# National Institute of Justice

# Law Enforcement Peer Support Training

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# NATIONAL INSTITUTE OF JUSTICE
# PEER SUPPORT TRAINING PROGRAM

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# Law Enforcement Peer Support Training Manual

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## STRESS AND THE LAW ENFORCEMENT OFFICER

## AN OFFICER- AND FAMILY-FRIENDLY MAINTENANCE PROGRAM

Although most law enforcement agencies provide professional support for officers involved in deadly threat encounters, such as a shooting incident, few offer counseling services on a routine basis to officers suffering from other types of job-related stress. But many officers who experience a high level of stress on a daily basis often develop stress symptoms similar to those displayed by victims of or participants in a single traumatic event. Without the proper assessment and intervention, officers with symptoms of daily stress often become high risks for more serious emotional and behavioral problems.

For the officer who is faced with some form of high stress on a daily basis, the results can eventually become harmful both on the job and at home. Often officers become confused about their condition and attempt to solve their problems on their own, without much success. Although some agencies have professional counselors on staff, many officers are reluctant to seek help because they fear negative responses from their fellow officers and possible damage to their careers. These officers often describe feeling isolated and that no one understands how they feel or that no one really cares about their well-being. They feel that they are expected to just "tough it out." And officers under stress, like victims of trauma, often experience additional traumatization from a seemingly unresponsive or adversarial system.

Without proper assessment and intervention, many of these officers reach a point of desperation and act in a manner that brings shame to themselves and the

agency and/or places themselves, other officers or the public in harm's way. Thus, most cases of job-related traumatic stress involving law enforcement officers go undetected until an otherwise preventable tragedy occurs. Four major factors create this situation:

1. Lack of understanding about stress other than so-called traumatic stress of crisis situations.
2. The code of not showing any form of weakness.
3. The fear that seeking counseling will trigger negative reactions within the agency and harm career opportunities.
4. Lack of counseling resources within the agency except for more extreme cases.

**AN OFFICER-FRIENDLY SOLUTION**

Most agencies would agree that their most valuable asset is the officer. Yet, more attention is given to routine preventative maintenance of equipment and vehicles than to this essential and expensive component, the officer, who is expected to function daily at a very high level of professionalism with a minimum level of maintenance. When a major negative event does happen with an officer, forces within the department are often gathered to provide some form of crisis intervention. But for some officers, crisis intervention is too late. Therefore, the logical solution rests upon an "officer-friendly" concept of routine maintenance and prevention rather than crisis intervention. That is, *ALL* officers within an agency should be provided routine and regularly scheduled assessment and intervention services by individuals within the agency who are trained to assess stress related

emotional and behavioral problems. Problems detected at an early stage are much more likely to respond to intervention than when they are more firmly entrenched.

To implement this type of program, peer support personnel will be trained to assess stress and provide appropriate intervention strategies for law enforcement officers and their families. At the agency level, each officer will meet with a peer support person for a "check-up" on a regularly scheduled basis (monthly sessions are recommended). Officers will be informed that peer support personnel will be supervised by a experienced project staff member. The information shared between the officer and peer support personnel is deemed confidential except under certain circumstances (e.g., peer support personnel and project supervisors believe that the officer poses a serious threat to himself/herself or others). If the officer seems to be adapting well to the job assignment, no additional sessions are scheduled, except for the next routine maintenance and evaluation session.

If problems requiring additional counseling are detected, appropriate intervention strategies are discussed with the officer and implemented. For example, additional sessions with the peer support person, a professional counselor, or other culturally appropriate persons may be scheduled. In some cases additional community resources may be utilized, as deemed appropriate by peer support or project personnel. In other cases, the officer may be encouraged to ask for a job reassignment as an appropriate solution to a stress management problem. Requests for job reassignment should be processed within agency guidelines, but without prejudice to the officer. Peer support and project personnel can assist in this process, if the officer and the agency agree to include them into

the job reassignment process.

Since the program is designed as an officer-friendly maintenance program in which all officers participate, no one need fear other officers' responses, no one has to hide their problems for fear of career damage, and no officer will have to wait until his/her problems have reached crisis proportion.

