes in your behavior which you or others have noticed. As you talk (over a period of time) the reactions should begin to fade.

7. It is common for some reactions to continue for some time or resurface after being triggered by another event. We generally suggest contact with a professional counselor if reactions are seriously disrupting your ability to function in your day- to-day tasks, or accelerating three or four weeks after the incident. You may contact professional counseling resources through your supervisor or through **CAPE Employee Assistance Program.**

SUMMARY

Resolution of traumatic stress is a healing process. It's important to allow yourself time to grieve your losses, such as physical injury or feelings of security, and to give yourself permission to heal at your own pace. Having a traumatic stress reaction is like catching the flu. We can't cure the virus, but we can help alleviate the symptoms and promote personal growth.

Although one of the most critical elements of the healing process is being able to talk about the event and your reactions to the event, some people may have difficulty listening to you and may not be able to provide the support you need. It is important that you actively seek support from many sources, including family, friends, co-workers, and possibly, professional counseling and victim support groups. Your life history, values, social support, impact of the event, and degree of personal responsibility are all factors affecting resolution of trauma. As a long-term goal, it is important to integrate the event into your life. This will help you make plans for the future with a new sense of strength and vitality.

Recognizing Emergency Personnel with Posttraumatic Stress Disorder

This subject is an extremely difficult one, as the tendency of some people is to "diagnose" others when they are seeing only part of the overall situation. As you read through this page, keep in mind that it takes a professional who knows PTSD to diagnose this disorder from other disorders. One supervisor recently asked me how anyone can separate those with PTSD from the variety of other mental disorders, or those faking it. My answer to this question: the same way you recognize a Volkswagen. There is no substitute for a trained experienced psychologist/psychiatrist that works specifically with PTSD, and especially one that knows the social environment in law enforcement or the emergency medicine field. Part of the problem with this disorder is that there are far too few that have a lot of first hand experience with PTSD and emergency workers.

If you are exhibiting these symptoms, or know of someone with these symptoms, my recommendation is you talk to a professional psychologist/psychiatrist about getting help. If you know of someone with these symptoms, you may want to talk to a professional before talking to the person. The officer may not admit to the problem, if he/she even knows there is one. Professional guidance is of major help.

Cognitive Versus Non-Cognitive Symptoms

By now you should have read the medical definition of PTSD, and at least some of the article by Dr. Blum. One thing that is very important to understand about recognizing PTSD symptoms, is that the person who exhibits them generally cannot tell you "I have PTSD", unless they are already diagnosed and in therapy. It's not like having a cold or the flu, or a broken leg. The "locking in" of the emotions of the trauma means that the person may or may not remember the traumatic event, but fails to make the connection to what's going on somatically, that is, the physical problems they are having, to the event. They may have bits and pieces of what is happening to them now, but they fail to connect it back to the original traumatic event. They may, in fact, outright deny that they are having any problem, other than the day to day stresses of the job, when in fact they feel inside that they are going crazy.

Another difficulty with PTSD is there is generally a period of time that elapses between the trauma and when the behaviors start to show. With acute PTSD this is a much shorter time than with chronic PTSD, which can conceivably be years between the trauma and the fallout.

What I've listed below are behaviors and symptoms I have seen others experience, and some I have experienced myself. This list is not all-inclusive, and, again, may be indications of something other than PTSD. If it is PTSD, they will exhibit more than one symptom from each of the three areas, though you may not see more than one or two.

Another thing to remember, a few of these behaviors are normal for police officers. It's when they go from "normal" to the extremes that they become abnormal. If you know the person, you know what's normal. Watch out for these changes.

Intrusion

- extreme nightmares
- extreme paranoia
- sense of shortened future, impending doom

Avoidance

- loss of interest in sex
- depression
- isolation-especially from loved ones
- avoiding work-increased absenteeism

Somatic Problems

- problems urinating
- frequent headaches
- chest pains
- intestinal pain
- diarrhea, constipation, irritable bowel syndrome, blood in stool
- frequent, meaning very frequent, belching
- very high use of antacids

Chances are you will see only a few of these things, not all of what is really going on. Some of these behaviors a person will outright hide, such as the addictions, for obvious reasons. These symptoms are a window to the soul. You may get only a peek, don't ignore it. You're not helping the person if you do. These symptoms are digressive, meaning over time they will probably get worse.

When the person finally gets help, for a time it will seem like they get worse. The reason for this is part of the therapy is linking the symptoms to the original trauma, then "unlocking" the feelings.

Triggers

Due to the way traumatic memories are stored, when something arises in the present that reminds someone with PTSD of a past trauma, they may feel the feelings associated with that past trauma. These are called triggers. If the original feelings were of helplessness, sorrow, and depression, that's what they will feel when the memories are "triggered". If the original feelings were sadness and anger, these are what they will feel when the memories are "triggered". Triggers can produce very intense emotional feelings, and sometimes can even produce violence (i.e. when the person re-experiences rage).

One of the key parts of therapy is being able to recognize your triggers and have a plan in place when they occur. Triggers are common with PTSD, even if the person has no memory or a partial memory of the original trauma. The emotions caused by triggers can vary in intensity, from slight to extreme.

Memories are formed by all the senses, not just by sight, and can be triggered by any of the senses, not just visual. When they are triggered and replayed, it may be the visual memory, or it may be one of the other senses, such as smelling the burnt flesh, or hearing the screams. It may also be a replay of the physical sensations, which is very common with many people who have suffered physical trauma. Or, it may be a combination of several or all of the senses replaying their memories.

Things that can activate these triggers are many, and related directly to the original trauma. They can be set off by time of day, day of week, time of year, locations, people, certain smells, certain sights, certain sounds, certain touch, and more.

In the case of police officers, especially if they are working field duty and not aware they have PTSD, these triggers can be dangerous, especially if a suspect causes the trigger and it replays a memory of a previously similar suspect who caused the officer's original trauma. The current suspect may find himself or herself getting dealt with rather violently real quick. I've experienced this myself, and seen other officers also do this. In some situations it can be a survival tool as there is real danger to the officer. But in a number of occasions a suspect will unknowingly trigger these flashbacks, and find themselves being dealt with rather violently. There have been officers and departments sued, paying large sums of money because of these flashbacks caused by triggers, and they never knew what set the officer off. Not all cases of officer violence are caused by this, but I've seen many that have been.

The Code of Silence

Panic attacks are usually over within 10-20 minutes at the most, but not always. If they go longer it may become necessary to seek professional advice. Many times, if a person knows they get them, they will recognize what is happening and have several minutes where they can find a place that is safe, and process the feelings associated with the attack by themselves. In therapy they can be taught tools that will help them get through the attacks.

If you know someone who gets panic attacks, please know that there is a very good reason why they get them, and it's not that they are crazy. I've known an officer who gets them now and then, and who was ridiculed by other officers and supervisors when the officer asked to be excused from a meeting because of a panic attack. Unfortunately, due to a lack of training, most officers haven't a clue about panic attacks. If they knew why they happened, they'd be more than a bit understanding, and as a supervisor I would hope there would be discreet inquiries made of the officer (after the panic attack), as to why they are occurring. As a supervisor you should be more than a little concerned if an officer has panic attacks, and knows what's happening. It may be work related, it may not be work related, but panic attacks will affect work performance and certain assignments.

If a police officer or emergency medical worker gets panic attacks and knows what they are, they will probably keep it to themselves and not let anyone else, especially at work, know. These attacks are indicative of very deep emotional pain and/or a disorder that is not going to go away on it's own.

Return to the PTSD and Police Officers Home Page

Development of Regional Support TEAM Guide

DEADLY FORCE INCIDENTS: DEVELOP A TEAM TO SUPPORT YOUR FELLOW OFFICERS

Effects of Deadly Force Incidents:

Law enforcement personnel know that the possibility of being involved in a shooting during one's career is likely; training and experience prepares officers for the automatic reaction needed to take control of a situation. What is not so apparent are the emotional after-effects of such a shooting for the officer involved, and for other police personnel and family members of the involved officer.

Whether having been shot at or having shot, officers can face a range of post-traumatic emotions causing a loss of focus and concentration, tearfulness, intolerance and hypervigilance. Some may have to return to the street even with these distracting symptoms. Officers not on the scene can experience the same symptoms, reliving their own experiences or feeling an increased amount of stress and anxiety in this risk-filled occupation. Family members become worried and unsure how to support their loved ones.

Traumatic Incident Committee (TIC) Team:

The Portland Police Bureau in Portland, Oregon has developed an effective, supportive and organized team to provide peer support to officers and family members involved in deadly force incidents. The Traumatic Incident Committee (TIC) Team has a mission to respond to critical incidents, offering support to officers and their family members who have been involved in a use of deadly force situation while in the line of duty.

TIC Team members respond to the scene of the incident, or hospitals and other locations where an officer is in need of assistance and support. That emotional support can last several weeks or months after the event, depending on the need. Family team members have proved to be very beneficial, because they too, know what is involved in going through a traumatic incident and how important family support is to the recovery of that officer. **This is a role that *cannot* be filled by others, not even mental health professionals. The best support comes from those Officers and family members who have experienced the trauma of deadly force, survived it and learned from it.**

TIC consists of police officers and family members who have weathered the trauma of an officer's involvement in a critical/traumatic incident. All members have been involved in incidents themselves, and provide an "I've been there" perspective. All TIC members meet guidelines for membership and volunteer their time. Professional training is essential for the members to assist them in helping officers and families work through the very emotional and life changing events of the incident.

Development of a TIC Team for Your Agency:

The Portland Police Bureau's TIC Team has partnered with its employee assistance program (EAP) mental health professionals to provide assistance to other police and law enforcement agencies in the development, organization and implementation of a Traumatic Incident Committee Team. Included in this free service are:

- Development of a mission statement which meets the needs of your **department's personality**
- Guidelines for membership, including new members, regular members and inactive members
- Establishment of response protocols
- Development of Callout procedures and duties of the "Up-Team."
- Organization of Critical Incident Stress Debriefings (unique Command Staff issues)
- Critical Incident Stress Debriefing training with specific focus of deadly force incidents
- Training needs for TIC personnel
- How to partner with and maximize support from your mental health professionals

There is no training that can fully prepare officers for the emotional effects of a deadly force encounter. What works is the preparation and organized response offering the support, education and information that comes from officers who have been through the experience and the mental health professionals who can provide the psychological information and offering further assistance. The TIC Team you develop will hopefully never have a need to be used, but it takes only one shooting to impact an entire force. Be prepared with an organized, effective team to support your fellow officers. ***Call Your EAP Office for More Information about this supportive service***

Psychological Reports, 1993, 72, 899-904.

SOURCES OF POLICE STRESSORS, JOB ATTITUDES, AND PSYCHOLOGICAL DISTRESS[1]

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Summary.—Sources of police stressors, job attitudes, and psychological distress were measured and analyzed from a sample of 103 police officers. Analysis indicated that police organizational stressors, mediated by job satisfaction and organizational goal orientation, increased psychological distress 6.3 times more than inherent police stressors. The indirect effect of organizational and inherent stressors appeared to nullify the distress-reducing potential of increased job satisfaction. Results are discussed in terms of these findings and the possible implications for further studies and intervention.

Police work has been cited as a stressful occupation (Selye, 1978; Eiburg, 1975; Kroes, 1985; Violanti, 1985; Reese, 1986). Although some researchers argue that police work has not been adequately compared with other occupations (Terry, 1983), they still agree that officers experience stressed problems in their work. The specific factors related to stress in police work have been categorized in various ways, including organizational practices and characteristics, the criminal justice system, the public, and the specs of police work (Territo & Vetter, 1981; Reese, 1986; Aron, 1992).

Of job stressors mentioned by officers, two major categories appear to emerge as the most bothersome, organizational and inherent police stressors (Selberger, Westberry, Grier, & Greenfield, 1981; Martelli, Waters, & Martelli, 1989). Organizational stressors refer to those events precipitated by police administration that are bothersome to members of the organization. Inherent stressors refer to events generally occurring in police work which have the potential to be psychologically or physically harmful to officers, such as danger, violence, and crime. Many researchers posit that organizational stressors more strongly affect officers than inherent stressors (Reiser, 1974; Violanti, 1981; Grier, 1982; Graf, 1986; Martelli, *et al.*, 1989). Grier (1982) examined the effects of job satisfaction and organizational police stressors and reported high stress scores to be related to job dissatisfaction. Martelli, *et al.* (1989) examined job satisfaction and commitment in police officers and found them both to be negatively related to organizational stressors.

Despite these studies, there is little evidence on the relationships among organizational and inherent stressors, mediating variables, and psychological

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distress. In addition, few studies consider that external work stress individual distress are two distinct factors. One may perceive externa events as bothersome and also experience internal physiological and logical reactions to such events. The purpose of the present study explore relationships between organizational and inherent police st mediating factors of job satisfaction and goal orientation, and indivic tress.

Method

Sample

The sample consisted of full-time sworn police officers employe large police department in southeast New York state. Officers in the represented a variety of ranks, experience, age, and ethnic back From 300 officers in a prescribed geographical area 110 officers were ed by purposive sampling. Surveys were administered to these offi way of interdepartmental mail; participation was voluntary and c tiality was protected by the use of "check-off" responses. Names or id ing information were not requested, and officers were assured tha responses would be reviewed only by researchers conducting the stu veys were returned directly to researchers and not through police adm tive channels. The response rate was 93% (N = 103).

Measures

Police work stressors.—The 60-item Police Stress Survey develc Spielberger, *et al.* (1981) was used in the present study to measur stressors. Work stressors, in contrast to individual stress, may be descri those factors in the police environment which are external to the offi are subjectively perceived as bothersome or frustrating (Lazarus, 198 survey was originally factored into two major components, (1) organiza or administrative factors and (2) inherent police work factors. Exam items that represent the organizational component are court decisi stricting police, assignment of disagreeable duties, lack of recognitio good work, disagreeable department regulations, lack of participation decisions, and excessive inappropriate discipline. Example of items of ent stressors included responding to a felony in progress, high speed c dealing with crises, physical attack upon one's person, and the death jury of other officers. Officers responded to each item on a scale of 0 t where 0 indicated "no stress" and 100 indicated "maximum stress." Th quency of occurrences portion was not included to keep the survey as possible and to reduce bias (Grier, 1982; Martelli, *et al.*, 1989). Of scores were the sum of items for each stressor scale. Both factored were reliable (alpha = .90 and .92, respectively).

Psychological distress.—Psychological distress was measured by the

ter for Epidemiological Studies Depression Scale. This 20-item scale is a self-report survey composed of items describing feelings of depression, fear, loneliness, and sadness (Radloff, 1977) and has been shown to indicate types of distress that may accompany depression (Devins & Orme, 1985). Officers were asked to reply on a four-point scale, ranging from "rarely or none of the time" to "most all of the time," and to indicate by number how often they experienced each of the symptoms. Scoring ranged from 0 to 60, with higher scores indicating increased depression. Each respondent's score was the sum of the ratings of the 20 items. The CES-Depression scale had good consistency in the present research (alpha = .78).

Job attitudes.—Job attitudes may be important factors which mediate job stressors and personal distress. Job satisfaction was measured with a six-item scale developed by Martelli, *et al.* (1989). The scale measures attitudes towards satisfaction with salary, co-workers, promotion, supervision, and work. Respondents replied on a seven-point scale ranging from 0 (very dissatisfied) to 7 (very satisfied). Attitudes toward organizational goal orientation were assessed by a 9-item scale developed by Porter, Steers, Mowday, and Boulian (1974). This scale utilized a 7-point response format ranging from "strongly agree" to "strongly disagree" (alpha = .78).

Results

Interrelationships among police organizational and inherent stressors, work attitudes, and psychological distress were explored using regression and structural equations. Regression allowed for a controlled examination of the form and strength of relationships among the variables, while structural analysis provided estimates of direct and indirect relationships as well as the conceptual model's fit to actual observations (Duncan, 1975).

Fig. 1 provides a path model of direct and indirect effects of police stressors and job attitudes on psychological distress. Table 1 provides direct, indirect, and total effects of these same variables on psychological distress.

The path model in Fig. 1 indicates that organizational stressors directly and significantly increased psychological distress in officers (.30 Standard Deviation), directly decreased organizational goal orientation (– 0.04 Standard Deviation), and significantly decreased job satisfaction (– 0.46 Standard Deviation). Inherent police stressors directly increased job satisfaction and goal orientation, while decreasing psychological distress slightly (– 0.03 Standard Deviation). Job satisfaction appears to directly decrease psychological distress (– .14 Standard Deviation), and goal orientation directly and significantly increased distress (.26 Standard Deviation).

Table 1 provides path coefficients for the *indirect effects* of job satisfaction and goal orientation, which acted as modifiers of the relationship between police stressors and psychological distress. Indirectly, organizational job stressors appeared to decrease the distress-reducing potential of job satis-

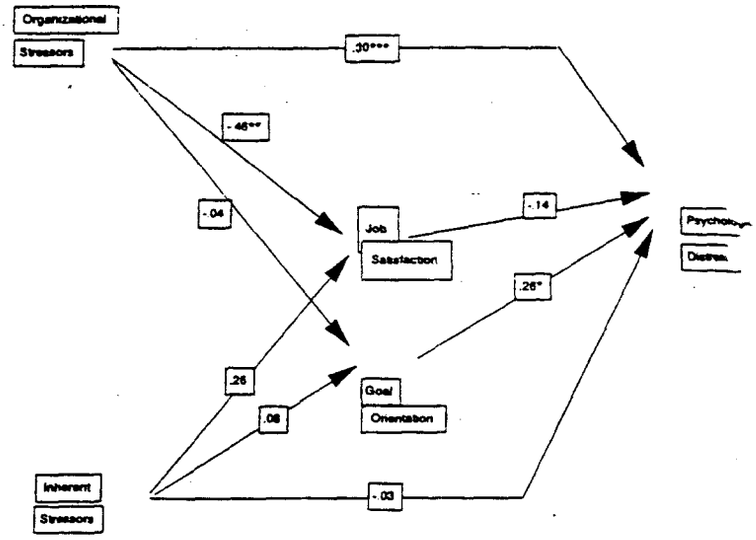


FIG. 1. Path model: police stressors, job attitudes, and psychological distres
**$p < .01$. ***$p < .10$.

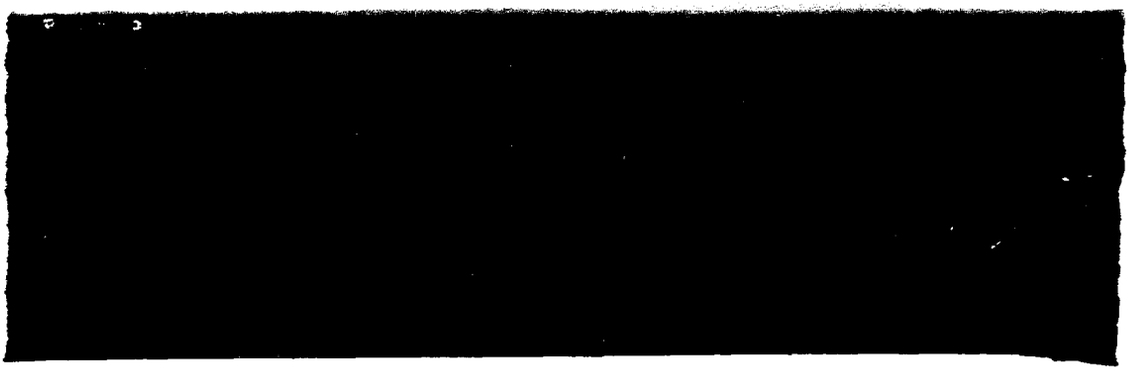
faction. As Table 1 indicates, the indirect effect of organizational stre
distress through job satisfaction was −.064 Standard Deviation, wh
direct effect of job satisfaction alone was −.14 Standard Deviation.
job stressors had a similar effect, indirectly lowering the direct effe
satisfaction on distress from −.14 Standard Deviation to −.036
Deviation. The indirect effect of organizational stressors on distres
goal orientation reduced the positive effect of goal orientation on
from .26 Standard Deviation to .01 Standard Deviation. Inherent jo
ors similarly reduced direct effects of goal orientation on distress
Standard Deviation to .02 Standard Deviation.

The total effect of organizational stressors on psychological distre
cluding direct and indirect effects, was .246 Standard Deviation.
effect of inherent stressors on psychological distress was −.046 Stan

TABLE 1
PATH ANALYSIS: INDIRECT REGRESSION ESTIMATES OF POLICE STRESSORS ON PSYCHOLOGICAL DISTRESS MEDIATED BY JOB ATTITUDES

Job Stressors	Direct Effect	Indirect Effect Mediators		Total
		Job Satisfaction	Goal Orientation	Indirect
Police Organization	.30	−.064	.010	
Inherent in Policing	−.03	−.036	.020	

Note.—In path analysis, indirect paths are multiplied together. Total effects are determi
adding direct and indirect effects together. See Fig. 1.



viation. Thus, the total effect of organizational stressors on distress was about 6.3 times as great as that of inherent stressors.

Discussion

The present findings provide some evidence that sources of stressors may be important determinants of individual distress in police officers. Most interesting was the finding that organizational stressors had a *total effect* on distress of approximately 6.3 times that of inherent police stressors. Public perception centers on the inherent aspect of policing, and police stress is thought to be directly related to such factors as danger or violence. The present findings demonstrate that the focus of investigation on police stress should include the police organization.

It appears that job satisfaction is an important factor. Officers who directly reported higher job satisfaction also reported significantly lower distress. However, when officers faced organizational stressors, the ameliorating effect of job satisfaction was markedly reduced. Inherent stressors had a similar effect on job satisfaction and distress. The same was not true for goal orientation, which directly increased distress among officers regardless of the type of stressor. Attempts by officers to fulfill the goals of the police organization may have produced a stressful overload. Factors such as conflicting, ambiguous, or unclear goals may underlie increased distress (Aron, 1992).

There are several suggestions for research. First, a panel or longitudinal design might help to explain variance in stress scores over time. The present study was cross-sectional. Secondly, additional intervening variables such as personality and coping strategies should be included in analysis. Coping is certainly important when considering mediation of distress (Lazarus, 1981; Pearlin & Schooler, 1978).

Finally, police management may consider present results as useful ideas for possible intervention. Although inherent job stressors cannot be changed, organizational policies and practices that increase distress may be changed. The present study indicates that increased job satisfaction is important in reducing distress. Police administration might formulate policy to promote and maintain satisfaction with work, while at the same time decreasing organizational stressors. Newman and Beehr (1979) recommended that one of the first steps in effective reduction of stress is establishing which factors contribute to such stress. In this way, the organization might better be able to avoid the sometimes negative psychological effects that stressors and distress have on workers' health, morale, and productivity.

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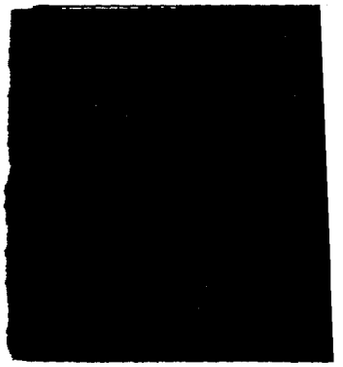

Psychological Reports, 1997, 81, 835-845. © Psychological Reports 1997

DUTY-RELATED STRESSORS AND PTSD SYMPTOMS IN SUBURBAN POLICE OFFICERS[1,2]

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Summary.—This study examined the effects of duty-related stress on police officers. Using a sample of 100 suburban police officers, an anonymous questionnaire requested demographic information and included a measure of duty-related stressors, SCL-90–R, the Posttraumatic Stress Disorder scale of the Impact of Events Scale–Revised, and a locus of control scale. Also assessed was whether Critical Incident Stress Debriefing was experienced. The results showed significant correlations between scores on duty-related stress, somatization, and symptoms of PTSD. 13% of the sample met the DSM-IV (1994) diagnostic criteria for PTSD. Results of the regression analysis showed the best predictors for the diagnosis of PTSD were associated with the factor of Exposure to Death and Life Threat, which corresponds to the DSM-IV A1 criteria. Finally, 63% of the respondents stated that a critical incident debriefing would be beneficial following an extremely stressful event related to duty.

In recent years there has been a growing literature on the causes of Posttraumatic Stress Disorder (PTSD) (Wilson & Raphael, 1993), and studies have shown trauma can affect public safety officers such as police and fire personnel (Mitchell & Everly, 1995). Police officers are frequently exposed to traumatic stressors, for example, they are expected to cope with several types of critical incidents such as situations of abuse, those involving victims of serious accidents and hostages, riot control, violent confrontations, failed resuscitation attempts, and assistance in disasters (Gersons & Carlier, 1995, p. 326). The purpose of the present research was to explore the possibility of PTSD symptomatology and somatization as well as observing the subjective stress encountered by police officers in the line of duty. By using standardized scales that measure the variables in question, this study was focussed on whether police officers report significant somatization and PTSD symptomatology. This study also examined the everyday occupational stressors to which police officers are exposed and how these stressors may affect their physical and mental health.

Based on previous research on other emergency service professions, the present study was designed to assess whether suburban police officers are susceptible to posttraumatic reactions to stress encountered in the line of duty. It was proposed that suburban police officers would experience signifi-

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stressors such as shooting incidents may even lead to a chronic form of PTSD (Posttraumatic Decline) as described in a study on work-related trauma in police officers (Gersons & Carlier, 1995). Posttraumatic Decline is usually characterized by a rearousal of symptoms in the face of an immediate, emotionally disturbing event, for example, exposure to the next critical incident or traumatic event.

Other critical incidents besides shooting situations are also associated with PTSD symptoms in police officers. Situations such as being called to the scene of a battered or dead child was ranked extremely stressful and, based on these findings, it was concluded that the likelihood of PTSD in police officers may be greater than those in many other occupations (Mann & Neece, 1990). Support for this conclusion is found in work by Martin, *et al.* (1986) who surveyed 53 officers about their stressful experiences in the line of duty and their reactions to those experiences. Sixty percent of the 53 officers reported that one or more events they experienced was highly stressful such as being shot at, being physically threatened, or having their families threatened, and working with victims who were badly beaten or who had family members killed. Thirty-two percent of the officers reported being exposed to three or more violent stressors. Also, Weiss, Marmar, Metzler, and Ronfeldt (1996) identified predictors of symptomatic distress in emergency services personnel exposed to traumatic critical incidents. This study also reported that replicated analysis on levels of symptomatic distress were positively related to the exposure to the critical incident.

In addition to police officers, other studies have focused on the frequent reexposure to critical incidents experienced by emergency services such as firefighters and emergency medical services. Corneil (1995) found that 16.5% of his sample of 1,154 firefighters reported having PTSD symptoms. Corneil also found that traumatic incidents such as suicides and maiming accidents contributed to PTSD symptoms (p. 36). Related to this finding, Moran and Britton (1994) suggested that length of experience in active emergency service is an important factor because workers may decompensate in proficiency upon continued exposure to extreme stress (p. 576). They also reported that a lack of coping skills puts all emergency service personnel at greater risk for developing stress disorders; however, they also stated that it would be unlikely that any coping skill could defend against chronic exposure to traumatic stress (Moran & Britton, 1994).

Other researchers have suggested intervention techniques are beneficial to emergency service professionals. Critical Incident Stress Debriefing is an intervention program designed to facilitate the prevention of posttraumatic stress among high-risk occupational groups such as firefighters, police officers, emergency medical services, disaster response staff, and public safety personnel (Mitchell & Everly, 1995). Gersons and Carlier (1995) stated that

officers between the ages of 20 and 60 years. Five questionnaires were excluded from the sample as data were incomplete. The mean age was 36 yr. Eighty three percent of the sample were Euro-American, 10% were Hispanic, 4% were African American, and 3 indicated other status.

A scale to measure duty-related stressors was composed of 25 items. The subjects were asked to indicate whether they had experienced the event, e.g., item number one . . . "Have you ever had to discharge your weapon in the line of duty?", and to rate the level of stress associated with the incident, e.g., "If yes, how stressful was the experience for you?". The responses to stressor questions were rated on a 3-point scale. The questionnaire also contained the standardized scale for PTSD, the Impact of Events Scale–Revised (Weiss, 1993) which was scored by DSM-IV criteria for PTSD. A somatization scale, Symptoms Checklist–Revised (SCL-90–R), a locus of control scale (Harel, *et al.*, 1993), and an assessment of whether the police officers had been debriefed was also asked in the questionnaire.