**PROGRAM OUTLINE**

1. Assemble a cadre of professionals experienced in the evaluation and treatment of stress related symptoms associated with law enforcement personnel.
2. Develop agency and culturally appropriate training program.
3. Conduct training program for appropriate agency personnel
4. Implement maintenance program using peer support personnel for officers and their families at agency level.
5. Provide follow-up training and consultation for Peer Support Officers.
6. Conduct program evaluation to determine effectiveness of program.

**PROJECT GOALS**

1. Increase skills in effective interviewing techniques and evaluation procedures.
2. Increase knowledge and understanding about various types of traumatic stress.
3. Increase skills in detecting the varied warning signals of traumatic stress.
4. Increase skills in providing effective intervention strategies once traumatic stress is detected.
5. Decrease stress-related emotional and behavioral problems among officers, including the negative impact of these problems on the officers, the officers' families, the agency and the public.

6. Increase morale and level of job satisfaction.

**RESPONSIBILITIES OF PEER SUPPORT OFFICERS**

Peer Support Officers will participate in three training programs conducted by Project staff:

- Initial Peer Support Training Program (5 days)
- Special Topics Training Program (2 days)
- Critical Incident Stress Training Program (2 days)

Peer Support Officers will meet with each Officer assigned to them on a monthly basis for assessment of stress and implementation of intervention strategies, if appropriate.

Peer Support Officers will meet, on a monthly basis, with a Project Supervisor who will provide consultation, support and additional training throughout the length of the project.

**SUMMARY**

The purpose of the program is to work toward a common goal of helping officers become the best officers they can without sacrificing their mental health in the process. A mentally healthy officer will serve his/her agency with distinction and will seldom engage in personally harmful behavior, become a personnel problem for the agency or a threat to the public. When the officer is reassured that the agency cares about him/her, he/she feels less isolated and is willing to work on whatever problems may surface. The bottom line is higher moral, a more efficient operation, less turnover in the ranks, and better service to the public.

## PRINCIPAL INVESTIGATORS

- Dr. Kevin Gilmartin, Ph.D., is a Licensed Psychologist practicing in Arizona since 1974. He has worked in a law enforcement capacity since 1970. From 1977 through 1995, Dr. Gilmartin supervised the Behavioral Sciences Unit for the Pima County Sheriff's Department. In that capacity he performed consultations with management, field operations and investigative operations. He supervised the Peer Counselors and the Hostage Negotiations Team. He created the Peer Support Team for the National Parks Service Western Region. In 1982, Dr. Gilmartin received the International Association of Chiefs of Police Service Award for his work in the areas of police psychology and hostage negotiations. He consults with Federal, State, Local and Tribal law enforcement agencies throughout the country. His interests and publications include law enforcement integrity, peer counseling, counseling the problem employee, and workplace violence. He is a frequent contributor to Police Chief on a variety of issues.
- Dr. Larry A. Morris, Ph.D., is a Licensed Psychologist in the State of Arizona. Since 1970 he has specialized in evaluating and treating victims and perpetrators of interpersonal violence, including law enforcement officers and their families. Dr. Morris has also been the director of, or consultant to, several national, regional and local programs designed to evaluate the effectiveness of social action projects. He also brings to the present project extensive experience in training Native American paraprofessionals to work as counselors on reservations or urban settings.

- Dr. J. Michael Morgan, Ph.D., is a Licensed Psychologist in the state of Arizona and has been in practice since 1970. He has been involved with law enforcement since 1975. He and Dr. Gilmartin created and trained the Peer Support team for the Tucson Police Department in 1993. Dr. Morgan supervised that team from its inception to the present. He is also the Clinical Director of the Southeast Arizona Critical Incident Stress Management Team. His interests include clinical treatment of PTSD, research and application of pre-employment psychological assessments, and family and marital therapy with police officer families. He has a long standing interest in the use of indigenous/paraprofessional community mental health workers and first trained and supervised these workers in 1970 through 1972 in a community based mental health program in Denver, Colorado. He consults and works clinically for a variety of Federal, State, City and Tribal agencies.

## ABSTRACT

The Old Pueblo Fraternal Order of Police Lodge #51 created a consortium of the Tohono O'Odham Police Department, the White Mountain Apache Tribal Police and the University of Arizona Police Department to develop a Peer Counseling Program. The purpose of the program is to develop effective methods for reducing stress in police officers and their families in two policing groups that have received very limited attention in the Peer Support literature: Native American police departments and campus police departments. Native American police agencies have policing environments that contribute significantly to officer stress including high crime rates, immense geographic areas and high levels of poverty. Use of Peer Support in university policing settings has been only superficially explored. Proposed is a Peer Support format modified to include evaluation and counseling sessions on a regularly scheduled monthly basis for each officer serving in these three departments. Family members, primarily spouses, will be strongly encouraged to attend each of these sessions. Peer Support Counselors will be trained in a model similar to that traditionally used; however, the content will be modified to be culturally appropriate and specific to the three departments' unique circumstances. Special attention will be given to preventing stress-related domestic violence in police families. Program effectiveness will be evaluated through a Pre- and Post-Intervention model using several standardized measures of stress, as well as data associated with job performance variables. Post-intervention measures of program satisfaction will also be administered to police officers and appropriate family members.

# PEER SUPPORT

The purpose of this course is to serve as an introduction for those public service professionals who wish to serve either in a full or part-time capacity as Peer Supporters. That is, individuals who, in addition to performing their own public safety or law enforcement function, possess the motivation, interest and skill to assist their fellow professionals in overcoming many of the difficulties, emotionally and physically, that occur to individuals choosing a career in public safety.

As our society has evolved over the past two or more decades, many of the traditional social support systems where individuals turned in time of need or crises no longer exist. Most Americans, and in particular public service employees, find themselves investing emotionally through ever increasing degrees to their professional role. As Peter Druker stated in one of his treaties on management, "it is no longer enough for a place of employment to provide people with a place to make a living, it must provide them with a place to make a life." In ever increasing numbers, people find that the major source of emotional support and investment is the work place. With public safety professionals in particular being subjected to greater than average stressors, there needs to be a well-trained and empathetic cadre of individuals who can assist their fellow professionals overcome the "problems in living", transient crises and day-to-day difficulties that impact all of our lives. For the law enforcement professional or those dealing with traumatic and critical incidents, this is particularly important.

As Peer Supporters, the development of intervention strategies, listening skills and specific knowledge of public safety stress is essential. The necessary expertise of the Peer Counselor can be broken down into two major elements: 1. **KNOWING HOW TO LISTEN;** and 2. **KNOWING WHAT TO LISTEN TO.**

The basic format of the present course revolves around the above two elements. As a public safety professional, being in a position to assist your fellow officer is both personally and professionally rewarding.

# PLEASE LISTEN

**When I ask you to listen to me
and you start giving advice,
you have not done what I asked
nor heard what I need.**

**When I ask you to listen to me
and you begin to tell me that I shouldn't feel that way,
you are trampling on my feelings.**

**When I ask you to listen to me
and you feel you have to do something to solve my problems,
you have failed me....strange as that may seem**

**Listen, Please!
All I ask is that you listen
Not to talk nor "do"....just hear me.
Advise is cheap. A quarter gets both "Dear Abbey" and astrological forecasts in the same newspaper.
That I can do for myself, I'm not helpless,
maybe discouraged and faltering....but not helpless.**

**When you do something for me that I can and need to do for myself, you contribute to me
seeming fearful and weak.**

**But when you accept as a simple fact that I do feel what I feel, no matters how seemingly irrational, then I can quit trying to convince you and can start understanding what's behind
what I am saying and doing....to what I am feeling.**

**When that's clear, chances are so will the answers be, and I won't need any advise. (Or then, I'll be able to hear it).**

**Perhaps that's why, for some people, prayer works, because God is mute, and doesn't give advice or try to fix what we must take care of ourselves.**

**So, Please listen
and just hear me.**

**And if you want to talk, let's plan for your turn,
and I promise I'll listen to you.**

**Anonymous**

# PEER SUPPORT DESCRIBED

PEER SUPPORT IS A PROCESS WHEREBY A PERSON DISCUSSES A PERSONAL ISSUE WITH A NON-PROFESSIONAL; USUALLY A FRIEND OR CO-WORKER. THE PERSON DEFINES A PROBLEM AND SOLVES IT HIMSELF/HERSELF.