Horowitz (1986) introduced the Impact of Events Scale as a self-report measure that could be representative of any traumatic life event and that measured the two most commonly reported symptom clusters of trauma which are intrusive symptoms such as nightmares, intrusive thoughts, images, or feelings, and avoidance symptoms such as attempts to deflect or avoid experiences affiliated with the trauma and the associated numbing of responsiveness (Weiss & Marmar, 1997). To measure thoroughly the response to traumatic events, the dimension of hyperarousal symptoms were added to the Impact of Events Scale to revise it. Weiss, *et al.* (1995) "developed a set of seven additional items, with six to tap the domain of hyperarousal and one to parallel the then DSM-III–R and now DSM-IV diagnostic criteria" (Weiss, *et al.*, 1997, p. 403). The Impact of Events Scale–Revised consists of a total of 22 items—7 intrusion items, 8 avoidance items, and the more recent 7 hyperarousal items. Each subject was asked to answer the items as they related to the most disturbing or stressful situation they had encountered in the line of duty and then to report their reactions to this incident(s) in the past seven days.

"The SCL-90–R is a 90-item self-report symptom inventory developed by clinical psychometric research; it is designed primarily to reflect the psychological symptom patterns of psychiatric and medical patients" (Derogatis, 1992, p. 2). The SCL-90–R is scored and interpreted in terms of nine primary symptom dimensions and three global indices of distress. These nine primary symptom dimensions are Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism (p. 2). The three global indices of distress are Global Severity Index (GSI), Positive Symptom Distress Index (PSDI), and Positive Symptom Total (PST) (p. 2). For the purpose of this study only

mean for this nonpatient
SCL-90-R was .36 (σ = .42).
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. All subjects were clearly
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rned within 48 hours or
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prior to daily active-duty

lated stressor scale were
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ed to a principal compo-
yielded seven orthogonal

or variables in a tradi-
erion variables were the
cale–Revised to observe
m clusters of Posttrau-
ing, and hyperarousal.
ion for the duty-related

TSD Scores.
(N = 100)

4	5	6
.92‡	.47‡	.36‡
.60‡	.30‡	.35‡
.71‡	.37‡	.29‡
	.45‡	.31†
		.19

TABLE 2

PRINCIPAL COMPONENT ANALYSIS WITH VARIMAX ROTATION OF DUTY-RELATED STRESSORS: LOADINGS BY FACTOR

Duty-related Stressor Dimension	Factor Structure and Item Loading						
	Death Encounter 1	Death Exposure 2	Physical Threat 3	Emergency Response 4	Pursuit 5	Deadly Force 6	Situation Intensity 7
Discharge Weapon	−.07	−.03	.20	.21	−.15	.23	.62
Assault/Weapon	.14	−.18	.74	.14	−.11	−.25	.22
Foot Pursuit	−.13	.15	.34	.31	.61	−.11	.33
Vehicle Pursuit	.10	−.00	.23	.70	.14	.14	.26
Use Force	.20	.13	.67	.30	.30	.04	.03
Cardiopulmonary Resuscitation	.39	.26	.00	.29	.19	.06	−.03
Killed Civilian	.05	−.07	−.01	.13	.11	.78	.07
Life Threat	.01	−.08	.46	.26	.16	.50	.43
Witness Officer Injury	−.17	.20	.64	.04	.14	.30	.01
Witness Civilian Die	.43	.35	.38	.09	−.17	.40	.03
Fatal Motor Vehicle Accident	.50	.24	.51	−.11	.04	.23	.06
Child Abuse	.06	.75	.00	.16	.02	−.15	−.15
Riots	.63	.08	.09	.45	−.00	−.15	.11
Area Search	.17	.07	.02	−.00	.82	.16	−.05
Rape Victims	.15	.49	.12	−.15	.16	.38	.01
Notify Victims	.14	.72	.09	.00	−.01	.09	.16
High Speed Chase	.41	.02	.20	.32	.47	.15	−.02
Rescue Fire Victims	.06	.16	.07	.71	.03	.07	−.06
Deal With Disease	.65	.02	−.21	−.03	.00	.22	.14
Big Raid	.34	.17	−.05	−.08	.17	−.08	.78
Suicide	.47	.45	.10	−.18	.25	.12	.27
Dead Bodies	.38	.49	.15	−.05	.08	.07	.22
Arrest With Weapon	.51	.27	.45	.15	.18	−.04	−.16
Domestic Violence With Weapon	.62	.27	.23	.11	.13	−.17	.00
Dead Children	.11	.74	−.02	.28	.06	−.12	−.01

which were labeled as (1) :al Threat, (4) Emergency and (7) Situational Threats. ns of measure duty-related ecific stressor events asso- (Death Encounter) loaded n die, responding to a fatal in high speed motor vehi- isease (such as HIV), and ce situations (betas = .39 to

used to identify which of he measures of PTSD and e and age predicted total nptoms of intrusive trau- dicted by the factor Death ($R^2 = .32$, $p < .05$) as were 05).

D PTSD IN POLICE OFFICERS

Beta	R^2	F
.32	.32	8.55
.38	.39	6.53
.26	.26	5.25
.32	.32	8.68
.32	.32	8.42
.38	.38	12.48
.39	.52	13.63

d report significant scores supported. Police officers n self-report measures de- Given the over-all cooper- ice officers would not an- contention that police of-

ficers experience substantial amounts of stress, somatization, and PTSD symptoms because of the nature of police work was supported by the results of this study.

The hypothesis that police officers would exhibit symptoms of somatization and posttraumatic stress resulting in an external locus of control was not supported. This hypothesis originated from early literature on war veterans with PTSD who reported having an external locus of control after war trauma (Harel, *et al.*, 1993). The police officers in the current study were still being exposed to daily stress and trauma. This may account for their score as internal locus of control since they needed to continue functioning in the line of duty. Another possibility is that police officers as a population may simply exhibit an internal locus of control as a job requirement. Further research should be conducted before a formal conclusion can be made.

It was also expected that police officers would have higher stress in the line of duty especially after being on the force five years or more. This hypothesis involving higher stress in officers on the force five years and over turned out different from expectation. This hypothesis was based on voluntary information given from various participants who seemed to agree that five years of experience and under would constitute a "rookie." This information was used as an indicator of where to divide the sample between more and less experienced officers. It was expected that there would be a positive, linear relationship between years on duty and symptoms of stress subjectively reported. Regardless of "rookie" status, eleven years and under is a better gauge for concentrations of symptomatology, meaning those officers with fewer years (11 or less) of experience reported more PTSD and somatic complaint symptoms.

One interpretation is that those with the least experience may be at the greatest risk for PTSD symptoms. The reason for this interpretation is that younger officers may not have developed successful coping mechanisms to deal with critical incidents. On the other hand, younger officers may not be as hardened or as numb to intense stressors as older veteran officers. Also, younger officers may report higher PTSD Symptoms because they are more likely to be on street patrol. This puts them at a greater risk for experiencing traumatic situations than the veteran officers who may have desk jobs. Finally, another possible interpretation may be that younger officers are likely to overstate trauma while veteran officers may be more conservative on self-report measures, which could account for the significant difference between these two groups.

Military police personnel were not the only demographic group to report significant posttraumatic stress based on the Impact of Events Scale–Revised. Other police officers with varied backgrounds reported significant stress they attributed to stressors encountered in the line of duty. The scale

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Accepted August 16, 1997

Biofeedback and Self-Regulation, Vol. 16, No. 1, 1991

Cardiodynamic Response to Psychological and Cold Pressor Stress: Further Evidence for Stimulus Response Specificity and Directional Fractionation

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In the present study 36 police officers were exposed to a psychological stressor (IQ quiz) and to cold pressor stress while several cardiovascular variables were monitored. Impedance cardiography was used to provide measures of heart rate, stroke volume, cardiac output, myocardial contractility, and total peripheral resistance. In addition, measures of systolic and diastolic blood pressure and peripheral skin temperature were obtained. A multivariate analysis of variance (MANOVA) indicated that significant increases in diastolic and systolic blood pressure during the cold pressor test were mediated by large increases in total peripheral resistance, whereas blood pressure elevation during the IQ quiz were accompanied by significant increases in heart rate and, to a lesser extent, cardiac output. Peripheral skin temperature decreased in response to each stressor. Additional analysis indicated a degree of stimulus specificity for several variables. For example, diastolic blood pressure showed greater in-

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creases to cold pressor than quiz, whereas systolic blood pressure increased more with the psychological than the physical stressor. Directional fractionation occurred for both myocardial contractility and cardiac output.

DESCRIPTOR KEY WORDS: stimulus response specificity; directional fractionation; stress; impedance cardiography; diastolic blood pressure; systolic blood pressure; cardiac output; stroke volume; heart rate; total peripheral resistance.

The use of impedance cardiography, a noninvasive technique of measuring stroke volume, cardiac output, total peripheral resistance, myocardial contractility, and heart rate, has permitted researchers to more clearly define cardiovascular response to cognitive/physical demands. Sherwood, Allen, Obrist, and Langer (1986) demonstrated that increases in cardiac output in response to a reaction time task were associated with increases in heart rate, while stroke volume decreased during cold pressor stress. Although not specifically stated by these authors, the findings illustrate the concept of stimulus response specificity which states that an individual's pattern of physiological activity (e.g., heart rate, blood pressure) will be similar in a given situation, but that the patterning may change when stimuli are varied (Ax, 1953; Engel, 1959, 1972).

In another impedance study Allen, Obrist, Sherwood, and Crowell (1987) found that increases in cardiac output to cold pressor and arithmetic were due to large increases in heart rate associated with small decreases in stroke volume. Total peripheral resistance decreased during a reaction time task and increased in response to arithmetic and the cold pressor stress. This latter finding indicated directional fractionation, a term used by Lacey (1959) to describe stimulus situations in which direction of change of autonomically controlled variables differed.

Several other studies have demonstrated the apparent sensitivity and reactivity of impedance-derived variables in that increases in both cardiac output and blood pressure in response to the cold pressor test and mental/cognitive behavioral demands have been shown to be manifested by different underlying hemodynamic patterns (Allen and Crowell, 1989; Sherwood *et al.*, 1986; Andren and Hansson 1980; and McKinney *et al.*, 1985). For example, blood pressure increases during cold pressor stress are mediated by large increases in total peripheral resistance, whereas blood pressure increases during mental arithmetic are the result of large increases in cardiac output.

The present study examined impedance cardiography-derived stroke volume, heart rate, cardiac output, Heather's index of myocardial contractility, and total peripheral resistance in response to a novel psychological stressor (IQ quiz) and a cold pressor test. Systolic and diastolic blood pressure were recorded along with peripheral skin temperature, a variable not monitored in past impedance studies. Skin temperature provided an additional indicator of sympathetic nervous system activity. Skin temperature is used extensively in clinical biofeedback, and a documentation of changes in relation to impedance variables could provide data indicating the overall physiological changes that occur during thermal training. We hypothesized that the IQ quiz would be an effective psychological stressor and, when compared with the standardized cold pressor test, would result in blood pressure increases through different hemodynamic patterns. That is, elevated blood pressure during the cold pressor test would be facilitated by large increases in total peripheral resistance, whereas blood pressure elevation in response to the quiz would be due to increased cardiac output.

METHOD

Subjects

The subjects were 36 healthy adult volunteers with a mean age of 36.6 years (33 males). All subjects were active duty police officers who agreed to participate in an experimental stress management program offered by the Connecticut police department. This experiment was conducted prior to participation in the stress management program.

Apparatus

Impedance derived variables were obtained noninvasively with an Instrumentation For Medicine model 400 Impedance Cardiograph. Four mylar band electrodes were placed on each subject. Two of them completely encircled the neck, with 1 in. between, and two were placed on the abdomen, one at xiphoid level and the other 4 in. below. A comprehensive overview of impedance cardiography and formulas was provided by Mohapatra (1981), and a review of the techniques used in psychophysiological research was provided by Miller and Horvath (1978) and Andreassi (1989). Blood pressure was determined by a Dinamap model 850 automated sphygmomanometer. Skin temperature was monitored with an Autogenic Systems feedback thermometer using a Coldspring research grade thermistor. The thermistor was taped to the dorsal surface of the distal phalange of the third digit of the nonpreferred hand.

Procedure

The experiment was conducted in a private room assigned to the project within the police station and all subjects were tested during normal duty hours. They were first interviewed to obtain demographic and medical history data while electrodes were attached by a second experimenter. After attachment was completed subjects sat upright in a padded conference chair for the entire procedure. Before the start of the experiment, subjects were instructed in a respiratory pause on command in order to minimize impedance recording artifacts. They were requested to hold their breath following a full, but not forced exhalation. A trial cardiograph recording was made prior to the start of the experiment to ascertain that each subject comprehended the instructions and could produce the desired respiratory manipulation. An impedance calibration signal was also recorded at the beginning and end of each session.

The psychophysiological assessment consisted of several conditions that employed a relatively unknown "IQ quiz" and cold pressor test. The IQ quiz was developed by Schiffer, Hautley, Schulman, and Abelman (1976) who found it to be an effective psychological stressor in hypertensive and angina populations. Those subjects with existing cardiovascular disorders responded to the quiz more strongly compared to normals, as evidenced by elevated heart rate and blood pressure and depression of the *S-T* segments of the electrocardiogram. The only other study found employing this stressor was that of Albright, Andreassi, and Steiner (1988), who found high correlations between Type A behavior and stroke volume reactivity in response to the IQ quiz. The quiz consists of tape-recorded questions that are designed to provoke the subject's anxiety by increasing the difficulty of questions under time pressure. Subjects have 5 s to answer before the correct answer is tersely given and the next question is delivered. A set of curtly delivered instructions preface the questions. The entire evaluation consisted of the following conditions:

Condition 1: A 5-min resting baseline period, during which time the subjects were instructed to remain quiet.

Condition 2: Two minutes of self-relaxation where subjects were instructed to close their eyes and allow themselves to become as relaxed as possible.

Condition 3: The IQ quiz. A 2-min trial was initiated after a standardized set of taped instructions and the first 10 questions or first 3 wrong answers (whichever came first).

Table I. Mean and Standard Deviations of Hemodynamic Variables for Baseline, IQ Quiz, and Cold Pressor Test (N = 36)

	Conditions					
	Baseline		IQ quiz		Cold pressor	
Variables	Mean	*SD*	Mean	*SD*	Mean	*SD*
Systolic blood pressure (mm Hg)	132.2	15.1	142.5	17.9	147.5	18.0
Diastolic blood pressure (mm Hg)	84.8	7.5	88.4	8.3	94.9	10.9
Heart rate (beats per min)	69.0	10.1	74.8	11.3	78.5	13.7
Stroke volume (ml)	64.8	17.4	62.7	20.3	51.9	21.9
Cardiac output (liter/min)	4.4	1.1	4.6	1.4	4.0	1.6
Contractility (Heather's index)	13.9	5.1	14.0	6.9	11.0	4.8
Total peripheral resistance (MAP/CO)	24.5	7.4	25.6	8.8	32.8	14.2
Skin temperature (°F)	90.2	7.0	88.6	6.2	87.8	6.3

Condition 4: A 2-min recovery period where subjects were instructed to remain quiet.

Condition 5: The cold pressor test during which subjects were instructed to immerse their right hand to the wrist, with fingers spread, in a bucket of ice water, for 60 s.

Condition 6: A 4-min recovery period during which subjects were instructed to remain quiet.

The IQ quiz and cold pressor test conditions were not counterbalanced due to the extreme effects the cold pressor test produced on skin temperature in the opposite limb. In similar protocols used in our laboratory, the 2-min recovery period was sufficient for all other variables to return to approximately their original levels.

All recordings were taken during the final 20 s of each condition with the exception of the cold pressor test, where measurements were made immediately after the hand was removed from the water and supported on the chair. This turned out to be the only reliable way of assuring that the automated blood pressure device did not reject readings due to movement artifact. Impedance cardiograph recordings were first obtained for five heart beats, then blood pressure was measured. We did not record these simultaneously for concern that the occlusive cuff would influence total peripheral resistance.

All cardiovascular measures for baseline, IQ quiz, and cold pressor conditions were analyzed using a multivariate analysis of variance (MANOVA).

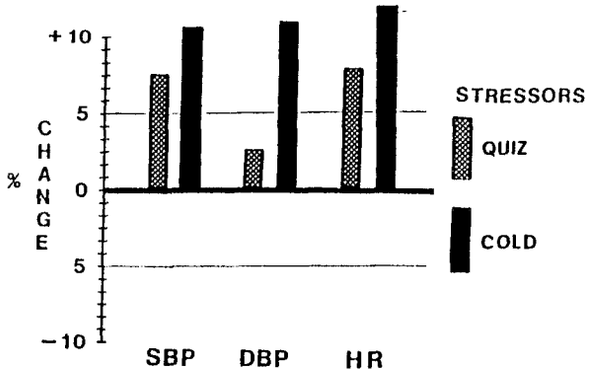

Fig. 1. Systolic blood pressure (SBP), diastolic blood pressure (DBP), and heart rate (HR) reactivity to the IQ quiz and cold pressor test in terms of percent change from baseline (N = 36).

RESULTS

When compared to baseline, significant increases in response to the IQ quiz were noted for systolic blood pressure (F = 49.98, df = 1, 34, p < .001); diastolic blood pressure (F = 13.58, df = 1, 34, p < .001); and heart rate (F = 53.34, df = 1, 34, p < .001). Skin temperature decreased significantly (F = 12.7, df = 1, 35, p < .001) from the nonimmersed hand. There was a near significant increase in cardiac output (p < .15), whereas stroke volume decreased slightly and total peripheral resistance was slightly increased. No change was observed for myocardial contractility (see Table I).

When compared to baseline, response to the cold pressor test showed significant increases in systolic blood pressure (F = 50.89, df = 1, 34, p < .001), diastolic blood pressure (F = 30.36, df = 1, 34, p < .001) and heart rate (F = 36.8, df = 1, 34, p < .001). Skin temperature decreased significantly (F = 15.67, df = 1, 34, p < .001). Response to the cold pressor test, when compared to the IQ quiz, indicated significant decreases in stroke volume (F = 11.88, df = 1, 35, p < .01) and myocardial contractility (F = 40.34, df = 1, 35, p < .001). Total peripheral resistance significantly increased (F = 11.74, df = 1, 35, p < .002) (see Table I).

When comparing responses to the IQ quiz and cold pressor test, significant differences were found for all variables. Systolic blood pressure (F = 6.68, df = 1, 34, p < .014) and diastolic blood pressure (F = 12.6, df = 1, 34, p < .001), heart rate (F = 6.15, df = 1, 35, p < .018), and total

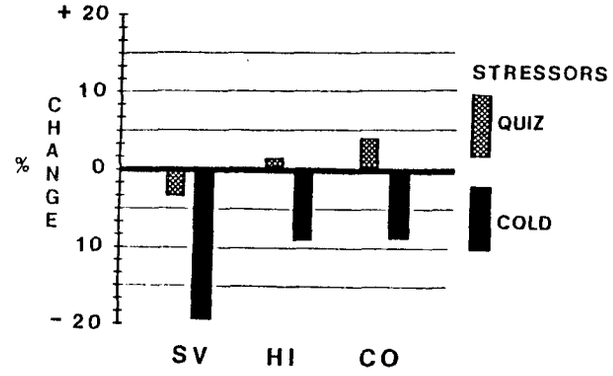

Fig. 2. Stroke volume (SV), Heather's index of myocardial contractility (HI), and cardiac output (CO) reactivity to the IQ quiz and cold pressor test in terms of percent change from baseline (N = 36).

peripheral resistance (F = 9.38, df = 1, 35, p < .004) were all larger for the cold pressor test as compared to the quiz; while stroke volume (F = 7.83, df = 1, 35, p < .008), cardiac output (F = 7.45, df = 1, 35, p < .010), myocardial contractility (F = 20.16, df = 1, 35, p < .0001), and skin temperature (F = 6.42, df = 1, 34, p < .016) were lower for cold pressor compared to the quiz. Figure 1 illustrates reactivity to the psychological and cold pressor stressors in systolic and diastolic blood pressure and heart rate in terms of percent change from baseline. Figure 2 illustrates directional fractionation in terms of percent change from baseline for myocardial contractility and cardiac output. In addition, response specificity is shown for stroke volume changes.

DISCUSSION

Physiological response to the IQ quiz stressor is similar to that reported in past studies for a mental/cognitive stressor (Sherwood *et al.*, 1986; Allen *et al.*, 1987). That is, systolic and diastolic blood pressure increased as the apparent result of increases in heart rate and a near significant increase in cardiac output. The effect on cardiac output appears to be due to increased heart rate, not stroke volume. This reactivity is probably due to sympathetic activation via beta-adrenergic influences. The

significant decrease in peripheral skin temperature further confirms this, i.e., the sympathetically mediated vasoconstriction in the digits. There also exists the possibility that these changes partly resulted from decreases in parasympathic activation (parasympathetic withdrawal) as suggested by Allen, Sherwood, and Obrist (1986). They observed individual ventilation differences in response to a cold pressor test. When looking at the effects of propranolol on extreme ventilation reactors, they found an incomplete blockage of cardiovascular reactivity. This suggests that increases in cardiac output, pre-ejection period, and heart rate may be due to parasympathetic inhibition in addition to increases in sympathetic activation.

The physiological changes observed with administration of the IQ quiz, along with subject reactions, support the use of this technique as a stressor in psychophysiological studies. It offers a useful alternative to cognitive stressors currently employed in psychophysiological assessments prior to the conduct of clinical biofeedback procedures.

Response to the cold pressor test also resulted in significant increases in the more traditional cardiovascular variables of systolic and diastolic blood pressure and heart rate, while skin temperature decreased. The increase in blood pressure was probably the result of the large increases in total peripheral resistance. The nonsignificant decrease in cardiac output was contributed to by a substantial decrease in stroke volume, which was not fully compensated for by increases in heart rate. The large decrease in stroke volume would also account for the significant decrease in myocardial contractility in conformance with Starling's Law where contractility is influenced by a decrease in the amount of venous return to the heart. Large increases in total peripheral resistance, and concurrent decreases in stroke volume during the cold pressor test, were also reported by Allen *et al.* (1987).

In conclusion, the IQ Quiz was confirmed as an adequate stressor in psychophysiological studies. Increases in blood pressure during the cold pressor test were facilitated by large increases in total peripheral resistance. The decrease in peripheral skin temperature during the quiz provided additional evidence that increased sympathetic activation mediated the changes observed.

Although not mentioned in other impedance studies, the cardiovascular response patterns observed with different conditions indicate stimulus response specificity and directional fractionation. Stimulus specificity was evidenced by greater changes in systolic and diastolic blood pressure, heart rate, stroke volume, total peripheral resistance, and peripheral skin temperature when comparing cold pressor test to IQ quiz reactivity. Directional fractionation was shown in myocardial contractility and cardiac output, since they decreased during cold pressor and increased during the IQ quiz. Thus, this study has added to the relatively few that have illustrated the concepts of stimulus response specificity and directional fractionation using impedance-derived cardiovascular variables.

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Stress in the Police Service

Cary L. Cooper, Ph.D.; M.J. Davidson, M.A.; and P. Robinson, B.A.

In this study, the sources of stress among supervisory police officers were explored. It was found that one of the major sources of stress across all managerial levels among the police was the perception that the police service was inhibited by unnecessary bureaucratic and outside obstacles, e.g., increased paperwork, interdepartmental politics, lack of adequate planning and resources and the inability of the courts to prosecute offenders. It was also found that junior and middle supervisory police officers were adversely affected by lack of available manpower and long working hours, whereas senior officers were affected more by the conflict in maintaining positive policing as well as good community relations.

Recent research[1-3] has shown that the job of policing is an extremely stressful occupation. Indeed, concern over the high incidence of stress-related illnesses among the police in the United States has reached such proportions that an International Law Enforcement Stress Association has been formed and publishes a quarterly journal called *Police Stress*. In addition, there is some evidence that there is a higher incidence of suicide among the police than among other occupational groupings, both in the United States[4] and throughout the world.[5]

Numerous sources of occupational stress have been identified as contributing to stress-related illnesses. Among them are poor police-community relations,[6] erratic and unsocial shiftwork hours,[2] shortage of manpower/longer working hours,[7] courtroom appearances,[2] and physical danger.[5] Little work has been done, however, to identify the full range of potential stressors acting on policemen at work. Most of the studies carried out to date have focused on one, or at most, two stressors at a time. In addition, few have explored the effect of these stressors on both the physical and emotional well-being of policemen. Finally, very little attention has been paid to stress among the supervisory ranks of the police, with most of the research focused on the policeman-on-the-beat.

It was the purpose of this investigation, therefore, to carry the research work further by extending the methodology to examine the effect of a wide variety of policing stressors on both physical and mental health (by use of multivariate statistical techniques), and by concentrating the investigation on the junior, middle, and senior supervisory ranks within the police service.

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Methods of Research

Sample – In this study, 191 police officers with managerial responsibility on a large metropolitan force in the United Kingdom constituted the sample. Table 1 highlights the demographic breakdown of the sample, which represents a 10% random sample of the total supervisory population of the force investigated.

As may be seen, the sample population extends from first line police supervisors (e.g., sergeants) to top senior management (e.g., chief superintendents), and from uniformed operational officers to detectives (e.g., Criminal Investigation Division).

Measuring Instruments – For the purposes of this investigation, both work stressor and demographic measures were needed as independent variables, and physical and mental health measures as dependent variables.

1. Physical Health – The type A behavior questionnaire originally developed by Bortner & Rosenman[8] was used as an indicator of cardiovascular well-being. In recent years, the Type A pattern of behavior has turned out to be a very strong predictor of cardiovascular disease.[9] Type A behavior can be characterized by "extremes of competitiveness, striving for achievement, aggressiveness, haste, impatience, restlessness, hyperalertness, explosiveness of speech, tenseness of facial muscles, and feelings of being under pressure of time and under the challenge of responsibility." Type B behavior, on the other hand, reflects the opposite pattern of behavior.

In an effort to minimize acquiescence response set bias, the research instrument selected to measure Type A behavior consisted of 14 bipolar adjectival scales with 11-point Likert-type rating continua, with half of the items expressed in high Type A terms (e.g., "always rushed," "goes all out,") and the others in low terms (e.g., "can wait patiently"). It is interesting to note that a random instrumentation of the Type A questionnaire to a cross-section of the population would normally produce the following configuration of Type A scores: A1 or extreme Type A behavior, 10%; A2 or moderate Type A behavior, 40%; B3 or moderate Type B behavior, 40%; and B4 or extreme Type B behavior, 10%. Our police sample, on the other hand, showed the following pattern: A1, 22.8%; A2, 47.1%; B3, 30.1%; and B4, 0.0%. This reflected a higher Type A distribution than would normally have been expected.

Table 4 – Multiple Regression Analysis of Work Stressors/Demographic Variables Against the MHQ Depression Scale for Sergeants

Step	Stressor Variable	Multiple R	R^2	R^2 Change
1	Age	.254	.065	.065
2	Length of Service	.255	.065	.000
3	Sex	.353	.125	.059
4	Male operational policemen	.430	.185	.060
5	Factor 1: Work overload	.484	.234	.049
6	Married with family	.484	.235	.000
7	Factor 2: Lack of personal recognition	.485	.235	.000
8	Factor 3: Unnecessary obstacles	.526	.277	.041

$F = 2.26$; $p = .03$.

leniency of offenders, poorly managed resources), "work function-environment interface issues" (e.g., community relations, the media), and "autocratic management consequences." These items predicted the bulk of the variance and they reveal an interesting collection of stressors. These results are consistent with findings in the executive stress field,[12] which have shown that middle managers (i.e., inspectors) suffer primarily from lack of autonomy, control and power. It seems that police middle range supervisors, when they are most at risk of coronaries, may suffer from the same stressors as their industrial counterparts. It is also interesting to note that, of all the ranks, inspectors had the highest Type A scores.

Mental Health – A multiple regression analysis of work stressor and demographic variables was carried out against the overall mental health index of the MHQ for the police sample as a whole. It was found that the job-related factors were not predictive of overall mental health, with an R^2 of less than 13% for nine variables. It was then decided to explore each of the supervisory levels individually (with the exception of superintendents, who were combined with chief superintendents because of the small numbers involved) to see if mental illness could be predicted by a certain configuration of job and demographic stressors for each rank. This was done for the overall mental health index and for each of the four subscales of the MHQ (anxiety, obsessionality, somatic symptoms, and depression).

For each of the supervisory police ranks, the job-related factors were significantly predictive of overall mental illness, except in the case of sergeants where these variables were predictive of depression only. In addition, some factors were present for all the supervisory levels and some were unique to particular levels.

1. Sergeants – As may be seen in Table 4, sergeants who scored high on depression tended to be older operational officers who believed they were overloaded, and who perceived a number of bureaucratic and outside obstacles to effective police functioning. They complained about the long hours and heavy work load, as well as the increased paperwork, lack of resources and the failure of the courts to prosecute offenders.

2. Inspectors – Inspectors showed some of the same stressors as sergeants (Table 5), feeling overworked and having to cope with the same unnecessary obstacles to police work. In their case, however, the most vulnerable officers were not the older inspectors, but those with short-service. Most important of all, these middle managers, unlike the sergeants, seemed to suffer from what they perceived to be an "autocratic management style."

3. Chief Inspectors – The chief inspectors who seemed to suffer some form of mental stress (Table 6) were older, long-service, operational officers, who perceived themselves as being overloaded, as having to cope with unnecessary bureaucratic and outside obstacles, as being undervalued, and as having a superior who utilized an autocratic management approach.

4. Superintendents and Chief Superintendents – With the exception of the problems of "unnecessary obstacles inhibiting the police function," the variables that predicted mental stress for this group of senior police managers (Table 7) were different, qualitatively, from those seen

Table 5 – Multiple Regression Analysis of Work Stressors/Demographic Variables Against the MHQ Overall Mental Health Index for Inspectors

Step	Stressor Variable	Multiple R	R^2	R^2 Change
1	Age	.052	.002	.002
2	Length of Service	.240	.057	.055
3	Sex	.255	.065	.007
4	Male operational policemen	.259	.067	.001
5	Factor 1: Work overload	.300	.090	.022
6	Factor 2: Lack of personal recognition	.302	.091	.000
7	Factor 3: Unnecessary obstacles	.397	.157	.066
8	Factor 4: Autocratic style	.507	.257	.099

$F = 2.08$; $p = .05$.

Table 2 — Factor Analysis of Work Stressors

Factor 1: Work Overload (59.6% of variance)

1. The fact that I have too much work to do, i.e., overworked
2. Having to process large amounts of paperwork
3. Checking the everyday paperwork of subordinates
4. Accommodating time pressures and deadlines on one's own work e.g., files
5. Checking the 'Quality' paperwork of subordinates
6. The accelerating pace of technological change in the police service
7. The fact that part of my work demands a high standard of quality e.g., complex files, high level reports, complex legal and evidential interpretation
8. Increased responsibility through losing experienced personnel to specialist departments and being left with a large percentage of probationary constables
9. Shift work

Factor 2: Lack of Personal Recognition and Frustrated Ambition (9.8% of variance)

1. Feelings of anonymity in a large organization due to remoteness from the decision making center
2. The fact that my job knowledge, skills and experience are not being fully utilized
3. The uncertainty of my future career picture
4. The fact that my previous ambitions look as though they will never be fulfilled
5. Incongruence between the results of promotion boards and the recommendations of departmental/divisional commanders
6. The inequitable distribution of promotions between different departments/divisions
7. Having insufficient opportunity of representing one's assets and achievements to a promotion board, e.g., in 25 minutes they do not get to know me well enough
8. Lack of supportive personal interest in me and my job by my senior officers
9. Perceived unjust treatment by my senior officers likely to adversely affect my career
10. Perceiving that the status of my rank has declined

Factor 3: Perceived Unnecessary Obstacles Which Inhibit the Police Function (6.9% of variance)

1. The inadequate treatment of offenders by the judiciary
2. Perceiving that the increased proportion of senior officers and administrative specilizations to operational policemen has adversely affected the operational function
3. The fact that manpower resources are not utilized in an optimum way
4. The lack of co-operation that exists between departments
5. Perceiving that there has been a lowering of general standards within the service, e.g., discipline, standards of report writing
6. Perceiving that the current high volume and complexity of paperwork could be substantially reduced thereby increasing operational efficiency
7. Being required to perform tasks without having available the necessary tools, men or equipment to do the job
8. Increased responsibility through losing experienced personnel to specialist departments and being left with a large percentage of probationary constables

Factor 4: Autocratic Management Consequences (6.5% of variance)

1. Being supervised by someone who adopts an autocratic management style, e.g., ultra critical, inconsiderate, always pulling rank, reluctant to delegate responsibility, takes no account of the feelings of the persons being supervised
2. Not being adequately consulted on matters concerning my job and those for whom I am responsible, i.e., lack of professional input
3. Adopting oneself an autocratic management style
4. Hindsight type criticism of operational decisions taken in an emergency
5. The inflexibility of the organization's decision-making processes
6. Being given tasks by my supervisors which conflict with other duties I have to perform
7. Insufficient regular interaction between the different management levels, e.g., meetings

Factor 5: The Effect of Perceived Police/Public Relations (3.9% of variance)

1. The lack of public confidence and support for the police service generally
2. Biased media reports of alleged police wrongdoing
3. Adverse publicity of the police service generally
4. Perceiving that the operation of the unit beat policing system has adversely affected police/public relations

Factor 6: Work Function/Environment Interface (3.5% of variance)

1. Having to resolve the dilemma/conflict between positive policing and fostering good community relations
2. Having responsibility for decisions which affect peoples lives
3. Responsibility for people, their problems and well-being
4. Crisis situations encountered in the line of duty
5. Having some responsibility for media contact or comment

Continued on next page

respondents, when asked about the areas of their jobs with which they were most dissatisfied, highlighted "administration and related policy, assignments and procedures." In a study by Hurrell[6] a greater proportion (65%) of U.S. police officers complained of feelings of dissatisfaction with management, 60% thought the departmental policies were too rigid and 48% reported communication of department policies to be poor. In a study conducted in Australia, Davidson[14] found similar results, with 68% of her sample dissatisfied with management, 63% believed the departmental policies were too rigid, and 63% reported poor communications and bureaucratic obstacles.

This study has gone a step further than the studies just mentioned by finding that organizational factors such as work overload, bureaucratic obstacles to police functioning and autocratic management approaches may be potentially damaging to the health and well-being of supervisory police officers. Given the very special role played by the police in society, it is important for governmental authorities and others responsible for the maintenance and development of the police service to give serious consideration to alternative strategies of work redesign and organizational change.

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No Penalty for Achievement

Estelle Ramey of the President's Adivosry Committee on Women stresses that it is not the entry into the work force of large numbers of women that causes stress; it is their dual role and nature of many of their low-status jobs that produce stress. She also cites a prospective study by the Metropolitan Life Insurance Company of "achieving women" (high status women who are listed in Who's Who) who have not lost any of the life expectancy advantage over men enjoyed by other women. On the contrary, age-adjusted mortality data show an increasing gap between women and men with respect to deaths from cardiovascular diseases, which belies the fast-growing assumption that women will have to "pay" for their rise in the occupational world.

– From *Women and Health – United States 1980:* Supplement to *Public Health Reports*, September-October, 1980.

An Examination of Hardiness and Neuroticism as Potential Moderators of Stress Outcomes

Holly Hills, PhD, and Nancy Norvell, PhD

The perception of stress is believed to result in negative consequences as a result of complex interactions among a number of variables. This study of a random sample of 234 male highway patrol officers examined the relationship among stress measures (perception of stress, report of daily hassles, and items unique to police work) and the specific consequences of stress (burnout, physical symptoms, and job dissatisfaction). Our hypothesis was that hardiness and neuroticism would moderate the relationship between stress and its consequences and that the Perceived Stress Scale (PSS) would emerge as a significant predictor of the strain experienced. The two moderator variables we examined exerted clearer main effects, rather than moderating influences, on the outcome measures. The authors found that the PSS was an important and significant predictor of stress-induced consequences.

Occupational stress may occur in response to work-related factors that affect the psychosocial and physiological homeostasis of the worker. These stressors may include work overload, job insecurity, poor worker-job match, role ambiguity, antiquated equipment, administrative demands, and lack of control or participation in decisions that affect the worker's environment.[1-3] Adverse effects on job performance include lowered productivity, high absenteeism, poor judgment, irritability, anger, and worker complaints.

It has become increasingly apparent that the same stress triggers different consequences in different individuals. Although some theories relate constitutional makeup to resiliency, most authors recognize that individuals draw on many resources to protect themselves from the negative effects of stress. These include lifestyle behaviors, social support, and personality.[4] Hardiness, a composite of the experience of control, challenge, and commitment, has been found to have a buffering effect on physical illness.[4-6] Eysenck,[7] who placed great emphasis on the interaction between stress and personality, defined strain as the response of a given individual to the objectively measurable stimuli called stress. Neurotic, or "high N" individuals, respond to stressful stimuli with strain, but the same stimuli do not produce strain in "low N" individuals. High N individuals do not experience more stress per se, but they do appear to be afflicted with more strain.

The idea that a relationship exists between stress and illness, and that it is in some way mediated by personality, has gained wide acceptance.[7] This acceptance has been described as the diathesis stress model. "Diathesis refers most precisely to a constitutional predisposition toward illness, but the term may be extended to any tendency or inclination a person may have to respond in a particular way to an environmental stress."[8(p64)] Traditional models make assumptions regarding occupations and levels of stress, but this model makes no such assumptions. Instead, the model proposes that psychobiosocial distress, that is, alcoholism, drug abuse, mental

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problems, etc, results from two factors—the inability to cope effectively with the level of stress experienced and a "complex interaction of genetic and social-psychological illness mediating variables."[9(p215)]

Occupational stress can lead to burnout, which is characterized by feelings of being emotionally exhausted, depersonalized, and diminished in personal accomplishment. Burnout seems to be a particularly serious problem for the helping professions—jobs with a high level of interpersonal contact.[10]

In order to investigate occupational stress, we chose to study law enforcement professionals. Although many descriptive reports have stated that the "police officer is under stress and pressure unequaled by any other profession,"[11(p21)] this has not been substantiated in empirical research. Malloy and Mays[9] reviewed research in the field and concluded that police officers may not be experiencing any more stress than other employed individuals. Lester and Gallagher[12] found levels of reported stress in police officers to be about the same as the level for department store managers. The fear of death or physical injury seems intuitively to be a possible area of great stress, yet this has consistently been missing when officers have been asked to list major stressors.[9] More routine experiences, such as constant shift changes, feelings of being on duty all the time, rapidly changing levels of stimulation during a single shift, and the inherent nature of the work have all been reported as stressful areas.[2,3] In our study, we sought to determine which variable (or combination of variables) accounts for the greatest amount of variance in the prediction of stress consequences (ie, physical symptoms, burnout, and total job satisfaction). We considered three hypotheses: that the perception of stress (as measured by the Perceived Stress Scale) would be the strongest predictor of each of the measures of outcome; that the criterion measures would follow the same profile, that is, more stressful work events would be reported along with higher levels of daily hassles and perceived stress; and that the relationship between stress scores on these measures and the incidence of reports of physical symptoms, burnout, and job dissatisfaction would be moderated by hardiness and neuroticism. Individuals possessing greater hardiness, we anticipated, would report fewer consequences in spite of objectively high numbers of stressful occurrences and daily hassles. We hypothesized that an examination of the relationship between the criterion and predictor variables would reveal hardiness and neuroticism as moderating or attenuating resilience, which would be in keeping with the findings of previous researchers.[4,13]

METHOD

Subjects

Participants in our study were randomly selected from the statewide list of all male troopers who had been employed for more than one year (N = 975). Of those surveyed, 81% responded (N = 234). The mean age of the men in the sample was 33.6 years (SD = 8.16), with a mean service with the highway patrol reported at 8.02 years (SD = 6.7 years).

Procedure

Participants completed a packet of questionnaires that surveyed areas pertaining to stress, its manifestations, and its moderating variables. Standard instructions for each of the questionnaires were read aloud to the participants. When they had completed the forms, the subjects sealed and mailed the packet to the investigators.

Measures

The Perceived Stress Scale (PSS) measures the degree to which situations in one's life are appraised as stressful.[14] The Hassles Scale is composed of 117 items that are thought to reflect the irritating, frustrating, and distressing demands of everyday life. We recorded frequency and intensity levels on each scale.[15] The Police Stress Inventory is a 60-item scale that is composed of four primary subscales. For this study, we used the primary subscales (40 items), which address concerns related to courts, administration, equipment, and public perceptions.[16] The Maslach Burnout Inventory (MBI) is a 22-item scale that contains three subscales that assess the different aspects of burnout, namely, Emotional Exhaustion (EE), Depersonalization (D), and Personal Accomplishment (PA).[17] We employed the Emotional Exhaustion subscale of the MBI as an index of burnout.

The Cohen-Hoberman Inventory of Physical Symptoms (CHIPS) is a list of 39 common physical symptoms that excludes obviously physical anomalies but allows for "typical" psychosomatic disorders.[18] The Job Descriptive Index is a 74-item checklist that produces scores on five subscales. These subscales reflect the level of satisfaction experienced regarding the nature of work involved, co-workers, administrative personnel, pay rate, and opportunities for advancement.[19]

The Hardiness Scale is a composite measure formed from existing questionnaires (the Security Scale of the California Life Goals Evaluation Schedules,[20] Alienation from Self, the Alienation from Work, and the Powerlessness Scales of the Alienation Test,[21] the External Locus of Control Scale[22]). Items on the scale have been

TABLE 1
Means and Standard Deviations of Predictor, Moderator, and Criterion Variables

Measure	*M*	*SD*	Range
Maslach Burnout Inventory			
Emotional exhaustion score			
Intensity	21.72	14.32	0.00–63.00
Frequency	16.19	11.14	0.00–54.00
Depersonalization score			
Intensity	14.64	8.60	0.00–35.00
Frequency	11.59	7.59	0.00–30.00
Personal accomplishment score			
Intensity	32.22	12.23	0.00–56.00
Frequency	29.42	11.37	0.00–56.00
Cohen-Hoberman Inventory of Physical Symptoms	14.50	13.42	0.00–100.00
Job Descriptive Index			
Subscale 1	32.70	8.83	3.00–54.00
Subscale 2	37.84	14.14	0.00–55.00
Subscale 3	31.01	13.60	0.00–59.00
Subscale 4	5.57	8.69	0.00–60.00
Subscale 5	24.79	17.86	0.00–64.00
Total score	129.94	41.16	11.0–252.00
Hardiness Inventory	0.00	2.20	−7.01–11.94
Eysenck Personality Inventory			
Lie scale	3.46	1.61	0.00–8.00
Neuroticism	8.16	4.65	0.00–22.00
Extraversion	11.58	3.44	1.00–18.00
Perceived Stress Scale	22.24	7.95	2.00–43.00
Daily Hassles Scale			
Frequency	39.32	36.22	0.0–118.00
Intensity	1.58	0.44	1.00–2.97
Police Stress Inventory			
Administration subscale	22.73	4.61	1.00–29.00
Courts subscale	20.76	3.81	1.00–29.00
Equipment subscale	19.11	4.29	1.00–29.00
Public subscale	18.04	6.13	1.00–30.00
Total stress score	80.63	14.01	2.00–30.00

DISCUSSION

Overall, our analysis of the data revealed that the independent influences of the two variables hypothesized to exert moderating effects—neuroticism and hardiness—appeared to exert more pronounced main effects rather than moderating effects. The independent variables employed in the predictor models (PSS, hassles, and the PSI scales) also contributed significantly to the prediction of emotional exhaustion, physical symptoms, and total job satisfaction in the majority of cases. As our hypothesis suggested, the PSS proved to be the strongest predictor of burnout and physical symptoms. The total score on the Police Stress Inventory, on the other hand, was the best of the independent variables studied at predicting total job satisfaction, as measured by the Job Descriptive Index. Approximately 15% to 22% of the variance in the outcome measures could be accounted for by these two variables.

Neuroticism—Main Effects Versus Moderating Influences

Neuroticism independently predicted burnout across all analyses and also achieved significance in the three

stepwise analyses. This may suggest that individuals who admit to more neurotic characteristics may be more self-evaluative toward their work. Greater neuroticism also appears to coincide with increased reports of physical symptoms, and it significantly predicted reports of illness across all of the analyses. Neuroticism also correlates negatively with the report of total job satisfaction. From this analysis, it appears that the individuals who are more neurotic report decreased satisfaction with their jobs.

Our examination of the moderating effects of neuroticism revealed that, although an individual might report many daily hassles, his degree of neuroticism would determine whether this experience would lead to the report of feelings of burnout. Specifically, higher levels of neuroticism were associated with increased reports of emotional exhaustion. The degree of neuroticism expressed appeared to influence whether the report of perceived stress would predict an individual's increased report of physical symptoms.

Our finding of a significant relationship between neuroticism and physical symptoms is consistent with the work of Saha and Sengupta,[26] who found a strong relationship between psychosomatic illness and neuroticism in 200 peptic ulcer and bronchial asthma patients. A similar moderating effect was found between the report of stressful situations specific to police work (total PSI score) and reports of physical symptoms. An individual's degree of neuroticism appears to influence the prediction of physical symptoms from report of "police stress." These explanations are consistent with the view that, as neuroticism increases, so does a "complainer" trait.[7]

Neuroticism also appeared to influence the relationship between attitudes toward court personnel and the report of total job satisfaction. Evidence of an inverse relationship between job satisfaction and neuroticism has also been found by other researchers.[27] It appears that neuroticism affects whether a person will be more likely to transfer personal negative attitudes surrounding work into more global feelings of diminished job satisfaction. Overall, however, neuroticism appears to exert main effects in the data analysis, and therefore in the interpretation, as opposed to exerting strong moderating influences.

Hardiness: Main Effects Versus Moderating influences

We examined the concept of hardiness, as measured by the Hardiness Scale, as a unitary phenomenon to assess its utility further in the prediction of stress outcomes, although we know that this application has been questioned by other authors.[28] The analyses involving hardiness revealed that it was a significant predictor of the outcome measures in both the regression analyses involving the forced inclusion of hardiness and the stepwise analyses. An individual's ability to perceive a sense of control, challenge, and commitment toward his or her work is predictive of the individual's attitudes toward it. We observed significant moderating effects on the relationship between stress and physical symptoms. This may indicate that, although an individual may perceive himself as being in a stressful situation, his "personality style" of hardiness may insulate him from experiencing physical symptoms. This interpretation follows from the research of Kobasa, Maddi, and Pucchetti[6] and from similar findings involving hardiness and effects of stressful life events on the report of burnout and physical illness that were found by Nowack and Hansom.[29] Overall, our data appeared to indicate that the personality style of hardiness exerted clear main effects, rather than moderating influences, in the prediction of the outcome variables.

Comments on Methodological and Statistical Factors

Overall, these analyses must be viewed critically and can offer only some support for the propositions of neuroticism and hardiness as moderator variables with somewhat stronger support for main effect influences. A number of questions arise from the findings of this study. Do we see more or clearer main effects because neuroticism/hardiness are more structural constructs? Structural measures, as described by Cohen and Wills,[30] only provide information about the existence of these personality features and little about the functions provided or created by their presence. Structural measures can fail to explain what aspects of themselves are responsive (or activated) in the face of stressful events. Thus, these measures tend to fail to exhibit moderating effects. Perhaps hardiness and neuroticism can be thought of as global functional measures that tap a general presence of resources or characteristics without assessing specific tangible functions. The measures employed in our study appear to tap global attitudinal patterns and offer no real explanation of how these qualities are employed in moderating relationships. This argument follows the research of Cohen and Wills on the buffering versus main effects of social support. Global measures are thought to tap main effects because they describe the existence of a wide variety of more stable traits. A functional measure of each of these constructs might tap only one highly specific aspect of how they are related to a stressful event and might result in the observation of moderating effects if the match was sufficient.

It is possible that the relatively stronger indication of main effects in this study could be due to aspects of the methodology or the statistical techniques employed. Ac-

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CULTURAL HURDLES TO HEALTHY POLICE FAMILIES

Rick Bradstreet, Ph.D.

The police profession contains norms for behaviors and traditions that have grown out of police service. While many of these norms contribute to effective job performance, they detract from healthy family life. Several of these major cultural norms, such as "being in control" and "us vs. them," are described in the contexts of professional service and family life. An educational/skills approach to mastering these norms is also discussed.

INTRODUCTION

All professions have norms of behavior that develop in response to the demands of daily work. The bizarre humor of emergency medical staff as popularized on the long-running TV show "MASH" is one example. The emphasis on respect for rank in the military is another example that is demonstrated by recruits starting and ending most sentences with "Sir," even when talking with civilians.

The police profession is no different; there are myriad traditions and behavioral norms that are part of the police culture. These norms are powerful: they are developed over years, imitated uncritically by rookies, and seldom reviewed on any basis. Because the norms are assumed necessary for success in police work, many officers unconsciously adopt them as part of their personalities and act out the accepted behaviors in their private off-duty lives. This creates a negative impact on the officers' families, as many police behavioral norms conflict with the principles of healthy relationships and healthy families.

This paper will describe the collision of police cultural norms and healthy family norms in the following manner: first, by briefly summarizing the major characteristics that are considered necessary for healthy families; second, by identifying and exploring the impact of five major police behavioral norms that interfere with successful family functioning; third, by briefly describing an educational approach that is designed to expose the police norm to review and persuade officers to develop alternative social skills for use at home.

CHARACTERISTICS OF HEALTHY FAMILIES

Several studies have explored the structure of healthy families in an effort to identify what behavioral characteristics are crucial for success. The Timberlawn Foundation in Dallas focused on studying apparently successful families and extracted the qualities that seemed to distinguish those families from dysfunctional families (Lewis, 1979). Another approach was to survey hundreds of mental health professionals and have them rank the characteristics that were necessary for a healthy family (Curran, 1983).

In addition to these research approaches, there have been many books published by clinicians who describe the crucial elements of successful families from their perspectives as family therapists and educators (Bach & Wyden, 1968; Bradshaw, 1988; Bugen, 1990; Davitz & Davitz, 1968; Klagsbrun, 1985; Maslin & Nir, 1987; Prather & Prather, 1990; Satir, 1988).

Although there are widely different approaches to treating families, there seems to be broad consensus that certain family behaviors promote long-lasting marriages and emotionally well-developed children. The major healthy characteristics include:

Communication skills: Each person being able to describe thoughts and feelings without having to agree with the spouse, parents, or children; Each person being able to talk about negative feelings (eg: fears, doubts, anger) and not just positive ones; A family tradition of talking regularly with one another; A tradition of joint problem solving and negotiated solutions.

Mutual respect and trust: Respecting each other and children's privacy; assuming that people want to act responsibly and honestly; Each person admitting problems and/or mistakes and seeking help; Each person affirming and supporting the others;

Shared activities and a commitment to having fun/being playful: Each person initiating time with partner/family members; A family tradition that allows members to act playfully; Family traditions and rituals that celebrate time together.

Responsibility to others: Learning how others think and feel; Providing service to each other and to people outside the family; Understanding the impact of individual decisions on partners.

A spiritual base: Regardless of the denomination or practice, some commitment to a greater power beyond human beings.

This list of characteristics is not exhaustive but captures the spirit of the elements that are present in successful families. The next section will describe how police cultural norms conflict with these fundamental family values.

THE NEGATIVE IMPACT OF POLICE NORMS ON THE FAMILY

Being In Control

Despite the recent emphasis on developing joint problem-solving skills as part of programs such as Total Quality Management (TQM) and Community Policing, police departments remain paramilitary organizations where there is a clear chain of command and an expectation that orders from supervisors will be obeyed quickly. There are also excellent safety reasons for obeying commands: in crisis situations on the street, there is not time to debate alternative strategies. During crises of physical danger, officers are rightfully expected to follow orders and they rightfully expect civilians to follow their commands without discussion. Successful officers develop a "command presence" and the ability to give clear orders on collision scenes or in breaking up domestic fights or in confronting a bully panhandler who is intimidating passers-by on the street.

The specific "take charge" behaviors that officers develop in the job include: a loud command voice; a dominating posture; an expectation that civilians will respond to commands, or else face physical force; "We can do this the easy way or hard way"; a "I don't care what you think, I told you to ..." These are very useful behaviors on the street, but not in the officer's home.

In the family atmosphere, these "take charge" behaviors are a potential liability to the officer, in several ways. First, family life is always "out of control" in the sense of being unpredictable, and spouses/parents are not given the same respect/obedience as street officers. As a result, many officers feel incompetent operating in the comparatively loose family setting, and try to overcome their anxiety by acting more controlling and autocratic. Rather than producing cooperation and closeness, this produces resentment, secrecy, lying, and rebellion from both spouse and children.

The second problem with "take charge" police behavior is a bias against listening skills, which re ...al for successful families. Giving orders and dominating the confusion are essential elements ... controlling street incidents. Listening skills are considered valuable in interviewing witnesses and ... ims but are otherwise viewed as too passive. As a result, few officers develop the patience to listen ...ntively nor specific skills such as summarizing or paraphrasing. In family discussions, officers tend ... speak for other family members, dominate whenever a dispute arises, and seldom listen thoughtfully ...ifferent viewpoints. This failure to skillfully listen tends to limit spontaneous personal expressions ...mates and children and also prevents intimacy.

The third bias of "take charge behaviors" is the dampening effect on problem-solving and ...otiating differences. As described earlier, healthy families have room for differences and disputes ...ween members. In contrast, "take charge" behaviors require obedience or passive acceptance of the ...ader's position. As a result, family members learn to avoid differences rather than air them and resolve ...n.

...e Role of Enforcer: Suspicious and Not Gullible

On the job there are many reasons to be suspicious of suspects' stories; even working traffic ...nforcement exposes officers to many creative lies by otherwise upstanding citizens. In order to be ...cessful in getting the facts and investigating crime, officers need to develop a "sixth sense" about when ...ple are lying.

The police culture also pressures officers to become suspicious. Rookies are regularly critiqued ... "too easy" and believing suspects' stories, and most rookies are burned several times when they ... out of their way to help a hard-luck juvenile only to discover later that the juvenile was deceiving the ...okie. Veteran officers take pride in their ability to see people's selfish interest rather than people's ...ocence. Detectives, of course, become more sophisticated in identifying different types of lies over ... and they also become more cynical and guarded personally.

Police work produces several behaviors that become second nature for officers. The first is to ...duct an interrogation whenever there is any doubt about what happened. The interrogation mode is ...cally a dominating style of dialogue in which the officer asks all the questions and the civilian just ...onds to the questions asked. The second behavior is the relentless search for people's hidden selfish ...otive. The working assumption is that everyone except young children and other cops are motivated ... selfish desires. The third behavioral axiom is: "don't act enthusiastic." The idea is to avoid looking ...ible or to be lulled into deception by some spontaneous friendly exchange.

These enforcer behaviors cause big problems at home. A major complaint of officers' wives is ... their husbands have become "too suspicious of everyone." Instead of remaining on friendly casual ...ns with neighbors and civilian friends, young officers begin to find fault with everyone. Everyone ...s become a potential cheat, liar, and scam artist as the officer defends against being conned.

Another blow to families is the cross examinations that officers inflict on kids and spouses. Since ...errogation works so well on the street, why not bring it home? The resulting resentment and lack of ...utual dialogue creates walls of silence in many homes. This controlling style of solving conflicts ...quently distances the kids and makes the civilian spouse into a mediator/advocate for the children ... the officer. Ironically, this dynamic in turn isolates the officer and causes him/her to become ...gid in order to "maintain respect."

Feelings are Luxuries and Suggest Weakness

Effective police work requires that officers focus objectively on deescalating crises and figuring out short-term solutions. Officers' emotions are distracting in that they focus attention inward rather than outward where the action/potential danger exists. Emotions are debilitating for another reason: They make the officer feel vulnerable and exposed and create a "personal stake" in the situation. Consequently, it produces more professional police behavior if officers are not processing their own emotional responses to incidents at the scene.

Police veterans reinforce this nonemotional model of mental health by teasing each other, probing for soft spots. The ideal response is to remain cool and unflappable and to have a ready come-back for any teasing dig one receives. Tender emotions such as sadness, longing, or childlike awe are discouraged and veterans describe the act of crying as "losing it."

Several typical police behaviors have consequently developed: Officers joke about tragedies or anything that is emotionally touching, in order to avoid their own natural reaction. There is an overemphasis on rationality in handling personal conflicts, as if there is not emotional charge attached to human dilemmas. Officers who are naturally sensitive to the emotional components of daily life have to develop an outer shell, and some overcompensate by acting tough and indifferent to human suffering. Finally, there is a reluctance to admit vulnerable feelings such as sadness, loneliness, or fear with a parallel willingness to express anger in reaction to all negative experiences.

At home, these behaviors translate into emotional caution and blind-spots for most issues that have subtle emotional cues. Officers actively avoid discussing issues with spouses where there is potential for conflict or there is existing tension. As a result, sensitive issues go unresolved and couples settle into an emotional distance that is lonely but not acknowledged.

Officers' habit of not expressing vulnerable emotions also creates emotional distance in the family. Often the spouse attempts to compensate by guiding and inviting emotional expression, but this eventually becomes frustrating for both. The officer complains that his/her spouse is too emotional and nags the officer. The spouse complains that the officer has become a robot and is no longer capable of being an intimate partner.

One frequent result of this secret emotional gulf is that officers are amazed when the spouse announces that he/she wants a divorce. The officer had no idea that things had become so distant and unhappy for the spouse. Since there is never much overt conflict, the officers remain puzzled how the relation had become bad enough to warrant a divorce.

Caught Between Two Lives: Multi-Roles at Work and Restricted Roles at Home

Police patrol work demands a wide range of skills and communication styles to be successful. The work requires contrasting responses: from driving in pursuits to walking silently in response to a burglar alarm; from giving loud voice commands at the scene of a collision to comforting an injured victim; from being frightened to death at one moment and bored to death the next. The work is a roller-coaster of changing demands and unpredictable challenges. Part of the satisfaction comes from the fact that police work provides officers with a full range of unusual experiences.

A second positive element is the close bond between partners. Because officers rely on each other in many moments of physical danger, they can become much closer than civilian partners in a more

ditional job. This close bond with another person is often a first for many officers and is a significant benefit in their lives.

A third positive element is the romantic image that police enjoy in movies and TV. Police characters have replaced the cowboy heroes who occupied the 50's & 60's. No profession so dominates the TV series as police dramas, and documentary style shows such as "COPS" and "911" are also enormously popular. As a result many officers think of themselves in more heroic ways, and carry a pleasant, albeit false, sense of importance while on duty.

By contrast, life at home is much more restricted and unromantic than life as a street officer. While the roles of spouse/lover and parent are demanding ones, officers seem to focus primarily on feeling responsible once they are home. Officers tend to give up their playful side, which is essential for intimacy, and shift into a protector/provider mode. Officers attempt to create a super-normal home life that is free of the gritty realities of work.

Unfortunately the effect of the officers' efforts is often a stiff, restricted lifestyle where the officer feels burdened and unable to relax. In their effort to create a "safe haven" for their families, officers often succeed only in creating a superficial, proper environment that neither the officer nor the family members enjoy. Naturally, this leads to officers spending more time at work and in the peripheral recreation activities such as softball leagues and fishing trips.

Inevitably, the officers' emotional bond with their partner become a sensitive issue with the officers' spouses. It is common for officers to prefer to go to work or their partner's home, rather than stay home and mow their own grass. That's because the officer can recover his playful persona only when he/she is away from home.

Rotating shifts exacerbate the difficulty of creating a happy family life. Enthusiastic young officers who love crime fighting prefer the evening or night shift, when more professional crooks are out. Ties with civilian friends dissolve over time as the civilians are available on weekends and evenings. The social activities of the shift may easily become the major social focus for the officers' families, as this group is always available.

Us vs. Them

Part of the appeal of police work initially is that there appears to be clear good guys and bad guys. In a world become too complex, police work offers young energetic idealists the chance to take crooks off the street, stand up to bullies and protect helpless victims from abuse. The movie and TV images depict police as an elite group: the only ones who can break traffic laws, openly carry handguns and put people in jail. Because so many aspects of police work are unique, many officers begin to believe that if a person is not a cop, they simply "can't understand" the life.

The danger of the job also contributes to the adversarial quality of police life. Rookies are taught not to relax even on simple traffic stops, and most departments have buried at least one officer who was killed making a routine traffic stop. Consequently, officers learn to trust no one but other cops. The slang language describing everyone from suspects ("perps") to petty criminals ("dirt bags") contributes to the us vs. them mentality.

The negative sensational media attention to charges of police abuse, fraud, or racism also results in a deep suspicion of outsiders. Most veteran officers have personally witnessed several controversial

news events that are portrayed by the media as direct conflicts between police and citizens. The news stories highlight the conflict and thereby create an "instant controversy," which fuels the distrust among police and civilians alike.

Some of the behaviors that develop are a separate police slang vocabulary and the competitive teasing game of "talking trash" among officers. There are lots of jokes about stupid civilians and especially about lawyers. People who are not cynical are viewed as naive or stupid. The habit of dominating verbal debates by repeating one position or using a command voice becomes second nature and the practice of debating/discussing issues is seen as academic or frivolous.

At home, civilian friends are gradually relegated to an outsider status as they are seen as "not knowing reality." This eventually separates the police couple from civilian friends and the more mainstream civilian life style.

Officers try to protect their spouses and children from the dangers of contact with criminals, but often the families end up feeling over-controlled and restricted. Frequently officers request that their spouses don't go out at night without them and not travel to nearby cities alone. Eventually the spouse resents this control and begins going out alone, which often produces a more demanding protective reaction by the officer and further conflict between the couple.

Teenage boys who have long hair or earrings or hang out with friends who do often provoke an overreaction by the officer who fears the teenager is headed toward a life of crime. The rebellious teen years are especially difficult for officers who deal with disrespectful young thugs in their work and so tend to overreact to suppress any rebellious attitudes for their own kids.

When an officer's marriage is unstable, his suspicion of outsiders makes things worse. Frequently, an unhappy wife will begin relying on other women for support and venting their frustration. The officer frequently will run down the friends as over-influencing the wife, which does double damages to the marriage by insulting the wife's intelligence and creating martyrs of the friends.

OVERCOMING THE BARRIERS

The goal is to empower officers to adjust their behaviors and attitudes to fit the culture they're in. On patrol, it is prudent to be suspicious of any story that a suspect offers; at home, it is prudent to accept the spouse's story about why he/she was late. The best vehicle to accomplish this goal is a preventive educator/skills model. There are four major principles in the model:

1. Identify the culture-based norms. Cultural norms have the most power to control officers' behaviors while the norms are hidden in daily work. Once a norm is identified it becomes a behavioral choice, not an imperative. It is useful to describe the benefits of the work norm in the context of work, so the officers understand that you are only challenging the impact of the norms at home.

2. Propose home life as a separate culture that requires different behaviors. There are many existing analogies for acting differently at work than at home. For example, officers "talk trash" at work and rarely curse at home. Most officers already think of home life as different, and, as we have described earlier, change their behavior into a constricted "responsible protector" mode.

It is not a radical shift to suggest that officers enlarge their communication skills and negotiating skills in order to be happier at home. Patrol officers already practice changing their approach when

ney're working with different types of people. They know from experience that they can best remain trol by adjusting their style to match the person they're working with: a patient, slow speaking style with senile elderly people for example, and a casual, quick cool style with teenagers.

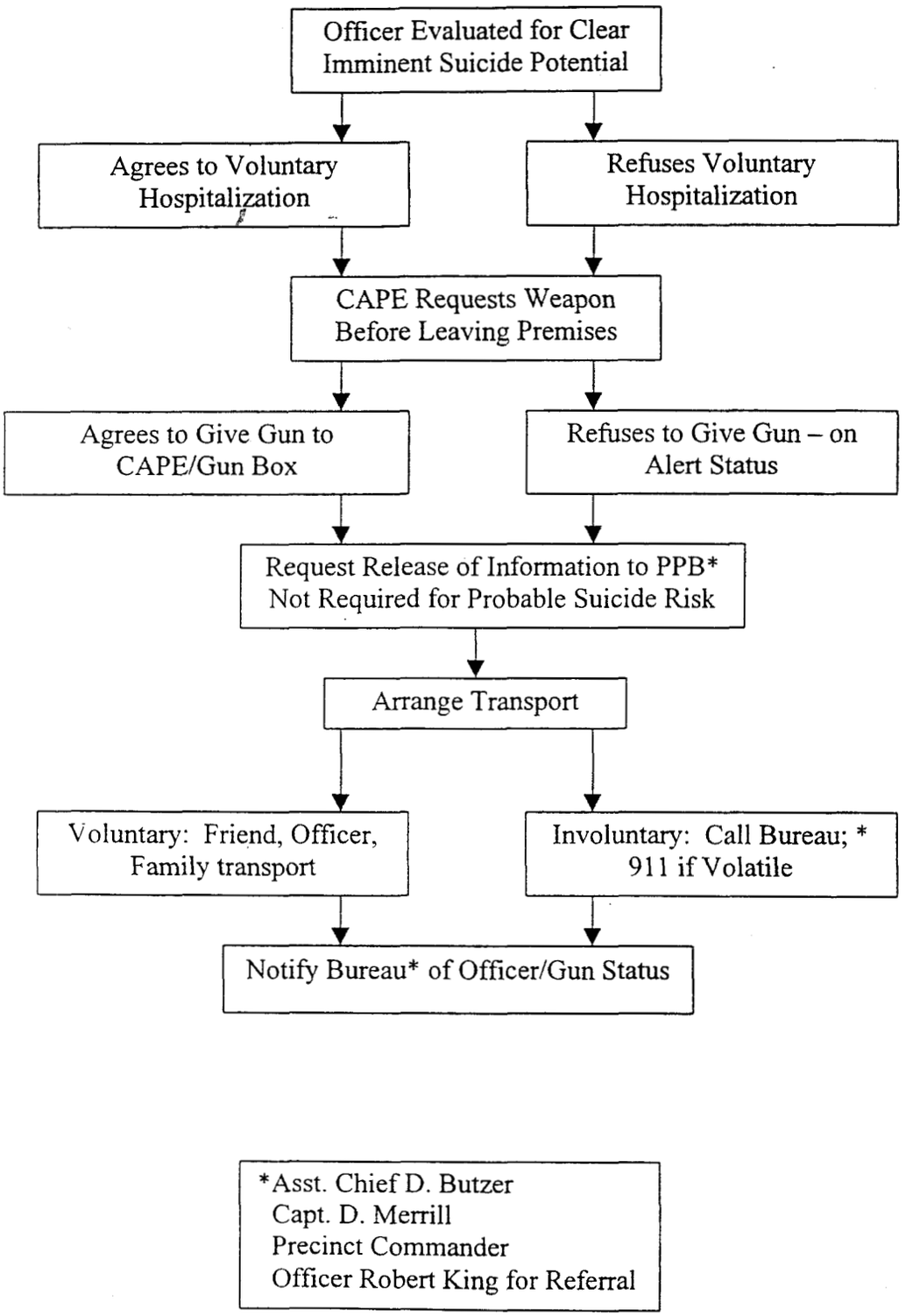
3. Describe specific skills to master. None of the family communication skills are new; they have been described and advertised for many years. Skills such as active listening and paraphrasing have even begun showing up in police curricula like George Thompson's "Verbal Judo." The important thing is to identify the skills and show how they will improve relations at home more than using the traditional police domination skills.

4. Be rational, practical, and concrete. These descriptions need to be rational, practical, and down to earth, as the "human potential" language or "marital systems" concepts will obscure the benefit to police officers. One of the reasons that such valuable tactical skills as empathizing, negotiating, and mediating have not received much attention in the police community is that the source of the skills (i.e. bridging relationships; resolving conflict) appeared unrelated to the more crisis-oriented demands of police work.

In summary, police officers' cultural blind spots can be overcome provided that they learn a new set of skills and attitudes that are suited for creating and maintaining successful relationships at home.

A

CAPE Intervention of Officers in Crisis
(Imminent Plan of Suicide)

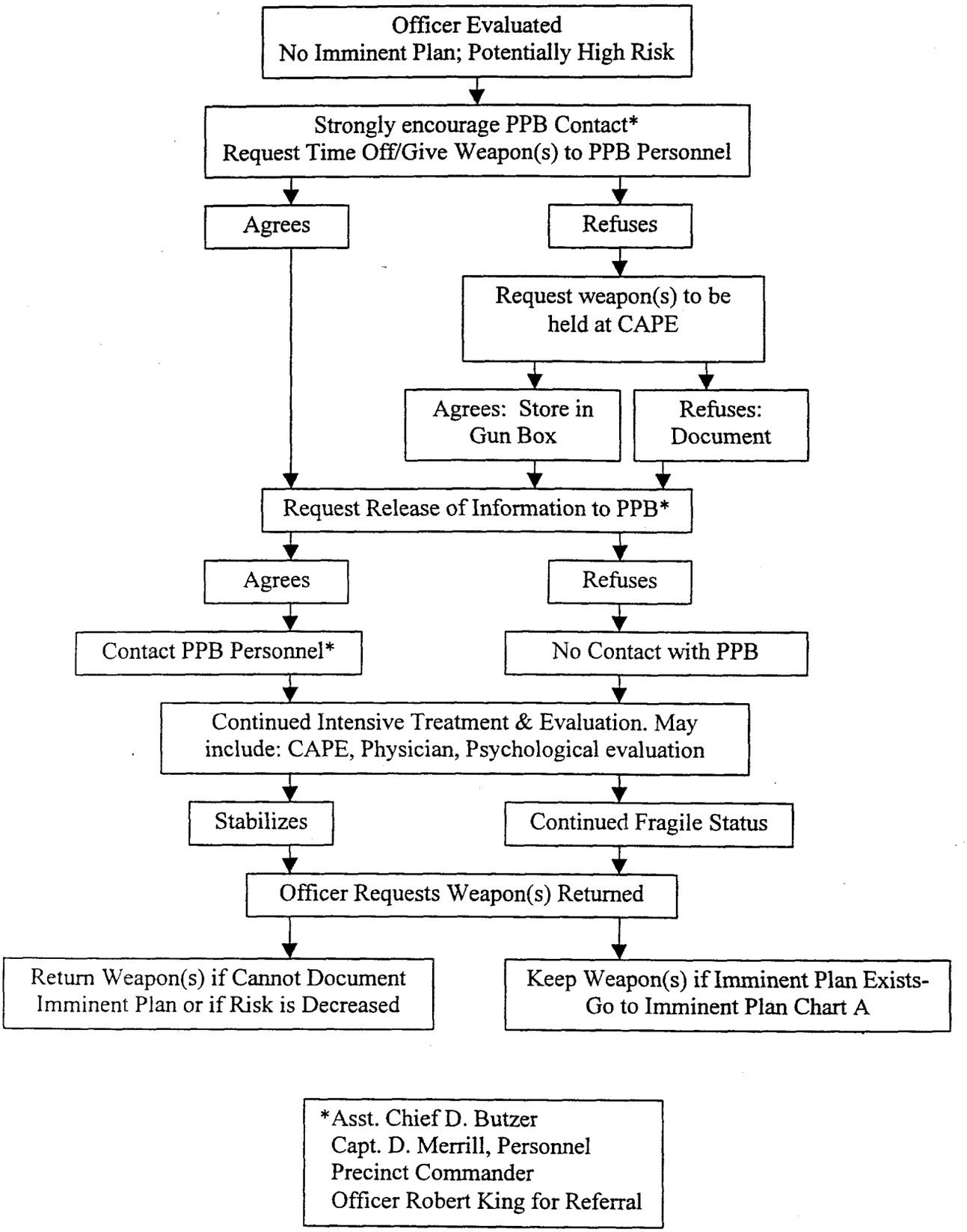


*Asst. Chief D. Butzer
Capt. D. Merrill
Precinct Commander
Officer Robert King for Referral

T:\Laura\Crisis A

B

CAPE Intervention of Officers in Crisis
(No Imminent Plan of Suicide)



*Asst. Chief D. Butzer
Capt. D. Merrill, Personnel
Precinct Commander
Officer Robert King for Referral

T:\Laura\Crisis B

Outline

PEER SUPPORT SKILLS FOR ONGOING SITUATIONS

I. Nature of enduring problem situations: "This ain't never going to change!"

A. Metaphors: "What's it like?"

1. Getting stuck: Tires a'spinnin', snow a'flyin', going nowhere.
2. "Vision problems": "What's that you see? Nothin' but the problem."

B. Using the principle of contrast: Half-full or half-empty?

Everyone is constantly making comparisons, and often people are not aware of their ability to control whether these comparisons make them feel good or bad. There are endless possibilities for comparison, no matter how bad or good a situation is.

C. Characteristic thought patterns of depression: Not just being sad.

1. All or nothing thinking
2. Overgeneralization
3. Using a mental filter
4. Disqualifying the positive
5. Jumping to conclusions
6. Magnifying the bad and minimizing the good
7. Emotional reasoning
8. "Should" statements
9. Labeling
10. Personalization (*Feeling Good*, Dr. David Burns)

II. Basic Communication: What you say and how you say it.

A. Modes.

1. Verbal content
2. Voice qualities
3. Body language

B. Congruency: Lining up your chickens.

"Mixed messages" occur when the different communication modes are used to send different, or even conflicting, messages. It is essential to be aware of the messages being communicated by each communication mode. This is especially important when you are feeling mixed emotions. Otherwise, it is easy to say one thing, but communicate anxiety or other emotions through your voice and body.

C. Congruency is not enough.

Once you have all your modes of communication sending the same message, make sure it is the message you want to send!

III. Rapport: "You're like me, I'm like you...."

This is the connection that causes people to listen to you. Without this connection, you can talk all day and it is as if you never said anything.

A. Authority rapport: "Yes, Sir! Yes, Ma'am!"

Much of professional influence is established by the rapport that comes from authority. In your role as an officer (for example) you are listened to by people because you are an authority. This will not be true in the peer counselor role.

B. Building personal rapport.

This is the rapport that that is essential for this role, and it is based on communicating a common ground and viewpoint. Without this, your peer will feel that you cannot understand them or relate to what they are feeling.

1. Commonality of content
2. Commonality of voice qualities
3. Commonality of body language

C. Using validation effectively: "If I <u>were</u> there, I would be there!"

Validation is the best tool for establishing rapport through content. Validation communicates that "I may not be in the exact situation, but if I **were** I would be feeling the same way." *Examples of validation: "If I were you, I think I'd feel the same way." "I think anybody in your position would be feeling exactly the way you are." "I'd be surprised if you weren't feeling lousy; that's how anybody would feel."*

1. Sincere validation.

It is essential that validation be sincere; people have a baloney detector that gets more acute the more stuck they are.

2. Deflecting criticism of validation.

Be prepared for validation to be taken as condescension. Respond to this with further validation. *Example: "I know it sounds to you like I'm just saying that to make you feel better. And you know what? It's still true that I would feel the same way!"*

D. Validation by self-disclosure: "You think you've got it bad? Why when I..."

1. The uses of self-disclosure.

Self-disclosure is the strongest form of validation; it communicates complete commonality. When used sparingly, it is very effective. *Example: "When I was on disability I think I felt the same kind of anger you're talking about. Sometimes the feelings were so strong I felt my head spinning."*

2. The dangers of self-disclosure.

It is very easy for self-disclosure to be unhelpful, as well. You must be careful to keep the focus on the peer's issues, and not on your own problems, past or present. Self-disclosure can also communicate that what helped you is the only good answer, the only solution that will help your peer. This can lead to unintentional advice-giving.

E. Listening vs. digging a groove: "Can you say, 'broken record?'"

This is a difficult balance; just listening can communicate interest, but it can also allow the person to go over the same ground again and again, and get more and more stuck. Doing nothing but listening can build rapport, but it can make change more difficult. Here is one way to know when you can try to shift your peer toward possibilities, and away from the negative focus. Test your rapport by using solution talk or gentle confrontation and measure the response. If you haven't established enough rapport, then your peer will return to discussion of the problem.

F. Opening a conversation: "You go first. No, you!"

Sometimes getting started is the toughest part. How you will start will be dependant on your relationship with your peer, and how it is that you have been notified of the situation. *Examples: "Robert over at EAP said you called and wanted to have a Peer Support person give you a call. So, what's going on? What's up?" "Laura, I've noticed that you've seemed real distracted lately, not like yourself. Do you want to talk about it? What's going on?"*

G. Group exercise.

IV. Facilitating change: Pace, then lead.

Now that you have built rapport with your peer, established commonality and sense of shared understanding and caring, you have the opportunity to help them (maybe!) move out of some of their stuckness. Building rapport by itself doesn't create change;

in fact, building strong rapport with someone who is stuck can cause you to feel stuck, too! Here are some tools you can use to help facilitate change.

A. Creating a safe environment: Not the therapist's couch, but at least an armchair!

One factor that helps people feel better is building rapport and talking about painful events while being supported and feeling validated. This doesn't always help people feel differently, especially if they are very stuck, but it can if they haven't had this opportunity. Sometimes everyone else has been so critical and demanding of them that they have retreated into being stuck, and when they don't feel defensive or criticized, they will begin to un-stick themselves. Here are some hints:

1. Validate, validate, validate!
2. Don't criticize.
3. Make supportive sounds and gestures.
4. Touch appropriately, if it fits with the relationship.

B. The power of language: Control minds, influence people.

How you use your language affects the emotional response of the listener. To understand your words the listener must process what you say, and this can cause different emotional reactions, depending on how you use your words. *Example: Compare these two ways of getting the same information. "When was the last time you felt even a little bit better?" vs. "How long have you felt this lousy?" Notice that the factual information that you receive will be the same, but the emotional content will be opposite.*

C. "Magic" language.

1. Solution talk.

A person's state of mind is affected by the emotional content of a conversation. The emotional content of your peer's problem is most likely depression and frustration. So, as long as the focus is on the problem, it is more difficult to move away from these feelings. So, questions that move the conversation toward possibilities, and away from the problem, can bring new, more empowering feelings.

"When is the last time you felt more positive about this? What was that like?

"When have you felt like you had a little more control in the situation?"

"What is working for you?"

"What has helped you before, when you have felt like this?"

"What do you think would happen if.....?"

"What else do you think you might be able to do?"

2. Re-framing.

The description of a situation affects the perceived meaning of the situation. Changing the description can allow for a change in the meaning, and emotion connected with it. Reframing is providing another accurate description of a situation, one that has different emotional content. Again, this will only be accepted when you have rapport. *Example: Peer: "I was treated totally unfairly. I don't know what they were thinking!" You: "It sounds like if you knew what was going on in their heads you might be able to understand it more; without that you feel completely mistreated. So, I wonder what they must have been considering, for them to do this?"*

D. Softening language.

Sometimes asking questions can be uncomfortable for the peer and the peer supporter. It helps to soften things by using soft openings, such as:

"I'm wondering whether…"
"I'm curious as to…."
"I can't help asking myself whether…."
"Tell me, ……"

E. Open-ended vs. closed-ended questions.

Use open-ended questions when you want your peer to expand on something. *Example: "What have you been doing that has helped you the most?" "What was that like?" "Tell me more about that."*

F. Interrupting effectively.

If someone is stuck, you may have to interrupt them to move the conversation toward solution talk. If you don't have rapport, it is practically impossible to do this, and even then you may lose your rapport when you interrupt. Here is an effective interruption technique: Use your peer's name, tell them you are interrupting, and tell them why. *Example: "Robert, I am interrupting you, because I notice that you are starting to wind yourself up again."*

G. Using gentle confrontation.

IF you have rapport, you can confront a peer who is deeply stuck, and who keeps coming back over and over to the details that upset and frustrate him/her. Again, this only works if you have rapport, and needs to be tailored to the situation and relationship. *Example: "Julie, it seems like all you want to talk about is how lousy everyone has treated you, and that only seems to make you feel worse."* NOTE: Validation should always be used along with confrontation.

H. "But"-busting.

One of the most common ways to lose rapport is to use words like "but," "however," and "although." These words decrease the importance of whatever comes before them, and unfortunately we often use them directly after validation or empathy. *Example: "I think most people feel bitter after being treated like this, **but** unfortunately it doesn't make them feel any better, just worse."* The validation gets lost. Compare these two sentences:

"I really wanted to talk to you and see how you were doing, but I am feeling completely worn out today."

"I am feeling completely worn out today, but I really wanted to talk to you and see how you were doing."

I. Group exercise.

V. Limits and self care: Who's taking care of you?

A. Monkey on your back syndrome: Monkey, monkey, who's got the monkey?

1. Taking responsibility for the problem.
2. Giving advice.

B. Advantages of taking responsibility.

1. It feels easier.
2. It feels more natural.
3. It temporarily reduces feelings of helplessness.

C. Disadvantages of taking responsibility.

1. It doesn't work.
2. It prevents peer from having ownership of changes.
3. It causes increased helplessness.

D. Minimum responsibility of the peer.

The choice of goals and actions must always be up to your peer, not to you. You can help them come up with options, through solution language, and by reference to your own experience or that of others, but they must be the one to make the final choices.

E. Your emotions: "If it's not my problem, how come I feel so bad?"

Be aware of your own emotions and responses to your peer's problems. Sometimes one of the reasons for taking responsibility and giving advice is to decrease your own anxiety or helplessness! It also can provide justification to yourself that you acted right when you were in the same situation. Be careful! Examples from group.

F. When there isn't any movement: Stuck, stucker, and stuckest.

Not every person in an enduring situation is ready to feel better after talking to you, or to anyone else. Some people are in very tough situations and are very stuck. This does not mean that there was no benefit to them from your interaction. Don't make the mistake of predicting the future; focus on the process. Did you try to build rapport? Did you care and express it as best you could? Then you were successful.

G. Knowing your limits: Every "Yes" has a "No".

Peer support is a voluntary responsibility, an addition to the demands and stresses of your job. It can be rewarding to help peers, and many of you are probably already doing it, but knowing your limits allows you to keep enough energy for yourself. It is especially important to know your limits around types of situations. If you are dealing with something in your own life, it is unlikely that you are in a position to help others with the same issues.

H. Group exercise.

VI. Assessment and Referral.

A. First level of assessment: Crisis vs. enduring situation.

The first level of decision-making is to know whether this is an immediate trauma situation, one in which you will be using your Emotional First Aid skills. Be aware that sometimes a trauma will occur on top of an enduring situation, so there will be overlap. Examples from group.

B. Second level of assessment: Does the peer want any help?

Sometimes you will be in a situation where you haven't been invited, and your peer doesn't want help. Be sensitive to this. Examples from group.

C. Third level of assessment: Peer support vs. outside resources.

These are the situations that feel beyond your ability to be the only or primary helper. These would include, but are not limited to, concerns about your peer's danger to themselves or others. These situations would also include ones where there is a need for a structured resource such as an Anger Management program or a Substance Abuse program. Rather than trying to know all the resources in the community yourself, in all these cases it can be helpful to use the EAP staff or CAPE staff to assist in finding a resource. Examples from group.

D. Use of CAPE Employee Assistance Program: "What do they do, anyway?"

CAPE is a referral that can always be made, for any level of problem. Even if it is a situation where you are comfortable providing support, it is helpful to remind your peer that CAPE is confidential, helpful and supportive. It doesn't have to be reserved for emergencies. On the other hand, it is a resource for emergencies, too. Any time you have concerns that a peer is depressed, having serious relationship difficulties, or seeming to have a deteriorating ability to deal with the enduring situation, CAPE can be a good resource.

E. Use of peer's support system.

Remember, you are not the only resource for peers. It is not uncommon for people to withdraw from their friends when they are in an enduring situation. Often they need validation to believe that the people they care about still want to talk to them when they have a problem. Ask about their resources, and encourage them. *Example: "It sounds like you're not talking to anybody about this. I know you've got a lot of friends who would want to be able to be there for you, just like you would want to be there for them. Can we hook some of them into this for you?"*

VII. Conclusion

Outline / Handout for spouses, partne

Until recently, little attention was paid to the impact officer involved shootings had on the officer's families. As a result, many families have been left to fend for themselves as best they can.

Preparation:

Preparation can reduce the negative impact of officer involved shootings on the family. This may be a difficult subject to discuss and yet discussion is important. Preparation can include:

Familiarization with the symptoms of trauma reaction.
Discussion regarding how your spouse would like to have the news delivered. Phone call. Personal visit.
Who would your spouse like to have deliver the news.
Who will assist your spouse if you are unable to do so.
How the investigation and grand jury process works.
What type of support you and your spouse would find helpful from each other and your larger circle of friends and family.
What you would find particularly unhelpful.
Funeral and memorial service arrangements.
Resources available. How to access.

The Law Enforcement Spouse/Partner

Advantages:
Understands policies and procedures.
Knows the level of training.
Greater access to inside information.
Law enforcement support group.

Disadvantages:
Can more easily understand on a gut level what the officer experienced.
May believe the need for a front.
May be surprised by overflow of emotion. Greater than if s/he had been the shooter.
May feel guilty about not being able to prevent powerlessness.

BOEC

CISM Peer Support Training

Spring 1999

Traumatic Stress Reference Material

Material compiled and presented by
Sgt. Denney Kelley

Stress Continuum

General Stress	Cumulative Stress	Critical Incident Stress	Posttraumatic Stress Disorder
Inescapable	Build-up of general stress	Caused by traumatic event	Requires 30+ days of symptoms post-incident, including: 1. Intrusion 2. Avoidance 3. Arousal
Normal	Destructive over time	Normal	Debilitating
Distress	Burnout	Painful/upsetting but normal	PTSD

Note: No amount of cumulative stress will result in Critical Incident Stress or PTSD.

Defining Critical Incident

Solomon-Any situation that results in an overwhelming sense of vulnerability or loss of control.

Mitchell-Any situation faced by emergency service personnel that causes them to experience unusual strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later.

Fay-An event which challenges ones worldview and produces a temporary state of psychological unbalance and emotional turmoil. (Mitchell)

CAPE
EMPLOYEE ASSISTANCE PROGRAM

Critical Incident Stress Information Sheet

You have experienced a traumatic event or a critical incident (any incident that causes someone to experience unusually strong emotional reactions which have the potential to interfere with their ability to function). Even though the event may be over, you may now be experiencing or may experience later, some strong emotional or physical reactions. It is very commons, in fact quite *normal*, for people to experience emotional aftershocks when they have passed through a horrible event.

Sometimes the emotional aftershocks (or stress reactions) appear immediately after the traumatic event. Sometimes they may appear a few hours or a few days later. And, in some cases, weeks or months may pass before the stress reactions appear.

The signs and symptoms of a stress reaction may last a few days, a few weeks or a few months and occasionally longer, depending on the severity of the traumatic event. With understanding and the support of loved ones, the stress reactions usually pass more quickly. Occasionally, the traumatic event is so painful that professional assistance from a counselor may be necessary. This does not imply craziness or weakness. It simply indicates that the particular event was just too powerful for the person to manage by him or herself.

Here are some common signs and signals of a stress reaction:

Physical*	Cognitive	Emotional	Behavioral
Chills	Confusion	Fear	Withdrawal
Thirst	Nightmares	Guilt	Antisocial acts
Fatigue	Uncertainty	Grief	Inability to rest
Nausea	Hypervigilance	Panic	Intensified pacing
Fainting	Suspiciousness	Denial	Erratic movements
Twitches	Intrusive images	Anxiety	Change in social activity
Vomiting	Blaming someone	Agitation	Change in speech patterns
Dizziness	Poor problem solving	Irritability	Loss or increase of appetite
Weakness	Poor abstract thinking	Depression	Hyperalert to environment
Chest pain	Poor attention/ decision making	Intense anger	Increased alcohol consumption
Headaches	Poor concentration/ memory	Apprehension	Change in usual communications
Elevated BP	Disorientation of time, place or person	Emotional shock	
Rapid heart rate	Difficulty identifying objects or people	Emotional outbursts	
Muscle tremors	Heightened or lowered alertness	Feeling overwhelmed	
Shock symptoms	Increased or decreased awareness of surroundings	Loss of emotional control	
Grinding of teeth		Inappropriate emotional response	
Visual difficulties			
Profuse sweating			
Difficulty breathing			

Any of these symptoms may indicate the need for medical evaluation.

NORMAL TRAUMATIC STRESS REACTIONS

1. During the Incident

   - Sensory acuity heightened and focused (tunnel vision 67%).
   - Functioning on "auto pilot," training kicks in.
   - Time distortion, slow (67%) or fast (16%) motion.
   - Depersonalization.
   - Auditory distortion, diminished (51%) or increased (18%) sound.
   - Rate of respiration increases.
   - Non-essential bodily functions shut down.
   - Pulse and blood pressure increase.
   - Hormonal release including adrenaline, cortisol and thyroxine.

2. Immediately Following the Event

   - Stress hormones continue at elevated levels.
   - Hyper vigilance.
   - Difficulty tracking.
   - Headache.
   - Nausea, vomiting, diarrhea.
   - Agitation.
   - Anger at what happened.
   - Exaggerated startle reflex, "jumpy."
   - Muscle tremors.
   - Feeling unusually cold or warm.
   - Hyperventilation/lightheaded feeling.
   - Profuse sweating.

NORMAL TRAUMATIC STRESS REACTIONS (Continued)

Note: Many officers report that they do not feel the full impact of the incident until two or three days afterwards.

3. <u>72 Hours to 30 Days Post Incident</u>

- Sleep/Appetite Disturbances.
- Agitation.
- Irritability/Anger Outbursts.
- Hyper vigilance.
- Difficulty concentrating.
- Headaches/nausea/other physical complaints.
- Mood swings.
- Shame/guilt.
- Preoccupation with the incident.
- Unusual feelings of vulnerability.
- Recurrent/intrusive/distressing memories.
- Nightmares.
- Flashbacks.
- Anxiety when exposed to events that resemble or symbolize the incident.
- Feeling like an outsider or distant from others.
- "What's the use" attitude or resignation to early death.
- Restricted range of emotions.
- Escapist or numbing behaviors.
- Depressed immunity/increased susceptibility to illness.

BIO-CHEMISTRY OF TRAUMATIC STRESS

1. Assessing a situation as life threatening results in a massive release of hormones. The purpose of this "chemical dump" is to permit a person to function at absolute peak efficiency for a brief period of time.

2. The amount of hormones released amounts to essentially an "overdose." The trade off nature has made is in favor of short-term effects from this overdose in exchange for the heightened abilities necessary for immediate survival.

3. These chemicals remain active in the body for up to two weeks and cause many of the symptoms associated with trauma.

4. Every detail associated with a life threatening incident is permanently etched into the memory but because of the effects of the stress hormones, these memories may be "filed" incorrectly.

5. This "misfiling" may cause gaps in what you recall, flashbacks, nightmares, or anxiety experienced seemingly at random. These are normal reactions to abnormal circumstances.

6. Physical exercise on a regular basis beginning within 24 hours of the traumatic incident and continuing on a daily basis can help "burn off" the hormones causing the symptoms.

7. Consumption of caffeine immediately after a traumatic incident and/or consumption of alcohol within a period of 72 hours after a traumatic event can make the symptoms worse.

THE THREE FACTORS WHICH PREDICT THE SEVERITY OF TRAUMA REACTIONS

1. Prior History of the Individual

   - Individuals with prior unresolved traumas and problems maybe more susceptible to psychological injury.

2. The Perceived Severity of the Trauma

   - Sudden, unexpected.
   - Person experiences vulnerability.
   - Person experiences loss of control.
   - Outcome.
   - Degree of injury, threat, death to self and others.

3. Nature of the Recovery Environment (what happens to person afterward)

   - Treatment by agency.
   - Peer support.
   - Command staff support.
   - Support from friends and family.
   - Psychological debriefing and treatment.
   - Public support.

Of the above three factors, No. 3, the Nature of the Recovery Environment, is the most important. How a person is treated afterward usually makes the biggest difference in how quickly they recover.

ABNORMAL TRAUMATIC STRESS REACTIONS

1. The persistence of any normal symptom(s) beyond a period of 30 days.

2. The presence of any symptom(s) to such a degree that normal social or occupational functioning is impaired.

3. Suicidal ideation.

4. A marked increase in the consumption of alcohol or other drugs.

5. Increased risk taking to the point of foolhardiness.

6. Episodes of domestic violence.

7. Obsessive second guessing.

PRIMARY FACTORS IN RECOVERY FROM STRESS AND TRAUMA

1. Self-Care

   - Healthy lifestyle choices.
   - Social/emotional support network of friends, peers, family.
   - Proactive in solving own problems (educate self about problems and coping strategies, seek help when needed, avoid victim mentality).
   - Spiritual foundation (not necessarily religious) that provides values, meaning, and purpose to life.

2. Peer Support

   - Peer support and counseling training.
   - Traumatic incident support team.
   - Alcohol recovery support team.
   - Peer adviser team.
   - Disabled officer support team.
   - Significant other support team.

3. Good Supervision and Administrative Support

   - Commitment to physical and emotional welfare of employees.
   - Training in supervision skills and mental health issues.
   - Administrative support for good supervision.
   - Good role modeling by supervisors.
   - Innovative program development.
   - Willingness to confront problems.
   - **People are First.**

PRIMARY FACTORS IN RECOVERY FROM STRESS AND TRAUMA (Continued)

4. Mental Health Professionals

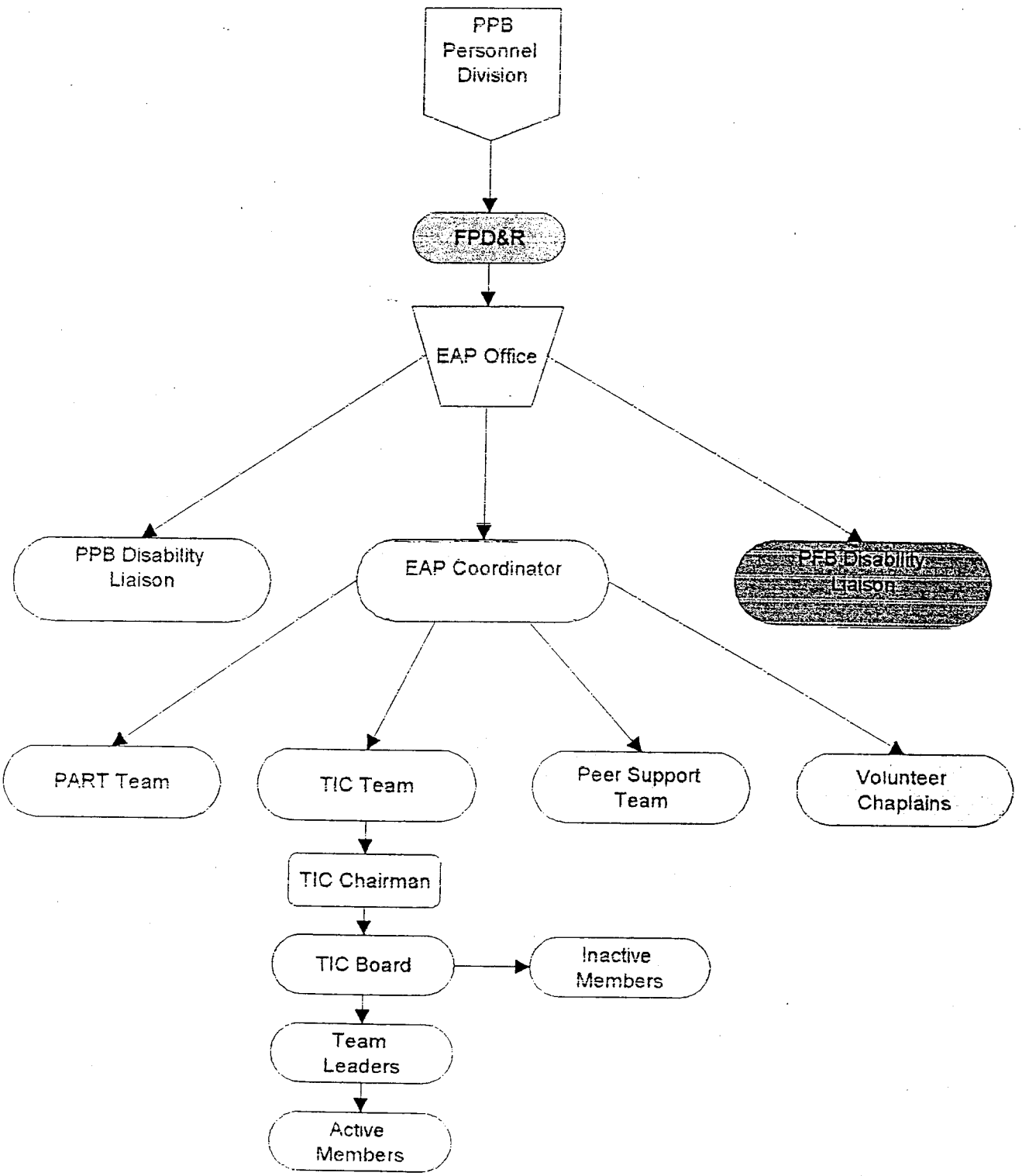
- Training for employees and supervisors.
- Clinical supervision in peer support issues.
- Traumatic incident debriefings.
- Psychotherapy.
- Consultation as problems arise.
- Psychological evaluations.

Peer Support Checklist

DO:

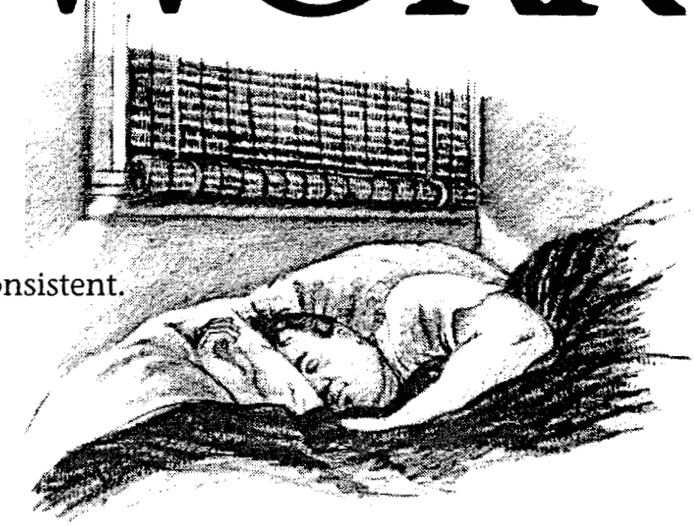
- ❑ Remember confidentiality.
- ❑ Respond in person as quickly as possible. Be prepared to spend some time with him/her.
- ❑ Get the individual some distance from the immediate scene.
- ❑ Let the person determine how much contact s/he wants to have with you; however, *never leave someone alone if you have concerns about his/her state of mind.*
- ❑ Remind the individual that his/her physical, sensory, emotional, and thinking symptoms are normal.
- ❑ Assist the person in contacting his/her family.
- ❑ Offer to stay with or help him/her locate a suitable friend to stay with overnight for a day or two.
- ❑ Ask questions that show your concern such as, "How are you doing?" or "What can I do for your family?"
- ❑ Be careful about making statements to the effect of, "I'm glad to see you're OK." It is better to say, "I'm sorry you had to go through that."
- ❑ Listen non-judgmentally. Listening is doing something.
- ❑ Be prepared to repeat instructions and information.
- ❑ Suggest the individual use an answering machine to screen his/her phone calls for a period of days.
- ❑ Encourage him/her to consider the use of available administrative leave.
- ❑ Know your limits. Support the individual to get professional help when necessary.

PPB TIC Team
Organizational Chart

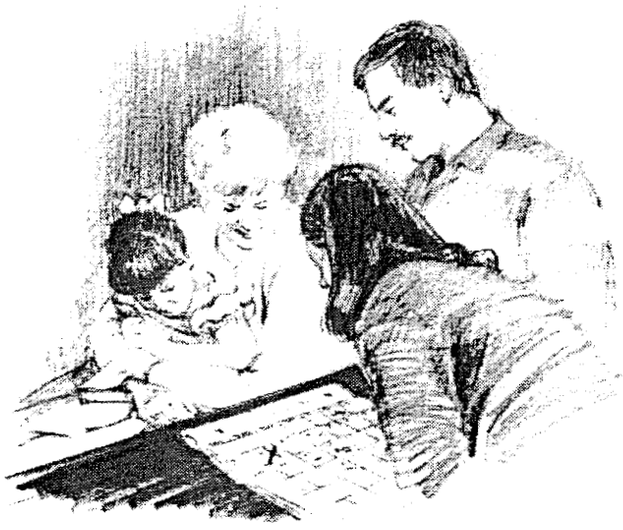


TIPS FOR SUCCESSFUL SHIFT WORK

SLEEP



- ❑ Your environment should be dark, cool, soundproof and uninterrupted.
- ❑ Plan a sleeping pattern and try to be consistent.
- ❑ Avoid inconsistent napping.
- ❑ Don't force sleep.
- ❑ Allow adequate time for sleep.
- ❑ Prepare yourself for shift changes.
- ❑ Avoid sleeping pills and alcohol.



SOCIAL LIFE

- ❑ Talk to your family about adjustments.
- ❑ Ask for support.
- ❑ Discuss house security.
- ❑ Have a family calendar which includes activities and sleep times.
- ❑ Plan quality time to compensate for times you can't be there.
- ❑ Surprise your spouse with love gestures.
- ❑ Work at keeping your sex life enjoyable.
- ❑ Keep physically active.

NUTRITION

- ❑ Eat one daily meal with your family.
- ❑ Eat more carbohydrates as you approach bedtime and less protein and fats.
- ❑ Sleep with light foods in your stomach.
- ❑ Avoid excessive fluids before sleep.
- ❑ Eat three healthy meals daily.
- ❑ Avoid spicy or greasy foods, especially when starting night work.

Use or Abuse?

Diagnosing Dependency

Dependence on alcohol or other drugs is a widespread problem. Many times, people don't recognize it. Chemical dependency is simply the inability to control the use of some physical substance—not being able to quit and not being able to limit how much is used. If you have a dependency problem, recognizing it can help you to move toward a happier and healthier life.

Myths

You might think of a chemically dependent person as someone who can't live without their drink or drugs, who is often drunk or stoned, who uses every day or is irresponsible, immoral, weak-willed or bad. The fact is, a person can be chemically dependent without showing such obvious signs. We are gradually beginning to realize that a person's genetic makeup may affect his or her chances of becoming dependent, and that dependency is often a physical condition that can't be cured by willpower alone.

Symptoms of Dependency

Here are some signs that might indicate a chemical dependency problem in you or someone you love:

- trying to cut down on or to quit using some substance and failing at it
- "blackouts," or lapses of memory after use
- using the substance while alone or hiding the evidence of use
- using the substance to forget about problems or worries
- doing things while "under the influence" that cause regret afterward
- not being able to enjoy an event without the substance
- neglecting responsibilities in order to use the substance
- family, friends or employer expressing concern about substance use
- being willing to do almost anything to get the substance
- financial or legal problems from using the substance

Problems Caused by Dependency

Chemically dependent people often act unwisely or inappropriately while under the influence of their drug. They may act in ways that will embarrass them later. They may endanger their health and lives, and the lives of others, by having unsafe sex or by driving while intoxicated. They may lose their jobs or families as people around them are hurt by their actions.

What to Do

Recognizing that there's a problem is the first step toward recovering from chemical dependency. If you think you might have a problem of this type, here are some steps you can take:

- Acknowledge the problem openly.
- Limit time spent with people who encourage drug use.
- Seek professional help from doctors or therapists who deal with chemical dependency and recovery. You might benefit from counseling or a recovery program at a hospital or private clinic.
- Seek out the support of people who are recovering themselves. Many 12-step programs, such as Alcoholics Anonymous, are available for various types of dependencies. Your employee assistance program can help you find these and other helpful resources.

GOOD GRIEF

Grief is the healing process we go through after suffering a loss. Although we normally think of loss as the death of someone close to us, life changes such as divorce or losing a job can also bring about grief. Learn about the process of grieving and tips for coping with different types of losses.

Five Stages of Grief

The first stage of grief is **denial**. It's hard for our minds to accept that such a loss has taken place.

Anger is the second stage. We probably had no control over the loss, so we react to our vulnerability with anger. We lash out at others or blame ourselves for the loss.

The third stage is **bargaining**. We want to trade something we can do for the reversal of the loss, saying things like "I'd do anything if only this hadn't happened."

Depression is the fourth stage. A feeling of hopelessness about the situation takes over.

The fifth and final stage is **acceptance**. We accept the reality of the situation and are able to move on in our lives.

Moving Along

How much time it takes to move through these stages depends on the nature of the loss, the individual who is grieving and the overall circumstances of the individual's life. The individual also may not experience the stages in this order. For example, bargaining may come before anger. The important thing to remember, however, is that grieving happens in stages. Being stuck in one stage and dwelling on the loss too long might require the intervention of a professional counselor.

Tips for Coping

Sharing grief with those close to us is important for moving through the grieving process. Bringing people together is one of the roles of funerals or memorial services for people who have died.

But sometimes it is difficult for others to relate to the depth of our pain if a death is not involved, such as when we lose a job. In cases such as this, professional counseling may help you through your grief process to move toward the final stage of acceptance.

Moving Toward Acceptance

Tips for Communicating Effectively With Your Children

Communication is a two-way bridge that connects you to your child's feelings. Healthy communication between parents and their children helps youngsters develop positive personalities and good relationships with other people.

Healthy communication builds your children's self-esteem because it makes them feel cared for and loved. With caring parents to listen to their concerns, children feel safe and able to express their feelings and needs directly in words. Children who are nurtured with their parents' attention learn how to manage their feelings without overreacting.

A strong bond with your children also helps you feel close to them and understand their needs. Understanding your children in this way gives you the tools to help them grow and manage the inevitable frustrations of being a parent.

Build the Bridge of Communication

✓ *Be available.*

Children need to feel that their parents are available to them. Even spending 10 minutes a day with each child makes the bridge of communication stronger. Get yourself into a quiet, attentive mood before you start listening to your child or talking about something important.

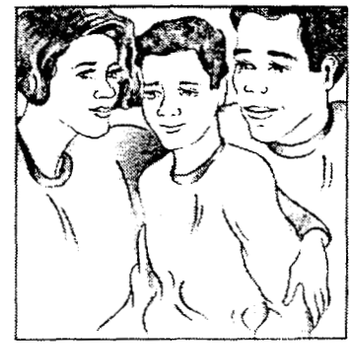
✓ *Be a good listener.*

Children believe they're important when they feel their parents understand them. Being a good listener helps children feel loved, even when they're upset and you can't do anything to fix the problem. Ask your child to tell you his ideas and feelings. Try to understand exactly what your child is saying. What your child is trying to tell you is important to him, even when it may not be to you.

✓ *Show empathy.*

You can show empathy even if you disagree with your child. Let your child know you've heard and appreciate her feelings. Showing empathy means making sure you understand what your child is feeling. Restate what your child has expressed and ask if your understanding of her feelings is correct.

✓ *Be a good sender.*



Your child will be in a better mood to listen to you if he feels heard and cared for. Make sure that what you say, your tone of voice and what you do send a consistent message. For instance, if you laugh when you say "no," your child will be confused about what you really want.

Be very specific about what you want your child to do. Use words to send messages, even with toddlers. Use feeling words when you praise your child's behavior. For example, you can say "I'm so happy," when your child puts his dirty clothes in the hamper. Encourage your child to praise himself as well.

Use "I" statements to tell your child what makes you unhappy about her behavior. It's better to say: "I was worried when you came home late from Jessica's house" than to yell "Why were you late for dinner again?" Tell your child what you feel and think, not what she should think or feel.

✓ *Be a good role model.*

Young children learn by copying their parents' behavior. If you use a lot of feeling words, it will help your child learn to do the same. Verbalizing feelings also helps children learn to control their behavior.

Communicating Effectively With Your Spouse

While romance might get a relationship started, good communication keeps it going. These healthy communication habits can help you strengthen your bonds with your spouse:

Make intimacy a priority.

With busy schedules and multiple demands, it's easy to let your need for intimate contact with your spouse slide, but intimacy strengthens a relationship like nothing else can. No matter how busy you are with work and family obligations, spend at least one hour of private time with your spouse every day. Even if you don't have time for romance, use the time to talk about the successes and frustrations of your day.

Find a good time to talk about difficult subjects.

When you have something difficult to talk about, check with your mate for a specific time to discuss it. Resist the temptation to talk when he or she walks in the door after a hard day at work. Try choosing a subject you want to discuss, and both of you write about it for 10 minutes; then talk about it for 10 minutes. Make sure you stick to the time frame. If you need more time, agree on when you can talk about it again.

Focus your concerns.

Think about what you want to say before you begin to talk. With sensitive topics, it might be tempting to avoid talking about what's on your mind. Get right to the point and after you've stated your request, listen closely to your spouse's reply. Stay focused on finding solutions to problems rather than on emphasizing differences.

Let both sides be heard.

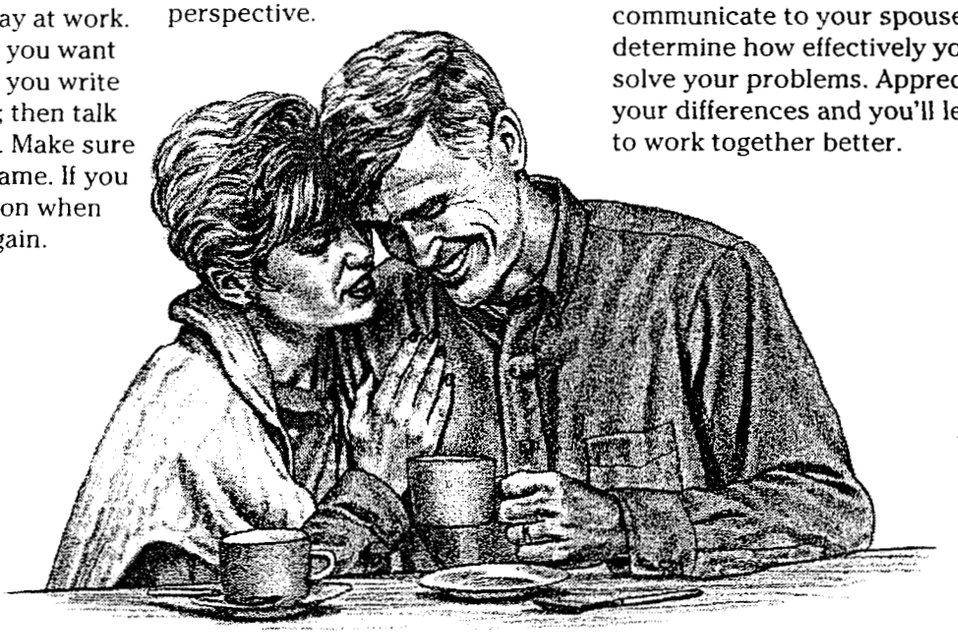
When you have a disagreement, remember that both of your needs are important. Use a firm and gentle tone of voice in stating what you need, why you need it, and what you want your mate to do. However, try not to elevate your needs above your spouse's. Listen and show that you see things from your spouse's perspective.

Be honest but not accusatory.

It's easy to blame the other person when you're angry or hurt, but blaming only invites retaliation. Talk about your feelings instead. For instance, avoid saying, "You ruined the plans again. You're always late." Instead, using "I" statements, say: "I'm very disappointed that you were late. I was counting on you to be home in time." This approach is less likely to provoke a defensive response and more likely to encourage an open discussion.

Value your differences.

Sometimes the differences in your temperaments and communication styles will be more evident than your similarities. When you feel this way, how and what you communicate to your spouse will determine how effectively you solve your problems. Appreciate your differences and you'll learn to work together better.



FAMILY COMMUNICATION

Keeping the Love Lines Open

You can enjoy special rewards for being part of a family. These include friendship, love and closeness, sharing for support and understanding, and acceptance of each other just as we are. However, the needs of family members change constantly. Most changes are natural to growing older and wiser together. Honest communication and careful listening can help assure that your family stays in tune, sharing maximum love and support.

Review Your Family Patterns

Do you feel that you understand each other's needs? Do family conflicts reach a satisfactory end? Here are three check points:

1 Is your approach positive, starting with how you feel? For example, "I feel important when you listen to me..."

2 Are you specific about the issue at hand? If you criticize, are you constructive? For example, "You didn't make your bed this morning. If you need more time, we can..."

3 Can you negotiate? Even if you disagree on an issue, can you agree on a compromise? For example, "I don't agree, but I'll try for a week because I understand your reasons."

Are These Problems Familiar?

Outside friends, school or work activities, separation of family members, and just plain fatigue can create problems. Messages become unclear because it's easier to blame or bully than to take the time to discuss things. You may hold feelings back because you don't want to "start something." As unresolved problems build, mutual respect can disappear. Finally, there just doesn't seem to be enough time or energy to pay attention to each other.

Try These Solutions

Here are standard guidelines for healthy communication.

1 Be honest and share feelings.

2 Listen and watch so you know when others are needy.

3 Develop a manner of speech that's open and clear.

4 Take responsibility for personal thoughts and actions.

5 Regularly discuss values and beliefs.

6 Encourage positive values, and act as a role model.

Create Quality Time

Your family may find that it's a lot easier to be patient with each other when all of you know what's going on. Some families set aside an hour a week just to talk about individual and group needs.

Some working parents feel that the first five minutes after they get home is critical. Regardless of how tough a day has been, taking the time for an individual greeting and hug says, "I recognize you." Tub time, tuck in time, kitchen time and other short periods can be loving when someone is willing to listen. A bonus is that when you pay attention to trivial things, your children may be encouraged to talk about the serious things.

Family Resources

Family counselors can help when there's no understanding or mutual effort to make things better. Each family member can learn to listen, to talk, to fight fair, to compromise and to cooperate.

Assertiveness

Saying "Yes", Saying "No"

Do you have trouble saying what you think? Speaking directly? Asking for help? If so, you may need to learn more assertiveness. Assertiveness is the ability to acknowledge the thoughts and feelings of others without downplaying the importance of your own.

Confront Old Fears

Many of us were taught as children to "be nice" and not to "say things like that." Since children are often unable to know what's appropriate, it might make sense that our natural honesty is silenced. But many of us carry those lessons into adulthood. When confronted with situations in which we really must communicate honestly, we don't know how. We're too afraid of hurting other's feelings, of being rejected or of making mistakes. But it's possible to be too polite. Don't let yourself get lost in your concern for others.

Enjoy Clearer Communication

Some people are highly skilled at getting what they want by manipulation, by trying to place blame or by trying to induce guilt feelings in others. Once you begin to communicate clearly, such people will probably stop using manipulative communication with you because they know it's not effective. Your interaction with others can then be more honest and more satisfying.

Keep to the Point

Sarah promised Joan that she would take her shopping on Saturday. But an emergency has come up and Sarah dreads calling her to cancel their plans. Joan can be difficult when she doesn't get her way. Sarah might be thinking, "Why doesn't she get her own car? Why does she always rely on me?" because Sarah is nervous about having to tell Joan she can't go. But the fact that Joan doesn't have a car or always relies on Sarah isn't the point of the conversation. The point of the conversation is to cancel plans with Joan.

Sarah states the situation:

SARAH: *"I'm sorry, but I can't take you shopping today, Joan. My husband has to go to work today and he has to take my car."*

Joan tries to make Sarah feel guilty:

JOAN: *"But you promised me! Now what am I going to do?"*

Sarah acknowledges Joan's disappointment, then restates the situation:

SARAH: *"I understand that you're disappointed and I'm sorry that there's been a change in plans, but I won't be able to take you."*

Joan, surprised by Sarah's firmness, realizes that she has no alternative:

JOAN: *"Oh. Okay. Maybe some other time."*

Sarah would like to go with Joan some other time, so she gives Joan a specific action:

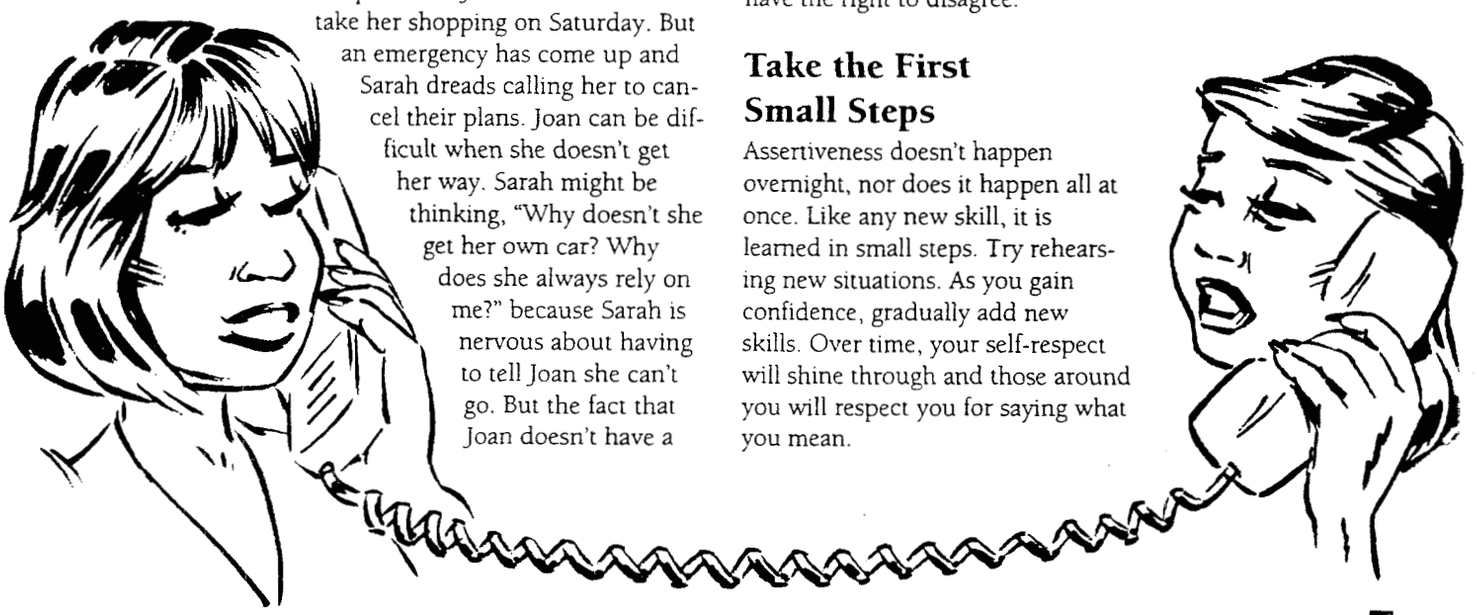
SARAH: *"Sure, Joan. Give me a call next week and we'll arrange another time."*

Learn Other Communication Skills

Use confident body language and a clear voice and tone. Be a good listener. Ask questions if you're not sure you understand. Use common courtesy. Remember that others have the right to disagree.

Take the First Small Steps

Assertiveness doesn't happen overnight, nor does it happen all at once. Like any new skill, it is learned in small steps. Try rehearsing new situations. As you gain confidence, gradually add new skills. Over time, your self-respect will shine through and those around you will respect you for saying what you mean.



Recognize the Warning Signs of Stress

When we experience situations we can't control, our "fight or flight" response pumps extra adrenaline into our systems. This jolt of powerful hormones readies our bodies for action. This physical response helped prehistoric humans survive by enabling them to run away from their enemies faster or to fight harder. By the time they won the battle or escaped, their bodies had discharged the tension of the moment and their stress response was followed by relaxation.

However, many of the stressful situations we experience today don't offer this outlet for release. In the workplace, stress often results from feeling a lack of control or from failing to get adequate recognition or feedback. Employees who are uncertain about their job future or overqualified for their positions may also experience work-related stress.

It's important for managers to understand and recognize the warning signs of stress. Workers under stress may be emotionally unstable and exhibit depression, irritability, anxiety, apathy or impatience. They may overuse drugs and alcohol and have difficulties with supervisors and coworkers. They may be tardy and absent more than usual.

Signs and Symptoms of Stress

- insomnia and other sleep problems
- appetite changes
- fidgeting or nervousness
- forgetfulness
- eating disorders
- sexual problems
- skin problems, such as psoriasis, eczema, hives and acne
- back pain
- cold sores
- digestive disorders, such as irritable bowel syndrome, diarrhea and ulcers
- tension headaches and migraines
- high blood pressure
- nervous tics
- trembling
- shortness of breath
- inability to concentrate

How You Can Help an Employee Who's Under Stress

If you notice an employee who's under a lot of stress, try to help determine what's causing the problem. The employee may benefit from clarification about a specific project or deadline. Perhaps the employee's stress is related to concerns about leaving an infant with a child care provider, or the availability of services for an elderly parent. If on-the-job stress seems to come from interpersonal conflicts, be supportive. Refer employees to counselors and conflict management services.

Your company's human resources department and Employee Assistance Program (EAP) are good sources of information on stress reduction, time management, child and eldercare services and other issues of interest to employees managing multiple demands in their lives.

Suicide

Suicide is a devastating act that almost always seems to friends and family members like a bolt from the blue. But people often give clues that they're thinking of suicide. Recognizing the warning signs of suicide could result in a life being saved.

Warning Signs

Giving away cherished possessions, making a will and being preoccupied with death are red flags for impending suicide. Furthermore, the old saying that people who talk about suicide don't do it is simply not true. Often such talk is a cry for help before it's too late.

Another warning sign of suicide is depression. Any of these changes could indicate depression:

- feelings of hopelessness, helplessness
- changes in eating, sleeping patterns or behavior
- withdrawal
- poor performance at work or school
- poor concentration

Risk Factors

Anyone who is depressed or has been depressed is at risk for suicide. The following are also risk factors:

- alcohol and drug use
- a history of physical or sexual abuse
- troubled teenage years
- death of a friend or family member
- and of a relationship
- a previous suicide attempt

What to Do

If you suspect someone is considering suicide, take warning signs seriously. Don't assume it will blow over. Share your concerns with someone who is in a position to take charge.

Getting a person past a suicide crisis involves being very direct. Ask these questions:

1. Do you feel there is no other way?
2. Do you have a plan to commit suicide?
3. If yes, how and when would you do it?

If the answers indicate the person is serious about suicide, don't try to talk him or her out of it. But do try to make a deal with the person: that they won't do anything without talking to you—or another trusted person—first. Then get help. Talk to a responsible family member, counselor, EAP professional or suicide prevention hotline immediately. If possible, have a trusted friend or relative stay with the person until the crisis is passed. Follow up with professional help. As a friend or family member, show understanding, compassion and caring, even though you may be angry with the person for putting you through this.

If You're Considering Suicide...

Reach out: Talk to a family member, friend or doctor. They will be able to get you the help you need and deserve. Or call your local suicide hotline. You can find it in the community service pages of your telephone directory. It's hard to see it when you're feeling down, but getting help can help you understand that your life is valuable to yourself and others.

UNDERSTANDING ANGER

CAUSE AND EFFECTS

Anger is an emotional cue which reminds us what we like and what we don't like. Although many of us were taught as children to stifle our anger, it's, in fact, perfectly natural. Anger can have many causes, but its effects depend on your ability to manage it. Learn to understand anger, the effects of denial and blame-placing, and the positive results that can come from accepting your own anger.

CAUSES

You cut yourself shaving. You burned the toast. You can't find the keys. Now the car won't start and you'll be late for work. No one did these things to you. They just happened. If you ask others, you'll find that such "disasters" are quite common and that they make almost everyone angry. We feel anger when we sense we've lost control, or when we feel vulnerable or afraid. We all have these feelings sometimes, and some of us are more easily irritated and annoyed than others.

DENYING ANGER

Many times we want to deny that we're angry because we're not in the habit of admitting it, or anger doesn't seem rational to us, or we're embarrassed by our lack of control. All humans feel anger, whether it's expressed. Thus, by denying anger, you deny that you're human.

BLAME-PLACING

Sometimes we want to blame others for our anger, even if it seems unjust. Some people do this regularly as a habit. People generally don't like to be around blame-placers, because they never know if they're going to be next in line to be blamed for something.

ACCEPTING ANGER

By recognizing and accepting your own anger, you're on the road to controlling it and releasing it responsibly. Acknowledging what makes you angry, instead of denying anger or placing blame, leads to self-understanding. Once you can identify common situations, you can change them, deal with them responsibly or make a conscious choice to ignore them. You can then reap the benefits of what this emotion tells us.

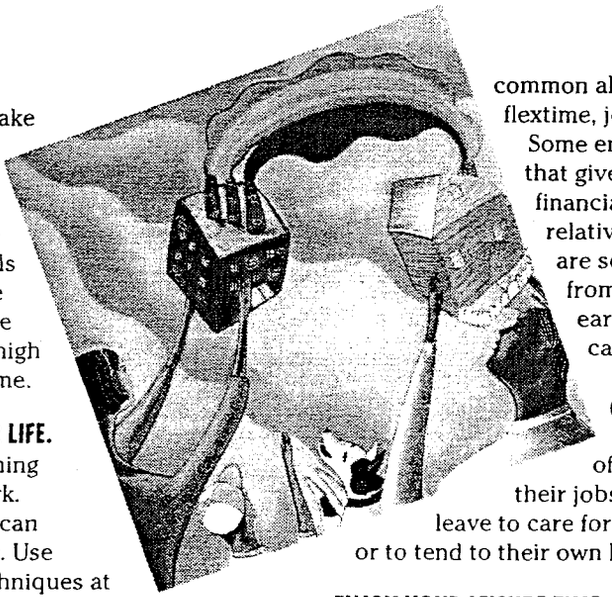
Combining Work and Family

How to Make It Work

If you're like most working parents, you juggle child care arrangements and concerns about your aging parents' capabilities with job worries and the evening's dinner menu. Your employer depends on you to be organized and efficient. Your family needs you to be nurturing and compassionate. You wear many different hats each day and you need every available resource to help you succeed.

What's available to help you manage these multiple roles? Your primary resources are within you. Of key importance is the value you place on family communication and the care you extend in nurturing your relationships with your spouse and children. Also important is your ability to make plans and prioritize your time. But most working adults need outside help to balance work and family obligations. Fortunately, many employers realize that their workforce is composed of people just like you. Most companies have special resources to connect you with services to assist you in managing your responsibilities.

Here are some ideas to keep in mind as you try to fit work and family responsibilities into a busy, but satisfying life:



CONNECT WITH YOUR FAMILY.
Make time for togetherness. Make sure your spouse and children know that their needs are important despite your busy schedule. Take time to enhance your parenting skills and learn how to communicate with your children. Private time with your spouse should take high priority when you plan your time.

ORGANIZE AND PRIORITIZE YOUR LIFE.
Learn and use long-range planning techniques at home and at work. Organize your household so it can function smoothly without you. Use effective time management techniques at work that streamline your job and reduce stress.

USE FAMILY SUPPORT SERVICES.
You can find out about child care and eldercare services in your community through local agencies and resource centers. Your Employee Assistance Program (EAP) frequently has information about these services. Your EAP also may be a good resource for books and videos about parenting and referrals to a wide variety of counseling services.

INVESTIGATE EMPLOYER-SPONSORED BENEFITS AND PROGRAMS.
Your company may offer the option of working a schedule other than the traditional 9-to-5 work week. Some common alternative work options include flextime, job sharing and telecommuting. Some employers offer benefit programs that give an employee a way to ease the financial stress of caring for an elderly relative. For instance, some programs are set up to deduct pretax dollars from an employee's paycheck and earmark the fund for dependent care expenses.

The Family Medical Leave Act (FMLA) guarantees employees the right to take up to 12 weeks of medical leave and return to their jobs. Employees may use FMLA leave to care for a child, a spouse or a parent or to tend to their own health conditions.

ENJOY YOUR LEISURE TIME.
Plan and enjoy relaxing activities with your spouse and family. Try to save some time for yourself. Establish a regular exercise routine (at least 20 minutes of aerobic exercise three times a week) and find other ways to enjoy personal time.

LET GO OF PERFECTION.
Realize that it's impossible to be a perfect parent, whether you work away from home all day or stay at home. Your ability to provide love, constructive discipline and guidance is the most important gift you can give your children. With good planning, organization and knowledge of how to balance work and family responsibilities, you can make it all work for you and your family.

DEPRESSION

Understanding the Disorder

Depression is no mere slump in mood. Unlike "the blues," which tend to clear up in a few days, depression frequently is both prolonged and recurring. It can't be ignored, and it can't be joked or whistled away. Sufferers of depression are likely to experience:

- **prolonged loss of interest in home, work and personal appearance.**
- **loss of interest in sexual activity.**
- **sudden changes and excesses in eating or sleeping habits.**
- **frequent, uncontrollable crying.**
- **lingering, unfocused nervousness or grouchiness.**
- **persistent feelings of hopelessness and futility.**

There are both physical and psychological causes of depression. Illness and chemical imbalances are physical causes. Psychological or emotional causes include distressing or threatening changes—death of a loved one, divorce or loss of a job—and continuing problems of emotional dependency and inadequate self-esteem.

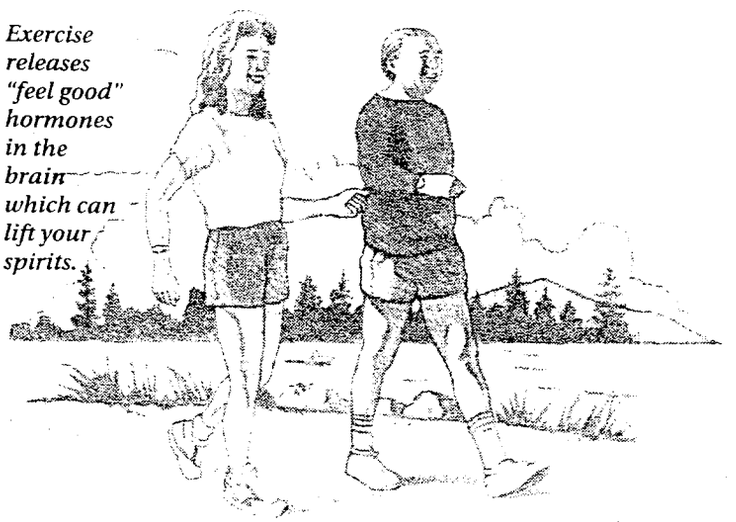
Untreated, depression can be debilitating and can lead to suicide. It's a serious condition requiring serious treatment.

Treatment for Depression

If you suspect you suffer depression, having a medical checkup is your first step. Even depression with emotional causes may call for treatment with medication, and that's a decision that must be made by a doctor who, in turn, must know the state of your physical health.

If your depression has a physical cause, treating the underlying illness may be the cure. Depression resulting from chemical imbalance can also be treated medically. Especially among elderly people, chance combinations of medications taken for various medical needs can produce depression. A doctor will want to get a complete list of all medicines you've been taking.

If your depression is traceable to an event or situation, professional counseling or therapy may be helpful. The doctor who does your physical checkup can refer you to a counselor or therapist.

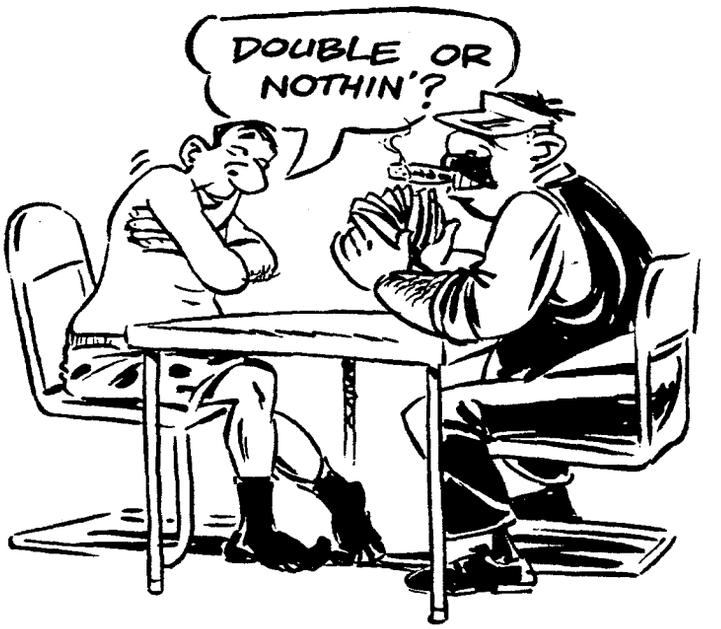


Exercise releases "feel good" hormones in the brain which can lift your spirits.

Self-Care Tips

In addition to seeking professional help, there are some things you can do which may help you feel better. Follow a healthy, well rounded diet, and get regular exercise. Aerobic exercise, such as walking, bicycling and swimming, is recommended. Scientists theorize that such exercise releases "feel good" hormones in the brain which can lift your spirits and help you feel more optimistic and emotionally in control. Again, these are often beneficial, but they're not an alternative to professional attention. Talk to a health professional.

Are You a Compulsive Gambler?



Recognizing the Syndrome

There are specific behavior patterns associated with compulsive gambling. Gamblers who recognize these patterns can cope with their addiction and recover a life free of gambling. Recovery programs providing help, guidance and healing are available.

An Addictive Disorder

Compulsive gambling is an addictive disorder. Experts speak of it as a "disorder of impulse-control." Compulsive gamblers are unable to control their chronic gambling. An emotional dependency exists. Such gamblers are impulsive, obsessive and irrational. They will gamble against all odds. For a compulsive gambler, to roll the dice, pick a number or play a hand becomes more important than family, home or work.

Not all people who gamble are addicted. There are some characteristic behaviors that may help you recognize when gambling has become compulsive. Do you:

- spend a lot of time gambling or thinking about it?
- increase your bets to "catch up"?
- boast about your winnings?
- gamble to feel good?
- have frequent or unexplained absences?
- experience mood swings—high when winning, low when losing?
- keep hidden funds or take out secret "loans" from family bank accounts?

The Addiction Process

People who are becoming compulsive gamblers go through three phases of addiction: winning, losing and, finally, desperation.

The Winning Phase

Gamblers win, lose, and break even—often. In this phase, the winning and losing seems an adventure. Gamblers get their "thrills." Excitement predominates. Worries disappear.

The Losing Phase

Gamblers begin losing more than they win. Self esteem ebbs. The gambler may borrow money to "get even." More time is spent gambling to recover losses and repay loans. A roller coaster ride begins: The stakes and the takes increase; but the losses come faster, and the ride down is a fearsome thing.

The Desperation Phase

Gambling becomes a full-time obsession. Life centers around "getting even" and paying off debts, often with borrowed or stolen money. Lies and secret loans abound. Still greater risks are taken. Depression becomes chronic.

A Family Affair

Compulsive gambling harms marriages and family life. The gambler's obsession steals time and attention away from the gambler's spouse and children. Feeling abandoned, his or her loved ones experience problems of self-worth and suffer bouts of depression. The family unit can unravel.

As the disease progresses, the gambler's work life also suffers. Work, it seems, begins to interfere with gambling. The gambler is often late to work, takes long lunches, uses the phone excessively or reads sports literature while working. All these are characteristic of the compulsive gambler. All are symptoms of the gambler's compulsive, uncontrolled pursuit of the big gamble.

There Is Help

If you think your gambling has gotten out of control, you've already taken the first step toward recovery— you've recognized the problem. Your company's employee assistance program may refer you to a professional counselor. Or you may choose, as many have, to find help through Gamblers Anonymous. Gamblers Anonymous is a self-help organization offering a 12-step recovery program similar to Alcoholics Anonymous. Check the white pages for a chapter near you.

Is Debt Dragging You Down?

Recognizing the Syndrome

"I WANT TO SHOP TILL I DROP." Behind the humor, some find a desperate, life-corrupting truth in this. For the compulsive shopper, shopping becomes an all-consuming passion. A shopaholic's behavior seems to say, "I want it. I'm going to buy it and to hell with everything else." Too frequently, this is exactly what happens: the purchases are made and the rest of the shopper's life goes to hell.

Addicted shoppers experience a "rush" when making a purchase. They find spending a "thrilling," "exciting" and even "wild" sensation. As with other addictions, the "high" experienced while absorbed in the satisfaction of the compulsion is followed by a corresponding "low." Shopaholics commonly suffer depression and guilt in the aftermath of their purchases. Yet they would rather shop than do anything else.

Symptoms of Addictive Spending

If you live from paycheck to paycheck with little or no savings, and pay only the minimum amount due on your charge accounts, you may have a problem with spending. Consider the following checklist:

- ➜ Is shopping your primary activity of choice?
- ➜ Do you pay one line of credit with another?
- ➜ Have you hidden or lied about your purchases?
- ➜ Do you frequently put friends' purchases on your credit cards and collect the cash?
- ➜ Have you felt nervous and guilty after a spending spree?
- ➜ Do you often charge groceries and toiletries because you're low on cash?
- ➜ Would others be alarmed if they knew your spending habits?
- ➜ Have you felt hopeless and depressed after spending money?

If you've answered "yes" to more than a few of these questions, you may have a spending problem.

Changing Spending Habits

One of the first steps in dealing with an addiction is to find the motivation to change. You may find it helpful to look at why you're spending the money. Many times, compulsive shoppers are harboring pent-up emotions, especially anger, and shopping may feel like a release for that anger. Dealing with the anger, rather than ignoring or masking it by shopping, is a step toward health. If the impulse to spend strikes, you can ask yourself, "What is it I really want?" and "What am I avoiding in my life?"

Control is the key to ending any addiction. If you've recognized yourself as being a shopaholic, you may be able to overcome your addiction by teaching yourself to monitor and control your compulsive behavior. But it won't be easy. Avoiding sales and limiting your access to credit cards may help. These are avoidable temptations. To help ensure lasting success, learn the skills that will enable you to use credit wisely and responsibly.

Getting Help

Shopaholics seeking information, advice, support or assistance will find a number of options available. Consumer Credit Counseling Services are available nationwide. You'll find them listed in the yellow pages. Debtors Anonymous is a self-help group for compulsive spenders and credit abusers. Your local telephone directory white pages will help you find it and other programs. If you feel that, as in many compulsive disorders, low self-esteem may be at the root of your problem, a professional counselor may be the answer.

SHORT "UN-STRESSING" SKILL

By practicing quick relaxation techniques, one can develop the ability to calm the body and the mind at will. The following technique is suitable for almost any location and can be easily done without those around you being aware of what you are doing. The procedure calls for taking five long, slow, deep breaths while becoming aware of the tension within. Begin the exercise by slowly stretching the arms, legs, and toes. While doing this, yawn as if you were tired. Then:

1. First Breath: **Take in a long, slow breath while counting to six. Breathe deeply into your diaphragm and hold the breath for four or five seconds. Now, exhale slowly as you silently speak the word, "relax."**

2. Second Breath: **As you take in another long, slow breath, concentrate on the muscles in your scalp, forehead, eyes, jaw, and face. Notice any tension you may be holding in these areas while you slowly exhale, silently speaking the word, "relax." Feel the tension fall away as you exhale.**

3. Third Breath: **As you take in another long, slow breath, concentrate on the tension in your neck and shoulders. Release the tension in these muscles as you exhale slowly, repeating the word, "relax."**

4. Fourth Breath: **As you slowly inhale, notice any tension in the muscles of your chest and abdomen. Relax these muscles as you slowly exhale sending the message, "relax," through your body.**

5. Fifth Breath: **As you take in another long, slow breath, focus on tension remaining anywhere in your body. Hold this breath for a few seconds and exhale slowly while repeating again, the word, "relax."**

You may wish to repeat this exercise several times in a row to really rid your body of stress. With practice, you will be able to release ever increasing amounts of stress. Relaxation does require practice. It is a learned skill. One of the most common mistakes is giving up too easily. Stick with the process and it will serve you well.

COPING STRATEGIES

POSITIVE

DIVERSIONS

GETAWAYS:	Spend time alone. See a movie. Daydream.
HOBBIES:	Write. Paint. Create something.
LEARNING:	Take a fun class. Join a club.
MUSIC:	Play an instrument. Sing. Listen to stereo.
PLAY:	Play a game. Goof off. Go out with friends.
WORK:	Tackle a new project. Keep busy. Volunteer.

FAMILY

BALANCING:	Balance time at work and home. Accept the good with the bad.
CONFLICT RESOLUTION:	Look for win/win solutions. Forgive readily.
ESTEEM BUILDING:	Build good family feelings. Focus on personal strengths.
FLEXIBILITY:	Take on new family roles. Stay open to change.
NETWORKING:	Develop friendships with other families. Make use of community resources.
TOGETHERNESS:	Take time to be together. Build family traditions. Express affection.

INTERPERSONAL

AFFIRMATION:	Believe in yourself. Trust others. Give compliments.
ASSERTIVENESS:	State your needs and wants. Say "no" respectfully.
CONTACT:	Make new friends. Touch. Really listen to others.
EXPRESSION:	Show feelings. Share feelings.
LIMITS:	Accept others' boundaries. Drop some involvements.
LINKING:	Share problems with others. Ask for support from family/friends.

MENTAL

IMAGINATION:	Look for the humor. Anticipate the future.
LIFE PLANNING:	Set clear goals. Plan for the future.
ORGANIZING:	Take charge. Make order. Don't let things pile up.
PROBLEM-SOLVING:	Solve it yourself. Seek outside help. Tackle problems head on.
RELABELING:	Change perspectives. Look for good in a bad situation.
TIME MANAGEMENT:	Focus on top priorities. Work smarter, not harder.

PHYSICAL

BIOFEEDBACK:	Listen to your body. Know your physical limitations.
EXERCISE:	Pursue physical fitness. Jog. Swim. Dance. Walk.
NOURISHMENT:	Eat for health. Limit use of alcohol.
RELAXATION:	Tense and relax each muscle. Take a warm bath. Breathe deeply.
SELF-CARE:	Energize your work and play. Strive for self-improvement.
STRETCHING:	Take short stretch breaks throughout your day.

SPIRITUAL

COMMITMENT:	Take up a worthy cause. Say "yes."
FAITH:	Find purpose and meaning. Trust God.
PRAYER:	Confess. Ask for forgiveness. Pray for others. Give thanks.
SURRENDER:	Let go of problems. Learn to live with the situation.
VALUING:	Set priorities. Be consistent. Spend time and energy wisely.
WORSHIP:	Share beliefs with others. Put faith into action.

NEGATIVE

ALCOHOL:	Drink to change your mood. Use alcohol as your friend.
DENIAL:	Pretend nothing's wrong. Lie. Ignore the problem.
DRUGS:	Abuse coffee/aspirin/medications. Smoke pot. Pop pills.
EATING:	Keep binging. Go on a diet. Use food to console you.
FAULT-FINDING:	Have a judgmental attitude. Complain. Criticize.
ILLNESS:	Develop headaches/nervous stomach/major illness. Become accident prone.
INDULGING:	Stay up late. Sleep in. Buy on impulse. Waste time.
PASSIVITY:	Hope it gets better. Procrastinate. Wait for a lucky break.
REVENGE:	Get even. Be sarcastic. Talk mean.
STUBBORNNESS:	Be rigid. Demand your way. Refuse to be wrong.
TANTRUMS:	Yell. Mope. Pout. Swear. Drive recklessly.
TOBACCO:	Smoke to relieve tension. Smoke to be "in."
WITHDRAWAL:	Avoid the situation. Skip school or work.

	Keep your feelings to yourself.
WORRYING:	Fret over things. Imagine the worst.

Reference: "Structured Exercises in Stress Management," Whole Person Press, Duluth, MN

If you are concerned about any difference in your treatment plan and the information in this handout, you are advised to contact your health care provider.

If you are a UIUC student and would like a hard copy of this handout, you may come to the Health Resource Center at McKinley Health Center, Room 222 during the hours of 8:00 am and 4:30 pm, Monday through Friday.

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Last modified: Thursday, October 03 1996

HOW VULNERABLE ARE YOU TO STRESS?

In modern society, most of us can't avoid stress. But we can learn to behave in ways that lessen its effects. Researchers have identified a number of factors that affect one's vulnerability to stress -- among them are eating and sleeping habits, caffeine and alcohol intake, and how we express our emotions. The following questionnaire is designed to help you discover your vulnerability quotient and to pinpoint trouble spots. Rate each item from 1 (always) to 5 (never), according to how much of the time the statement is true of you. Be sure to mark each item, even if it seems not to apply to you -- for example, if you don't smoke, check off 1 next to item 6.

		Always		Some-times		Never
1.	I eat at least one hot, balanced meal a day.	1	2	3	4	5
2.	I get seven to eight hours of sleep at least four nights a week.	1	2	3	4	5
3.	I give and receive affection regularly.	1	2	3	4	5
4.	I have at least one relative within 50 miles, on whom I can rely.	1	2	3	4	5
5.	I exercise to the point of perspiration at least twice a week.	1	2	3	4	5
6.	I limit myself to less than half a pack of cigarettes a day.	1	2	3	4	5
7.	I take fewer than five alcoholic drinks a week.	1	2	3	4	5
8.	I am the appropriate weight for my height.	1	2	3	4	5
9.	I have an income adequate to meet basic expenses.	1	2	3	4	5
10.	I get strength from my religious beliefs.	1	2	3	4	5
11.	I regularly attend club or social activities.	1	2	3	4	5
12.	I have a network of friends and acquaintances.	1	2	3	4	5
13.	I have one or more friends to confide in about personal matters.	1	2	3	4	5
14.	I am in good health (including eyesight, hearing, teeth).	1	2	3	4	5
15.	I am able to speak openly about my feelings when angry or worried.	1	2	3	4	5
16.	I have regular conversations with the	1	2	3	4	5

	people I live with about domestic problems -- for example, chores and money.					
17.	I do something for fun at least once a week.	1	2	3	4	5
18.	I am able to organize my time effectively.	1	2	3	4	5
19.	I drink fewer than three cups of coffee (or other caffeine-rich drinks) a day.	1	2	3	4	5
20.	I take some quiet time for myself during the day.	1	2	3	4	5

To get your score, add up the figures and subtract 20. A score below 10 indicates excellent resistance to stress. A score over 30 indicates some vulnerability to stress; you are seriously vulnerable if your score is over 50.

Signs of Stress

The first task is to recognize what stress (or fear or anxiety) is--to become aware if and when you have it. Ask yourself these questions: Are you often tense and unable to relax? Are you nervous--do you shake? Do you have trouble sleeping? Do you feel under a lot of pressure? Are you often restless and unable to sit for long? You feel like your troubles are piling up too much for you to handle? Answering "yes" to any one of these questions may mean you are over-stressed. Answering "yes" to 4 or 5 of these 6 questions doubles your risk of developing high blood pressure.

A brief list of signs would include:

1. Psychophysiological responses--muscles tight or aching, nervous tics like in the eyelid, hands unsteady, restlessness, touching yourself repeatedly, clearing your throat, frequent colds, pain, upset stomach, sweating, skin problem or itch, stiff posture, holding things tightly, strong startle response, headaches, high blood pressure, ulcers, heart disease, colitis, hemorrhoids, rashes, diarrhea, or frequent urination. These are somatoform disorders.
2. Behavioral-emotional signs--hyperactivity, walking or talking faster, in a hurry, irritation with delays, panicky, blushing, getting tongue-tangled, avoiding people, nervous habits (strumming fingers, eating, smoking, drinking), changing habits (becoming less or more organized), poor memory, confusion, stumbling over words, inattentiveness, excessive worrying, preoccupation with a certain situation, holding a grudge, irritability, crying, obsessive thoughts, compulsive actions, outbursts of emotions, bad dreams, apathy, etc. These are anxiety reactions.
3. Tiredness and lack of energy--general lack of interest, bored, watching TV and falling asleep, humorless, sleeping a lot, insomnia, can't get going, sighing, and moving slowly. (Or, sometimes, too much energy, as mentioned above.)
4. Anxiety intrudes on our consciousness or cognition in many ways: excessive preoccupation with the threatening person or situation, a desperate striving to understand why someone behaved the way they did, repeatedly obsessing about the upsetting event, unstoppable pangs of emotion (loss, anger, jealousy, guilt, longing, etc.), excessive vigilance and startle reactions, insomnia and bad dreams, aches and pains and other unwanted sensations. Plus all the words mentioned above in the introduction that reflect the subjective feelings we have, including nervous, up tight, scared, apprehensive, etc.

Naturally, no one has all these signs. Having only a few may mean nothing; yet, having only one to an extreme may be a sign of serious stress. You probably have a pretty good idea about how anxious you are; if not, discuss it with someone. There are over 100 personality tests of stress, anxiety, fears, self-doubt, risk-taking, etc., which could help you assess your emotional *dis-ease* (Aero & Weiner, 1981). Chapter 15 provides a journal approach to discovering your unique sources of stress. One of the best known tests of stress is the Type A Personality Test from Friedman and Rosenman (1974) which asks how often you experience racing against the clock, hating to be late, hating to wait, losing your temper when pressured, irritated by other's mistakes, speaking in a loud

critical voice, being competitive, rushing to do something quickly, feeling guilty if not working, etc. How often do you do these things? If a lot, you are likely to be a tense, competitive, ambitious, irritable Type A.

Because stress and anxiety are complex reactions (including feelings, actions, thoughts, and physiology), these emotional states can and have been measured many ways: self-ratings, observation by others, psychological tests, behavioral signs, and physiological or medical tests. The trouble is (1) each person has their own unique way of responding to stress, i.e. heart rate may increase but no stomach distress may occur in one person and the opposite pattern in another person equally stressed. (2) There is very little agreement among these measures, e.g. a person may rate him/herself as anxious but not appear anxious to others nor respond with stress on the physiological measures, like GSR (perspiration), blood pressure, or muscle tension. This is a major problem in studying stress scientifically. (3) The concepts of stress and anxiety are so broad and vague that general measures of anxiety do not predict very well how people behave or feel nor do such measures explain psychological problems or help a therapist develop a treatment plan. Being "anxious" roughly means "I'm having some problems" but more specifics must be known to diagnose and correct a particular disturbance. You may need to go deeper and find out exactly what is causing your stress. There are many possible causes which you need to know about before deciding what causes your anxiety.

Stressors--the External Situations that Lead to Stress

Changes cause stress

Almost any change in our lives is a stressor because there is a demand on us to deal with a new situation. This is Hans Selye's view, who has spent a life-time studying stress (1982). There are thousands of external causes of stress. Moreover, we can be *overstressed* when there are too many demands at school or work or interpersonally, and we can be *understressed* when there is "nothing to do" and we feel like we aren't getting anywhere. As mentioned before, there are bad stresses and good stresses. Here are some bad stresses (the percentages estimate the difficulty in managing that particular stress relative to death of a spouse, which is 100%): a spouse dies (100%), we get divorced (73%), have a serious illness (53%), we lose our job (47%), change occupations (36%), have more arguments with our spouse (35%), and so on. These are good stresses: when we fall in love and get married (50%), reconciliate after a separation (45%), retire (45%), have a baby (39%), buy a house (31%), get promoted (29%), have an unusual success (28%), graduate (26%), find new friends (18%), and take a vacation (13%). The more of these major life changes--good and bad--that have occurred in your life during the last year or two, the greater the chances of your becoming physically or emotionally ill (Holmes & Rahe, 1967). Other researchers have found that **having just one close, confiding relationship protects us** from many of these stresses.

Alvin Toffler (1970) wrote a best seller, *Future Shock*, putting forth the idea that technology was producing such rapid change that people felt unable to keep up with and handle the accelerating flow of information and choices. We are in a mobile society with few permanent relationships. Today almost everything is disposable, even our jobs and friends. We give them up and move on. Certainly, computers, robots, and cheap foreign labor may threaten our jobs. On the other hand, I would suggest that an equal amount of

stress or frustration is caused by changes being made too slowly rather than too fast, i.e. racial prejudice and greed don't go away fast enough, we'd like to make some changes at work but can't, or the slow driver in front of us drives us crazy--see frustration and conflict below.

Siegelman (1983) and others speculate that change is upsetting because we are leaving a part of our selves behind. Any change involves a loss of the known--a giving up of a reality that has given meaning to our lives. We are also afraid we won't get the things we want after the change is made. No wonder changes are resisted. Siegelman and others also believe that there is an opposite force to the resistance to change. Of course, many of us seek change; there is an urge to master new challenges, to explore the unknown, to test ourselves. And she says, "mastering the anxiety of venturing promotes new levels of growth." How do you see yourself? As wanting things to stay comfortable and the same or more as wanting things to change? This is probably an important personal characteristic to be aware of and to consider if you need to change this attitude.

Daily hassles cause stress

Lazarus and Folkman (1984) believe the little daily hassles rather than the major life events bother us the most, causing mental and physical problems. The research at the University of California at Berkeley investigated the hassles of college students, middle-aged whites, and health professionals. Each group had some similar hassles: losing things, concern about physical appearance, and too many things to do. But each group had different concerns too: middle-aged persons worried about chronic money matters, professionals fretted about continuing pressures at work, and students were stressed by wasting time, not doing as well as they would like, and loneliness. Note, these are not major life changes, but chronic conditions.

Stress may come from constant, steady tension in a relationship, continuing lack of friends, no interest or excitement day after day, or inability to find meaning in life, as well as from the big, awful eruptions in life discussed above. Also, the little unexpected occurrences and disruptions, like a flat tire, an uninvited visitor, a headache, a long form to be filled out, etc. cause stress too. Lazarus's little hassles were found to be more related to physical health than Holmes and Rahe's major life events. So, both big and little events create stress; you need to be aware of both. And, in fact, as Lazarus points out, health can better be viewed as a result of effective or ineffective coping rather than as simply a result of stress in the environment. You may not be able to avoid stress, but you can learn to cope.

SYMPTOMS EFFECTIVENESS CHART

Progressive Relaxation is a means of recognizing tension in particular muscles or muscle groups and learning to consciously relax those muscles. There are four major muscle groups: 1) hands, forearms and biceps, 2) head, face, throat and shoulders, 3) chest, stomach and lower back, and 4) thighs, buttocks, calves and feet.

Breathing Exercises help a person relax by concentrating on each breath as you inhale and exhale. Full, deep breathing brings additional oxygen to all parts of the body, consequently the body can function better. Poorly oxygenated blood contributes to anxiety, depression, fatigue and irritability.

Meditation produces relaxation by focusing on one thing at a time. The amount of internal and external stimuli you respond to is greatly reduced. Meditation is a self discipline which increases effectiveness in setting and achieving goals, and improves self esteem. It also improves concentration and attention.

Imagination uses positive thinking - you are what you think you are. If you think sad or anxiety producing thought, you feel sad or anxious. You can refocus your mind on positive, healing images. A saying - "Every day in every way I am getting better and better." Effectiveness of imagination depends on your attitude. The desire to get better is not enough, you must believe you will get better.

Self Hypnosis is similar to sleep, however, there is never a complete loss of awareness. There is a narrowing of consciousness, accompanied by inertia and passivity. Hypnosis involves giving suggestions and using certain stimuli, such as visual fixation (pendulum, candle, fireplace or picture); concentration, repetition or relaxation. There are no reported cases of harm resulting from self hypnosis.

Autogenics is a systematic program to teach your body and mind to respond quickly and effectively to verbal commands to relax. What you do is relax, in a comfortable position, and concentrate on verbal suggestions of warmth and heaviness in your limbs. The exercises help reverse the body's fight or flight reaction to physical or emotional stress. Persons with serious diseases such as diabetes, hypoglycemia or heart conditions should be under a doctor's care while doing autogenics. (Some people experience changes in blood pressure.)

Thought Stopping involves concentration on unwanted thoughts and after a short time, suddenly stopping and emptying your mind. The command "stop" or a loud noise is generally used to interrupt the unwanted thoughts. Negative or frightening thoughts usually precede negative and frightening emotions. If your thought can be controlled, your level of stress can be significantly reduced.

Refuting Irrational Ideas is based upon the concept that what we think or "say to ourselves" affects our emotions. Basic to irrational thinking is the assumption that things are done to us. In reality, nothing is done to us. Events happen in the world. We experience these events, engage in "self talk" and then experience an emotion as a result of our self talk. If our self talk is irrational and unrealistic, we create unpleasant emotions. Because self talk occurs almost automatically, it is easy to think that emotions come spontaneously from events. If we analyze the situation and look at it rationally we can recognize causality and results.

Coping Skills Training teaches how to relax to reduce anxiety and stress. We have learned to feel

nervous or anxious in certain situations. Coping skills training teaches, instead, to relax using progressive muscle relaxation so that whenever we experience stress, we can let go of the tension. Write down a list of your stressful situations --from least anxious to most anxious. Think about the situation, then relax away the stress you feel. Secondly, develop personal verbal remarks to counteract the stress ("stay calm...you've dealt with this before").

Assertiveness Training teaches you to stand up for your legitimate rights, without pushing others around or letting them push you around.

Time Management can be stated as three steps: 1) establish priorities that pinpoint your most important goals, and that allow you to base your decisions on what is important and what is not, 2) create time by realistic scheduling and elimination of low priority tasks, and 3) learn to make basic decisions.

Biofeedback is the use of instruments to become aware of processes in your body that you usually do not notice, and to help bring them under voluntary control. Biofeedback helps you find out which components of your nervous system are and are not relaxed. Biofeedback is often used in addition to other stress reduction methods.

Nutrition is important because when you are under stress your need for all nutrients increases, especially calcium, vitamin C and the B vitamins. Without the right balance of nutrients you may suffer from chronic, subclinical malnutrition and not know it.

Exercise is one of the most effective means of stress reduction. Vigorous physical exercise is a natural outlet for your body when it is in the fight or flight state. After exercising, your body returns to its normal equilibrium and you feel relaxed and refreshed.

Breathe...Breathe...Breathe

Stress Management Techniques

1) Deep breathing exercises: Don't ever underestimate this one!

2) Spot checking and scanning: Putting little colorful dots in places to remind you to breathe and relax your muscles.

3) Thought-stopping: This is when you actually talk to yourself, saying "Stop" when you are thinking negative, unhelpful thoughts.

4) Progressive muscle relaxation: Being able to constrict and relax your muscles, including scalp, face, jaw, shoulders and all larger muscles.

5) Constructive self-talk: Being able to truly talk to yourself as a mentor, a friend or parent, reminding yourself of the person you are inside.

6) Biofeedback: Usually requires medical equipment that shows you a reading of your heart rate and breathing patterns so that you can "think" it slower, more relaxed.

7) Exercise: Of course. This actually helps metabolize the stress chemicals running around our bodies; that's why it works! It doesn't have to be running a marathon; walking, yoga, gardening and golfing are just a few ways to keep moving.

Most of these can be self-taught with a book, tape or counselor; classes are taught by Providence, Legacy and Kaiser Hospital Systems at no or little cost.

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* Suggested Reading in **bold**

Traumatic Incidents in Police Work: When Your Children are Affected Too

by

Jim Fairchild, MS, CEAP

The impact of traumatic events in police work has gotten widespread attention in recent years. The effects of these events on the officers involved, co-workers, spouses, and partners have been well documented. New and innovative intervention programs have been developed to help mitigate the affects of traumatic stress. Often forgotten, however, are the children of officers who may be emotionally impacted by what happens to their parents and to police officers in general.

Many parents' natural instinct is to attempt to shield children from an awareness of evil in the world; to try to preserve their innocence for as long as possible. This approach tends to be ineffective at best and destructive at worse. Children pick up information from adult discussions, radio and television broadcasts, and from playmates. When parents do not help their children understand the information they inevitably acquire, children's fears may be magnified.

Children can suffer traumatic stress reactions just as adults and can develop posttraumatic stress disorder. Since they have fewer coping skills and far less life experience than adults, children have more difficulty putting trauma in perspective. They depend on their parents for protection and safety. When the traumatic incident happens to a parent, children my experience profound feelings of powerlessness and vulnerability.

Symptoms of Trauma in Children

The symptoms exhibited by children in response to trauma vary with the developmental stage of the child.

Very young children, birth through age one year, may have no reaction to shootings or other traumatic events in which they are not directly involved. They lack the ability to engage in abstract thinking such as, "A bad man shot a police officer. My mommy is a police officer. My mommy might get shot." Therefore, vicarious traumatization is not much of an issue. More critical for these children is the symptomatic reaction of their parents to traumatic events. If a parent becomes highly anxious, withdraws emotionally, begins spending less time at home, abuses alcohol or other drugs, or exhibits unpredictable mood swings, these behaviors become the source of emotional maladjustment for the child.

Symptoms of traumatic stress in children of this age tend to be limited to increased fussing, crying, and general agitation as well as delays in learning new and expected developmental skills such as recognizing and using simple words or crawling and walking. One should use caution in rushing to the conclusion that minor developmental delays indicate symptomatic behavior as many normal children experience such delays.

Preschoolers, ages two through five years, are able to grasp some concepts associated with traumatic events which occur to others but their ability to fully understand the nature of these events remains limited. They tend to fill in the gaps in their understanding with magical and imaginary thinking, ("A bad man shot at my daddy. He might come to our house and try to shoot me too."). Children of this age continue to have a very self-centered view of the world and often see unrelated events as having a cause-and-effect relationship ("I was bad and mommy was mad at me. Mommy got hurt at work. If I hadn't been bad, mommy wouldn't have gotten hurt.").

When children in this age group are experiencing symptoms of traumatic stress, they are often unable or unwilling to tell their parents. They may not have the ability to put their feelings into words or they may be afraid to tell their parents because they feel responsible for the traumatic event. Behavioral signs of traumatic stress in preschoolers includes:

1. Anxious, clingy behavior. Following parents around. Emotional scenes at times of separation such as when a parent leaves for work or when the child is left at day care.

2. Regressive behaviors such as bed wetting, crawling instead of walking, using baby-talk, thumb sucking, or refusing to go to bed at night.

3. Nightmares.

4. Aggressive behavior directed toward playmates, siblings, parents or their toys.

5. Magical thinking associated with the traumatic event ("My mommy got hurt because I was bad.)"

6. Repetitive talk and/or play, often recreating the traumatic event as they imagine it to have been.

Elementary school age children, ages six through twelve years, are much more aware of the world and have a far greater ability to grasp the nature of traumatic events which happen to their parents. They are typically less self-centered and do not feel the sense of personal responsibility for everything that happens to their parents as preschoolers do. They tend to have the ability to make more realistic assessments of the dangers in the world and recognize that these real threats can be very frightening.

Being more aware and having greater social contacts apart from the family than younger children, elementary age children gather more information about adults, adult problems, and events in the world than many parents imagine. Attempts to shield these children from information about the world is largely ineffective. What they don't discuss with their parents, they will hear from their peers. It is better that children hear about events from their parents so their parents can put these events in context. It is not advisable for a child's initial exposure to information to come from classmates in the oversimplified form of childhood communication ("Your dad shot a man. Your dad is a murder.").

Symptoms of traumatic stress in elementary school age children include:

1. A significant decline is school performance characterized by distractibility and difficulty concentrating. Often misdiagnosed as attention deficit disorder.

2. Sleep disturbances including difficulty falling asleep, waking in the middle of the night, and/or nightmares.

3. Regressive behaviors including clinging, crying, and other behaviors they have outgrown.

4. Temper tantrums, aggressive play, oppositional behavior resisting adult authority.

5. Complaints of physical illness.

6. Nervousness, difficulty keeping still, exaggerated startle reflex.

7. Withdrawal, isolation.

8. Reckless play. Risk-taking.

Teenagers, ages thirteen through eighteen, often exhibit mood swings and acting out behaviors in the absence of traumatic events. When faced with such an event in the family, teenagers tend to have the maturity and life experience to fully appreciate the event and place it in its proper context, however, their emotional reactions can range widely and erratically from those of mature adults to those of much younger children. It is important that parents of teenagers recognize that they while they may appear mature physically, emotionally, they continue to need reassurance and guidance from parents and other adults.

Symptoms of traumatic stress in teenagers include:

1. Withdrawal from adults. Secrecy. Feeling that only peers can understand.

2. Behaviors which suggest that they have given up on a future which is uncertain. These include alcohol/drug abuse, sexual acting out, truancy, abandonment of important goals such a college or occupational preparation.

3. Outbursts of temper. Fighting. Property destruction. Revenge fantasies.

4. Mood swings without significant provocation.

5. Regressive behaviors including clinging, following parents around to ensure the parents are safe, and the need for greater emotional reassurance.

6. Insisting, as opposed to suggesting, that parents find a safer line of work.

7. Preoccupation with music, books, and art with death themes.

8. Depression. Suicidal ideation/attempts.

Parents of teenagers reviewing these symptoms might recognize that many of them are characteristic of "normal" teenage behavior. The difference between normal and symptomatic at this age is a matter of duration and degree. Should you detect any significant change in your teen's behavior or emotion immediately following a traumatic event, it is likely there is a connection.

What Can Parents Do

Parents who wish to assist their children in the aftermath of a traumatic event are first advised to be aware of their own symptomatic behavior and to bring it under control. Good intentions are not enough. An excellent parent in the midst of a traumatic stress reaction is not going to be very effective in helping a frightened child.

Other helpful actions include:

1. Remember that children of all ages have difficulty expressing their fears in words. They tend to act out in regressive ways. These regressive behaviors are an attempt to secure a more intensive level of nurturing and attention from parents. Lecturing or punishing at these times is exactly the wrong response. Showing love, acceptance, encouragement, and assistance with problem solving will help extinguish regressive acting out.

2. Take your children's fears seriously. Never laugh at them or tell them they "shouldn't feel that way." Acknowledge that life is sometimes scary. Offer reassurance. Teach them what you have learned about calming fear when you are afraid.

3. Don't try to protect your child from an awareness of evil in the world. Help your child understand evil in age appropriate ways and help your child learn survival skills. Children who are over-protected are often the most susceptible to fear and victimization. Children who develop survival skills gain a sense of confidence.

4. Talk to your children about death. From an early age, they are exposed to death through the media and in life around them. A pet may die, a grandparent, or a classmate. Death is a frightening subject for a child but ignorance is more frightening. Do not use words like "Went to sleep" or "Left us." Children who hear this type of explanation may become fearful of going to bed or may feel that grandpa left because he didn't love the child. Be honest in your explanations. Encourage your children to talk about their feelings and answer their questions. Remember that death is a complex concept. Children will not be able to grasp the concept all at once. Let them guide the level of your explanation with their questions.

5. Be realistic in your reassurance. If your child asks you if you will die, answer truthfully but add that you "don't plan to die for a long, long time." If you child asks if you will be killed at work, use the same answer emphasizing that you are careful, well trained, and work with other officers who will help you stay safe. Do not tell your child that you will not die or will not be killed at work. Should you death occur after such a reassurance, you child may experience it as not only a loss but a betrayal.

6. If you are aware that your name will be used in the media or if there is a high profile situation involving another office such a line-of-duty death, break the news to your child in person if possible. Help your child place the event in perspective. Encourage and answer questions.

7. When an incident occurs, help your child maintain a sense of security by keeping routines such as bedtime and mealtime rituals as normal as possible.

8. Seek professional assistance if your child's behavior changes radically following a traumatic incident or if the behavior change persists over time. Remember, some degree of symptomatic behavior following a traumatic incident is normal in children as well as adults. If you are concerned that your children's reaction is not within normal limits, contact CAPE. CAPE's staff includes therapists whose area clinical specialization is the treatment of children and adolescents. This service is free and confidential.

Children and adults can develop strength, compassion, confidence, and reverence as the result of the trails they face in life. As parents, we can help our children learn and grow through adversity.

Definitions

- Stress: A "load" on the system, usually understood as external (load on an outlet before circuit "blows") but with people, it's internal.

- Stressor: A specific problem, issue, challenge, change or personal conflict that is being loaded into your system.

- Stress Reduction: Eliminating the source of stress by making changes, taking action. You have the control to eliminate the stressor.

- Stress Management: Coping and managing the stressor, adapting to it. You do not have the control to eliminate it.

Stress Reactions Are:

- Set of physical changes....(chemical/hormonal change; a reminder that our head is connected to the body) including:

  Increased arterial blood pressure
  Increased blood supply to the brain
  Increased triglycerides
  Decreased blood to kidneys, skin, gastrointestinal system
  Activation of adrenaline
  Increased glucose production
  Suppression of immune system mechanisms

- Which occur in reaction to the perception of a threat....(physical, mental or emotional; fear or concern about "incoming" information)

- And which prepares the body for fighting or running away

- Stress is a survival mechanism; can save lives....(see, think and react quickly; absolute necessity)

- Unchecked, it can do harm physically and emotionally....

Symptoms of Stress

Physical (Body)

Appetite/Weight Gain or Loss
Headaches
Tension
Fatigue
Insomnia
Colds, Flu Illnesses
Muscle Aches
Stomach Aches
Pounding Heart
Grinding Teeth
Rashes
Diarrhea
Excessive Sweating
Tremors, Shakes
Shortness of Breath
Blurred Vision

Emotional (Feelings)

Anxiety
Frustration
Depression
Mood Swings
Temper Outbursts
Nightmares
Crying Spells
Irritability
Excessive Worry
Discouragement
Frequent Accidents
Restlessness
Hopeless/Helpless
Suicidal Thoughts
Abuse of Alcohol,
Drugs, Sex, Food

Mental (Thinking)

Forgetfulness
Concentration Problems
Confusion
Racing Thoughts
Boredom
Difficulty making decisions
Spacing Out
Dulled Senses
Reduced Productivity
Recurrent thoughts

Interpersonal (Relating)

Isolation
Not keeping Friends
Hostility
Sub-Assertive Behavior
Distrust
Sexual Problems
Nagging
Manipulation of Others
Work Performance
Aggression

Spiritual (Beliefs/Faith)

Emptiness
Cynicism
Apathy
Martyrdom
Loss of Direction
Internal Conflict
Life has little Meaning
Self-Doubt
Feelings of worthlessness
Looking for Magic
Unforgiving, Judgmental

Four Obstacles to Effective Stress Management

1) Failing to listen to your body: lack of awareness of your body's reaction; you have no clue.

   - Headaches
   - Stomach aches
   - Sleeping problems
   - Racing thoughts
   - Anxiety

2) Denial: You refuse to notice the symptoms; don't want to "deal with it."

   - Increased conflicts with others
   - Increased blame on others
   - You're mad at everyone or everyone is mad at you
   - People avoid you; gives you relief as well as sadness

3) Don't believe that your reactions to stress can be changed or controlled.

   - Being stressed becomes a part of how you live and who you are.
   - Rely on "old ways" of handling stress: avoidance or aggression.
   - See stressors as ONE BIG STRESS, not as separate and discreet stressors; too big to tackle.

4) Don't know "How-To" sort out stressors.

   - Key to sorting out stressors:
     - Can you eliminate the stressor? Change it.
     - Can't eliminate the stressor? Adapt to it.

Unchecked Stress: Anger or Depression?

- Common stress reactions of police officers (look angry or withdrawn):

  Intolerance, impatience of self and others (home and work)

  Avoidance of police duties (avoids calls; parks car out of sight)

  Avoidance of family (overtime, sleeping)

  Cynicism toward public, Department, family, life in general

  Increase of addictive behaviors: alcohol, sex, gambling, pornography

  Affairs/Secrets

  Fatigue/lack of good sleep

  Absenteeism increases

  Procrastination of family, household needs (bills, repairs, etc.)

  Headaches, stomach aches

  Poor judgment; increased problems at work and home (IA contact)

- Anger as a Stress Reaction:

  Anger: A defensive **reaction** (0 -100 in seconds) to push away the source of pain causing hurt, unempowerment, being discounted, devalued, alienated, misunderstood, betrayed.

  - Think about it!

    Momentary blow-up? Able to find rebalance quickly and take responsibility for the outburst? If hurt and devalued, was the reason for the blow-up a reality or your perception? What was the intention? Malicious or not? Is it YOUR issue?

  - Change how you respond!

    Respond vs. React: Make the head think while the heart is pounding. Be curious about why YOU are reacting. Deep breaths. Time out. Come back. Practice.

- Depression as a Stress Reaction:

  Depression: Is a biological, situational and/or existential state, where personal resources are depleted, control is slipping and hope vague.

  - Think about it!

    Unresolved stressors can contribute to depression, decreasing personal resources while failed attempts to regain control cause anger and avoidance = alienation.

  - Change how you respond!

    Think about your own issues from the past and how they affect your relationships today; what works and what doesn't?

    Change might require counseling (mental health, pastoral, other) and/or medications, if appropriate.

Why Do People Respond or Adapt Differently To the Same Stressors?

- Family/Genetic Influences - What we "inherit"
    1. Family history of physical and psychological conditions
    2. Personality and Temperament
    3. Cultural background
    4. Gender

- Past Experiences - Wisdom
    1. Learned coping patterns
    2. Previous exposure to similar stress
    3. Lifestyle patterns

- Existing Conditions - Vulnerabilities and strengths that influence how you respond or adapt to the stress(ors):
    1. Health
    2. Motivation
    3. Support at work
    3. Support at home
    4. Relationship status with spouse (positive or not?)
    5. Other support outside work and family: friends
    6. Financial situation
    7. Other's health (children, aging parents)
    8. Children's situation (at school, peers, involved or struggling, etc.)
    9. Other?

- Existing Beliefs and Skills
    1. Spiritual or religious influence
    2. Open Communication Style
    3. Moral Values
    4. Accepts help (from counselor/pastor/other)
    5. Self-concept

Obstacles to Effective Stress Management
Beliefs Specific to Police Officers

What works at work doesn't necessarily work at home.

- Perfectionism: Need to be seen as flawless officer.
    1. Feel constant pressure to achieve (by self or others)
    2. Feel critical of yourself when not seen as perfect
    3. Feel you haven't done enough no matter how hard you try
    4. Cost: Extremely sensitive to feed-back; family will walk on eggshells around you, concerned about getting or receiving negative comments.

- Control: Need to be seen as reliable and strong officer.
    1. Need to be in control at all times on the job
    2. Worry how you appear to others when you are anxious or nervous
    3. Any sign of lack of control is a sign of weakness or failure
    4. Cost: Skeptical or impatient when delegating projects to others at home; your absolute involvement overrides other's ideas; some family will have to hide what they're doing from you.

- Detachment: Need to be seen as impartial and focused.
    1. Emotions are viewed as weak or vulnerable.
    2. Containing thoughts and feelings is exhausting.
    3. What begins as difficult, becomes usual
    4. Difficult moving between being detached and emotional when going from work to home and work again.
    5. Cost: Your ability to withhold emotions on the job can become a disability in emotional relationships at home; family will find ways around you.

Challenges for Law Enforcement families:

- Good or bad, recognize the organization's "real" needs (minimum - maximum)
- Respect your family members' needs differently than you do the organization's needs. Prioritize them.
- Understand your spouse's position; what do they need from you. Why aren't you wanting or able to give those things?
- Figure out and discuss what you're getting and not getting. Why, why not?
- Discuss the children; how are they doing? What is your part? Need to be more active? What is preventing that?
- Plan new ways of bringing up and resolving problems (family meetings).
- Commit to time together and as a family; build it into the schedule. Stick to it.
- Talk about what troubles you; take a risk and speak up.

- Understand what you can change vs. what you must manage in your family's relationship:
    - How do you approach a problem? (Scolding/pleading)
    - How do you avoid a problem? ("I forgot?")
    - What are your excuses? ("Too tired," "Not my job")
    - What is truly a reasonable expectation? ("Ok, its mine")
    - What is getting in your way? (Fatigue? Depression?)
    - Can you make a commitment? (Want to keep the relationship; want to like the relationship?)

The latest research finds:

- Men: listen to your wife's advice and guidance; it's usually valuable and good.
- Women: Stop criticizing and complaining as your method of communication; use your skills to encourage, not criticize.

GOAL: Manage Your Stress More Effectively!

- Become aware of your stressors and your emotional and physical reactions to them:

    1. Notice your distress. Don't ignore it. Don't gloss over your problems.
    2. Determine what events distress you. What are you telling yourself about many of these events?
    3. Determine how your body responds to the stress. Do you become nervous and physically upset? If so, in what specific ways?

- Recognize what you can change.

    1. Can you change your stressors by avoiding or eliminating them completely?
    2. Can you reduce their intensity (manage them over a period of time instead of a daily or weekly basis)?
    3. Can you shorten your exposure to stress (take a break, leave the physical premises)?
    4. Can you devote the time and energy necessary to making a change (goal setting over time)

- Reduce the intensity of your emotional reactions to stress.

    1. The stress reaction is triggered by your perception of danger...physical danger and/or emotional danger. Are you viewing your stressors in exaggerated extremes or taking a difficult situation and making it a "doable" challenge?
    2. Are you expecting to please everyone?
    3. Are you overreacting and viewing things as absolutely critical and urgent?
    4. Must you prevail in every situation?
    5. Work at adopting more moderate views; try to see the stress as something to cope with rather than something that overpowers you.
    6. Try to temper excess emotions. Put the situation in perspective.

- Learn to moderate your physical reactions to stress.

    1. Slow, deep breathing will bring your heart rate and respiration back to normal.
    2. Relaxation techniques can reduce muscle tension. Visualization and biofeedback can help bring back voluntary control over such things as muscle tension, heart rate and blood pressure.
    3. Medications, when prescribed by a physician, can help in the short term in moderating your physical reactions. However, they alone are not the answer. Learning to moderate these reactions on your own is a preferable long-term solution.

- Build your physical reserves.

    1. Exercise for cardiovascular fitness three to four times a week
    2. Eat well-balanced, nutritious and regular meals.
    3. Maintain or work toward your ideal weight.
    4. Avoid nicotine, excessive caffeine and other stimulants.
    5. At work, take breaks when able; decrease tendency for overtime. Plan vacations, and commit to them.
    6. Get enough sleep. Be as consistent with your sleep as possible.

- Maintain your emotional reserves.

    1. Develop some mutually supportive friendships/relationships outside of work.
    2. Pursue realistic goals that are meaningful to you; also find some that you share with your spouse and/or family.
    3. Expect some frustrations, failures and sorrows.
    4. Always be kind and gentle with yourself; critical and harsh self-talk are not helpful, only harmful.

- Be willing to seek assistance if your reserves become depleted.

    1. Do this for yourself; gain a new perspective and outlook. Confirm those obstacles with which you don't have control; learn how to manage them better.
    2. Do this for your family; increase your chances for a long-term and happy relationship that may not be problem-free, but is collaborative in its efforts to "team-up" against the stressors. A stress faced by one, is faced by all in a family.

Appendix D

Policies and Procedures

Contents

1. City of Vancouver Chapter 5 Personnel Rules, Policies and Procedures

2. Tulsa Oklahoma Police Department's Policy and Procedure Manual for Critical Incident Response Team policy

CHAPTER 5 - PERSONNEL RULES, POLICIES AND PROCEDURES

EMPLOYEE ASSISTANCE

R-A FREQ-3 years WASPC-13.4,13.6 CALEA-

PURPOSE

R-A FREQ-3 years WASPC- CALEA-

The purpose of this policy is to outline a Departmental response to employees whose job performance alters or deteriorates noticeably. It is the Department's intent to provide assistance to employees exhibiting below standard, unusual, or less than professional job performance attributable to trauma or personal stresses rather than negligence, lack of knowledge or illegal behavior.

POLICY

R-A FREQ-3 years WASPC- CALEA-

The Employee Assistance Program shall assist in the personal needs of employees. All information relating to the Employee Assistance Program shall be treated as confidential. Responsibility for the operation of the Employee Assistance Program rests with and is administratively controlled by the City's Human Resources Department.

REFERRAL OF EMPLOYEES

R-A FREQ-3 years WASPC- CALEA-

Any employee or spouse may call the counseling service(s) listed in the Employee Assistance Program for a confidential appointment. Supervisors may refer an employee to the Employee Assistance Program when a supervisor judges that an employee may need counseling assistance.

Job behaviors which may lead a supervisor or manager to conclude that an individual requires assistance include:

A. A series of sustained citizens' complaints;

B. Repeated complaints of the same nature;

C. Abrupt change in expected police response and/or behavior which may be indicative of severe emotional disturbance (e.g., excessive and continuous tardiness, absenteeism, sleeping during duty hours, excessive impatience, violent reaction to others, overreacting, non-eating, poor personal appearance, odor of alcohol, or physical symptoms of drug use, etc.);

D. A member involved in a shooting accident or other major incident which results in death or serious injury.

COUNSELING SERVICES

R-A FREQ-3 years WASPC-13.6 CALEA-

Employees are encouraged to utilize the services provided whenever they feel a need for counseling services. This service is provided by the Employee Assistance Program or the member's health care provider and shall be confidential. Employees desiring this service should refer to the City Human Resources Department for specific procedures.

Supervisors have a specific responsibility for monitoring the fitness of employees. Supervisors shall utilize the counseling process to identify problems and are encouraged to make referrals.

Nothing in this policy diminishes the rights and responsibilities of the Department to refer a member for a fitness for duty evaluation under appropriate circumstances.

TRAUMATIC INCIDENTS

R-A FREQ-3 years WASPC-13.6 CALEA-

PURPOSE

R-A FREQ-3 years WASPC-13.3,13.6 CALEA-

The purpose of this policy and procedure is to provide for assistance to members involved in a traumatic incident.

POLICY

R-A FREQ-3 years WASPC-13.3,13.6 CALEA-

It is the policy of the Department to provide assistance in the form of counseling services, legal representation and other support services, to the extent authorized by the City, to members involved in a traumatic incident. A traumatic incident is defined, but not limited to, a shooting incident, traffic fatality, serious physical assault/injury, or other major trauma which may impact a member.

ADMINISTRATIVE LEAVE

R-A FREQ-3 years WASPC-13.3,13.6 CALEA-

Any member directly involved in a traumatic incident resulting in serious injury and/or death shall be placed on "administrative leave" following completion of a report or preliminary recitation of basic facts concerning the incident, and pending investigation of the incident. This leave shall be without loss of pay or benefits. The assignment to administrative leave shall not be interpreted to imply or indicate that the member has acted improperly.

A. While on administrative leave, the member is subject to call for a departmental interview and to provide statements of clarification regarding the incident. Members shall be subject to recall to duty at any time.

B. Members of the police department may be made available to assist members involved in traumatic incidents.

C. Upon returning to duty, the member(s) may be assigned to office or special duty for a period of time as deemed appropriate by the Chief of Police.

D. Additional psychological evaluation, assistance, and counseling will be made available, if necessary.

E. During the investigation of the incident, the administrative leave period, and thereafter until the member returns to duty, the Department will be sensitive to the personal needs of the member and the member's family, and furnish all reasonable and appropriate support and assistance.

PROFESSIONAL SUPPORT

R-A FREQ-3 years WASPC- CALEA-

A. Mental Health. In all cases where serious injury or death results from a traumatic incident, the involved member shall be required to undergo a debriefing with a psychologist/psychiatrist as soon as possible, but usually not later than 48 hours after the incident. The purpose is to allow the member to express his/her feelings and to deal with the moral, ethical, and/or psychological effects of the incident. The debriefing will be at Department expense.

1. The debriefing shall not be related to any Department investigation of the incident and nothing discussed in the debriefing will be reported to the Department. The content of the

debriefing session will remain confidential and subject to the physician/patient privilege or psychologist/patient privilege.

2. When appropriate, the physician, psychologist and/or psychiatrist who has assisted the member may be requested to state a conclusion that the member is able to return to work, and state recommendations relating to the need for follow-up counseling or evaluation. Not later than one year after a traumatic incident there will be a further reevaluation by a psychologist at Department expense. A second opinion may be obtained by the Department or the member.

B. Legal Counsel. In the event a claim is made against the City or involved member, Washington law (RCW 4.96.041) requires that the City assume responsibility for the legal defense of the involved member as long as the act or omission was made in good faith and was within the scope of his or her official duties. Refer to VMC 2.46 -- Defense of Officials, Employees and Volunteers for the procedure and obligations of the member.

WRITTEN REPORTS REQUIRED

R-A FREQ-3 years WASPC- CALEA-

When possible, officers involved will complete a preliminary report detailing their actions surrounding a traumatic incident prior to leaving work following the incident. The preliminary report or statement is not intended to be a complete discussion of all elements of the incident. It shall be sufficient to inform the Department what occurred and to facilitate a thorough and efficient investigation. An interview with the involved member(s) will be scheduled so that investigative personnel can complete any necessary reports.

According to the labor agreement between the city of Vancouver and the Vancouver Police Officers Guild, members of that bargaining unit will comply with the following contract language regarding **deadly force** incidents:

> *It is recognized that the use of deadly force is a traumatic experience. During investigations regarding deadly force, officers shall provide sufficient information so as not to hinder the investigation or obstruct the securing of the scene or apprehension of suspects. However, any written statement or detailed oral statement shall be obtained after the officer is advised of his/her rights and allowed to consult with a Guild representative or attorney. Such consultation shall not unduly delay the giving of the statement.*

DESIGNATION OF SUPPORT RESOURCES

R-A FREQ-3 years WASPC- CALEA-

During the investigation following a traumatic incident, the involved member's supervisor and the investigator assigned to interview the member shall insure that Departmental policy regarding employee assistance during traumatic incidents is adhered to. The Chief of Police may designate members of the Department to insure that personal needs of an involved member are met during periods of administrative leave. Such designation shall be on a case-by-case basis.

CRITICAL INCIDENTS POLICY

Summary:
This policy is an excerpt from the Tulsa, Oklahoma Police Department's Policy and Procedure Manual. This document contains the department's Critical Incident Response Team policy.

Document Text:
Tulsa Police Department

Procedure
Subject: Critical Incident Response Team
Pages: 2
Procedure File No.: 31-310A
Supercedes:
Previous Date: 12/12/97
Approved By: Chief of Police
Date Approved: 3/18/99

This policy statement and the procedures thereunder are intended for Police Department use only. The policies, procedures and regulations are for internal Police Department administrative purposes and are not intended to create any higher legal standard of care or liability in an evidentiary sense than is created by law. Violations of internal Police Department policies, procedures, regulations or rules form the basis for disciplinary action by the Police Department. Violations of law form the basis for civil and/or criminal sanctions to be determined in a proper judicial setting, not through the administrative procedures of the Police Department.

PURPOSE OF CHANGE: To expand and clarify the definition of a Critical Incident.

POLICY:

The Critical Incident Response Team (CIRT) has been established to assist officers in coping with the physical and emotional reactions that can occur as the result of involvement in a critical incident.

Officers involved in critical incidents are encouraged to participate on a voluntary basis in follow-up contacts with CIRT members and/or Psychological Services.

If there is any doubt whether it is appropriate to notify the CIRT team in a particular incident, a supervisor should resolve the doubt in order favor of initiating the contact.

SUMMARY: Procedures to be followed when responding to critical incidents.

APPLIES TO: All Police Personnel.

DEFINITIONS:

Critical Incident - An event involving the immediate risk of death or injury to an officer or any other person which requires a greater than normal degree of emotional adjustment on the part of the officer. These events may include, but are not limited to shootings, violent crime scenes, serious injury or fatality traffic collisions, the sudden death of a child, or other similar incident.

Critical Incident Response Team (CIRT) - A group of Tulsa police officers who are specially trained to assist officers who have been involved in critical incidents.

PROCEDURES:

Supervisor

1. A supervisor will contact a CIRT member, either directly or through the dispatcher, whenever a Critical Incident has occurred. The supervisor, involved officer, or dispatcher will provide the CIRT member with information about the incident (e.g. location, nature of the incident).

(NOTE: Officers are encouraged to contact CIRT members at their own discretion).

Involved Officer

2. The involved officer may have any person contacted whom the officer desires to assist him/her following involvement in a critical incident (i.e. a CIRT member, a minister or chaplain, a close friend or family member).

CIRT Member

3. Be available to provide support to the involved officer if he/she desires assistance.

4. If the involved officer requests assistance, remain with the officer as long as necessary to provide short-term support. Inform the officer of additional resources that are available to the officer and to his/her family.

5. Discuss with the involved officer the various potential reactions that they may experience as the result of a critical incident.

6. Provide additional CIRT services as requested by the involved officer.

7. Advise the involved officer that Psychological Services will be notified of the critical incident and that the involved officer may be contacted by Psychological Services.

8. Notify Psychological Services and provide them with information concerning the incident.

PSC

9. Maintain a current list of Critical Incident Response Team members that includes each officer's home telephone number and current duty assignment.

REGULATION:

1. A CIRT member shall be contacted anytime an officer requests their assistance.

Contact Information:

Tom Rink
Officer
Training and Development Division
Tulsa Police Department
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Tulsa, OK 74117-1811
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Critical Incident Policy

Summary:
The Critical Incident Response Team (CIRT) has been established to assist officers in coping with the physical and emotional reactions that can occur as the result of involvement in a critical incident.

Document Text:
TULSA POLICE DEPARTMENT

Critical Incident Response Team

POLICY: The Critical Incident Response Team (CIRT) has been established to assist officers in coping with the physical and emotional reactions that can occur as the result of involvement in a critical incident.

Officers involved in critical incidents are encouraged to participate on a voluntary basis in follow-up contacts with CIRT members and/or Psychological Services.

SUMMARY: Procedures to be followed when responding to critical incidents.

APPLIES TO: All Police Personnel.

DEFINITIONS:

CRITICAL INCIDENT -- an incident in which an officer, in the course of his/her duties, is exposed to a situation involving the death or serious injury of any person, or a situation which could have involved the death or serious injury of any person. These situations may include, but are not limited to police involved shootings, heinous crime scenes, drowning or violent death of an infant or child, injury to a police officer, and traffic collisions.

CRITICAL INCIDENT RESPONSE TEAM (CIRT) -- a group of Tulsa Police Officers who are specially trained to assist officers who have been involved in critical incidents.

PROCEDURES:

Supervisor

1. A supervisor will consider the need for contacting a member of CIRT when it has been determined that a critical incident has occurred. Provide the CIRT member with information about the incident.

Involved Officer

2. The involved officer may have any person contacted who the officer desires to assist him/her following involvement in a critical incident (i.e. a CIRT member, a minister or chaplain, a close friend or family member).

CIRT Member

3. Be available to provide support to the involved officer if he/she desires CIRT assistance.

4. If the involved officer requests assistance, remain with the officer as long as necessary to provide short-term support. Inform the officer of additional resources that are available to the officer and to his/her family.

5. Discuss with the involved officer the various potential reactions that they may experience as the result of a critical incident.

CIRT Member

6. If the involved officer desires further CIRT services, arrange for other CIRT members to provide follow-up contacts.

7. Advise the involved officer that Psychological Services will be notified of the critical incident and that the involved officer may be contacted by Psychological Services.

8. Notify Psychological Services and provide them with information concerning the incident.

PSC

9. Maintain a current list of Critical Incident Response Team members that includes each officer's home telephone number and current duty assignment.

Contact Information:

Officer Tom Rink
Information Specialist
Training & Develop Division
Tulsa Police Department
Resource Center
6066 E. 66th St. N.
Tulsa, OK 74117
Phone: (918) 591-4528
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15.8.4 DEADLY FORCE INCIDENT - SUPERVISOR

The shift supervisor of a member involved in a deadly force incident will notify the administration as soon as practical. The Prosecuting Attorney will be notified, by the Administration, of any deputy involved in a deadly force incident in which death or injury results.

The member will remain at the scene, unless injured, until the arrival of investigators. After contact with investigators the member will be removed from the scene as soon as possible. However, if the circumstances are such that the continued presence of the member at the scene might cause a more hazardous situation to develop (i.e., violent crowd), the ranking deputy at the scene may instruct the member to respond to another, more appropriate, location. The member will not discuss the case with anyone outside the Sheriff's Office without specific approval from the Administration, with the exception of his/her clergyman, Guild representative, or legal counsel.

If the member's firearm is required as part of the investigation, it will be replaced or returned at the direction of the Sheriff or his designee. Individual circumstances will dictate when such replacement or return will take place as per section 15.18.18.

See 15.18.18 Weapons Replacement

15.10.0 COUNSELING - FAMILY

In all cases where any person has been injured or killed as a result of a deadly force incident involving a member, he/she and his/her family will have available to them the services of the Sheriff's Office chaplain, the Cowlitz County Employee Assistance Program, or other authorized services. The services provided shall not be subject to any investigation. The consultation sessions will remain protected as privileged communication.

15.12.0 LEAVE - ADMINISTRATIVE

Any member that has used force resulting in death will be removed from line duty assignment pending administrative review. This leave will be without loss of pay or benefits. The length of the leave shall be determined by the Administration. The assignment of administrative leave does not imply that the member has acted improperly.

When on administrative leave, the member shall inform the agency of

CCSO

15.18.6 DEFINITIONS

Line of Duty: Any official police action, whether on or off duty.

Officer-Involved Shooting Incident: A line-of-duty incident wherein a firearm is discharged by or at a police officer, excluding the intentional disposal of an injured animal and target practice, but including any accidental discharge which occurs during a line-of-duty incident.

Post-Traumatic Stress Disorder: An anxiety disorder that can result from exposure to short-term severe stress, or long-term buildup or repetitive and prolonged milder stress.

15.18.8 NOTIFICATIONS

The on-duty supervisor shall notify the following individuals of an officer-involved shooting incident and request their assistance as needed:

1. Patrol Lieutenant
2. Chief Criminal Deputy
3. Undersheriff
4. Sheriff

Families of involved officers should be notified by the Department as soon as possible about the incident. If a deputy is injured, Department personnel will attempt to notify his/her family in person and arrange for their transportation to the hospital or other appropriate place as may be necessary. Emergency notification forms are kept in a notebook and are on file with the Undersheriff. Deputies should update this form on a regular basis.

15.18.10 INCIDENT SCENE PROCEDURES

The following procedures will guide deputies and supervisors at the scene of a deputy-involved shooting incident.

1. The first deputy on the scene will secure the scene and be in charge until relieved by a supervisor. This deputy will handle all supervisory duties and responsibilities until such relief occurs.

2. A supervisor shall be dispatched to the scene of the incident and shall assume primary responsibility in caring for all involved personnel and citizens. Duties include rendering first aid; requesting additional medical assistance;

requesting additional personnel; assigning deputies to specific duties; arranging transportation; witness identification; and initial investigation of the scene.

3. The supervisor will insure all incident scenes are identified and secured to prevent contamination or unauthorized entry (e.g., escape/chase route, fatality scene, collision scene, suspect vehicle, deputy's vehicle, etc). The supervisor will ensure that personnel are posted to adequately prevent unauthorized entry.

4. The supervisor shall assign a deputy to the position of Incident Scene Recorder. This deputy will create a log and record all activities at the incident scene, to include date, time and names of people who enter or leave the incident scene and their purpose.

5. The supervisor will assign a deputy to ride in the ambulance with an injured person (with a tape recorder, if available) to perform the following functions:

   a. Protect, secure, discover and recover any evidence and document any statements.

   b. Protect and secure any involved person who is in custody.

   c. Record and document information from medical personnel.

   d. Gather identification from medical personnel.

6. The supervisor will insure that any outstanding suspect, vehicle and witness information is broadcast over the police radio.

7. The supervisor will advise the involved deputy(s) that a detailed interview will be conducted at a later time. The supervisor will also provide the involved deputy(s) with a general overview of standard operating procedures and investigations that will occur as a result of the incident.

8. The supervisor will insure that any discharged weapon(s) are left in place as long as the scene is safe and secure.

9. The supervisor will insure that discharged firearms, if holstered, are uncocked and that the firearm remains in the deputy's holster until such time as it is collected.

10. The supervisor will arrange for deputies directly involved in the incident to leave the scene as soon as practical. The deputies will be transported to the Hall of Justice or other

secure setting by deputies who were not involved in the incident. The supervisor shall perform the following duties:

a. Advise transporting deputies to not discuss the details of the incident with the involved deputy(s).

b. Advise involved deputies that they may seek legal counsel.

c. Instruct involved deputies **not** to talk about the incident with **anyone** except a personal or agency attorney, guild representative or attorney, or departmental investigator, until the conclusion of the preliminary investigation.

d. Cause involved deputy(s) to be sequestered separately.

e. Insure that no caffeine, nicotine, stimulants or depressants are taken by the deputy(s) prior to any investigative testing unless administered by medical personnel. This may be waived if the deputy elects not to submit to investigative testing **and** the Department elects not to seek a court order mandating such testing **or** conduct such testing under the auspices of an internal investigation.

11. The supervisor will insure all witnesses are located and identified and statements taken.

12. The supervisor will insure that all incident and supplemental reports are completed by all personnel involved in the investigation of the incident.

15.18.12 DEPARTMENT BRIEFINGS

The department administration should brief other department members concerning the incident so that rumors are kept to a minimum. Department members are encouraged to show the involved deputy(s) their concern.

15.18.14 MEDIA INQUIRIES

All personnel involved in a shooting incident are advised that they are not permitted to speak with the media about the incident. Deputies shall refer inquires from the media to the Sheriff's Office administration, unless otherwise authorized to release a statement pertaining to the incident.

15.18.16 REMOVAL FROM DUTY

Involved deputies will be placed on administrative leave pending evaluation, but shall remain available for any necessary investigations.

15.18.18 WEAPONS REPLACEMENT

Any weapons taken from the involved deputy(s) for evidentiary or investigative purposes will be replaced or returned at the direction of the Sheriff or his designee, taking into consideration the fitness for duty evaluation as described in 15.18.24. Individual circumstances will dictate when such action takes place.

15.18.20 FIREARMS RE-QUALIFICATION

Deputies directly involved in the shooting incident shall be required to re-qualify with their firearms as soon as practical. This applies to returned, replacement and personal firearms used in the incident.

15.18.22 POST-INCIDENT COUNSELING

All deputies directly involved in the shooting incident shall be required to contact a Department-designated specialist for counseling and/or debriefing before returning to duty. This will occur as soon as practical after the incident, preferably within 24 hours. The Department strongly encourages the involved deputy(s) and his/her family to take advantage of available confidential counseling services through the Employee Assistance Program.

In addition, and in a timely manner, the deputy and team members involved will be gathered together and will be instructed that they will undergo counseling and/or debriefing individually. After the investigation, after a resolution has been made, the entire team will be brought together and advised of the outcome.

15.18.24 FITNESS FOR DUTY EVALUATION

At the direction of the Sheriff, fitness for duty evaluations will be conducted by a Sheriff's Office-designated mental health/medical specialist to insure that a deputy is able to return to duty after being involved in a shooting incident. As a result of such specialist's evaluation, the specialist shall advise the Sheriff of the following:

1. Whether it would be in the deputy's best interest to be placed on administrative leave or light duty, and for how long.

2. If the deputy was relieved of his/her weapons after the incident, at what point they should be returned.

3. Whether further counseling/treatment is needed and what type is needed by the deputy.

15.18.26 DAILY STRESS RECOGNITION

As post-traumatic stress disorders may not arise immediately, or the deputy may attempt to hide the disorder, each supervisor is responsible for monitoring the behavior of unit members for symptoms of the disorder. The supervisor will immediately notify the Lieutenant of any concerns.

The Sheriff may order a deputy to seek assistance or counseling from a mental health specialist upon a supervisor's reasonable belief that stress may be disrupting the deputy's job performance. An appointment with a counselor will be scheduled by the Sheriff and the deputy will be directed by the Sheriff to attend.

15.18.30 USE OF DEADLY FORCE OUTSIDE COWLITZ COUNTY

15.18.32 Purpose

The purpose of this policy is to provide guidelines that shall be uniformly applied following any incident involving the use of deadly force during a police action occurring outside the Cowlitz County limits by a Cowlitz County deputy.

15.18.34 Policy

It shall be the policy of this Department to respond to and provide assistance at any incident involving the use of deadly force during a police action outside of Cowlitz County.

15.18.36 Investigation of Incident

The incident will be investigated by the law enforcement agency having jurisdiction over the incident.

15.18.38 Notifications