THE PEER SUPPORT PERSON UTILIZES GOOD ACTIVE LISTENING SKILLS, HELPS TO CLARIFY ISSUES AND SUPPORTS THE PERSON THROUGH THE PROBLEM-SOLVING PROCESS.

A PERSON WILL SELECT A PEER SUPPORT PERSON PRIMARILY BASED UPON TRUST. HE/SHE WILL ONLY SHARE PROBLEMS WITH SOMEONE CONSIDERED CREDIBLE, ABLE TO LISTEN WITHOUT JUDGEMENTS AND CAPABLE OF MAINTAINING CONFIDENTIALITY.

PEER SUPPORTERS HAVE THE RESPONSIBILITY OF UNDERSTANDING THEIR ROLE AND ITS LIMITATIONS, LEARNING AND EMPLOYING ACTIVE LISTENING SKILLS, AVOID "SOLVING" OR TAKING ON THE PERSON'S PROBLEMS, KNOWING AND, WHEN APPROPRIATE, REFERRING TO PROFESSIONAL RESOURCES.

## NOT GETTING IN OVER YOUR HEAD

* Most common civil suit for mental health practitioners -- Romantic involvement or sexual intimacy with a client/patient

* Dual role relationships . . . what are your other roles?

  - Peer support
  - Co-worker
  - Friend
  - Etc.

## *Learn where the boundaries are*

* Don't go solo - bounce it off of someone else . . . check out another perspective ... you may be too close (emotionally involved)

## AREAS TO BE VERY CAUTIONS IN

* Hallucinations . . . A break with reality; seeing - visions; auditory - hearing voices; tactile - ghost on body -- if auditory, it can be a real psychosis -- sometimes drug or alcohol induced

* Delusions . . . A false belief not supported by reality; persecution; blurred line of reality

* Thought disorder . . . Confused thoughts as manifested by their speech

* Suicide Idealization . . . extreme of chronic depression

* Homicide . . . judgement call based on the situation

* Physical or psychosomatic symptoms . . . Medical treatment

* Chemical dependency

* Sexual Dysfunction

* Eating Disorders

* Any symptom of extended duration

* Rape

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BEFORE YOU GET OVER YOUR HEAD . . . Have the courage to confront the issue and tell it like it is.

This is not something I have been trained to deal with. However _____ is. Would you be willing to see him/her? The idea is to make sure they get the help they need, even if you have to walk them through the process. Follow up to see if the person made and kept their appointment.

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Psychiatrist or and Medical Doctor (MD) - Medications

Clinical Psychologist (doctor) - Everything but medications

Clinical Social Worker, Licensed or Certified Counselor (masters degree)

Marriage & Family Counselor, Psychotherapist

# THE JOURNEY

Once upon a time there was a woman named Abigail, who was in love with a man named Gregory. Gregory lived on the shore of a river. Abigail lived on the opposite side of the same river. The river that separated the two lovers was teeming with crocodiles that had an insatiable appetite for people. Abigail wanted to cross the river in the worst way to be with Gregory. Unfortunately, the bridge she usually used to cross the river had recently been washed out. Abigail went to the riverboat captain and asked to be taken across. The captain agreed, providing that Abigail either pays an exorbitant sum of money or go to bed with the captain prior to crossing. Abigail had no money and promptly refused the other alternative. She went to see a friend about the situation. Her friend, who had a lot of money, listened patiently to her problems but did not want to get involved. Abigail was desperate to see Gregory and felt her only alternative was to accept the captain's terms, which she did. After the carnal adventure, the captain took Abigail to the other side of the river and into the arms of Gregory.

When Abigail told Gregory about having to go to bed with the captain in order to get across the river, Gregory cast her aside with disdain. Heartsick and dejected, Abigail turned to another friend Slug, and told her what Gregory had done. Slug, incensed at Gregory and feeling compassion for Abigail, sought out Gregory and beat him unmercifully. Abigail was very happy to see Gregory suffering. As the sun sets on the horizon, we hear Abigail laughing at Gregory.

Please rank the characters in order, from one to five, with one being the person who was the most reprehensible, and five being the person who was least reprehensible.

1. _____

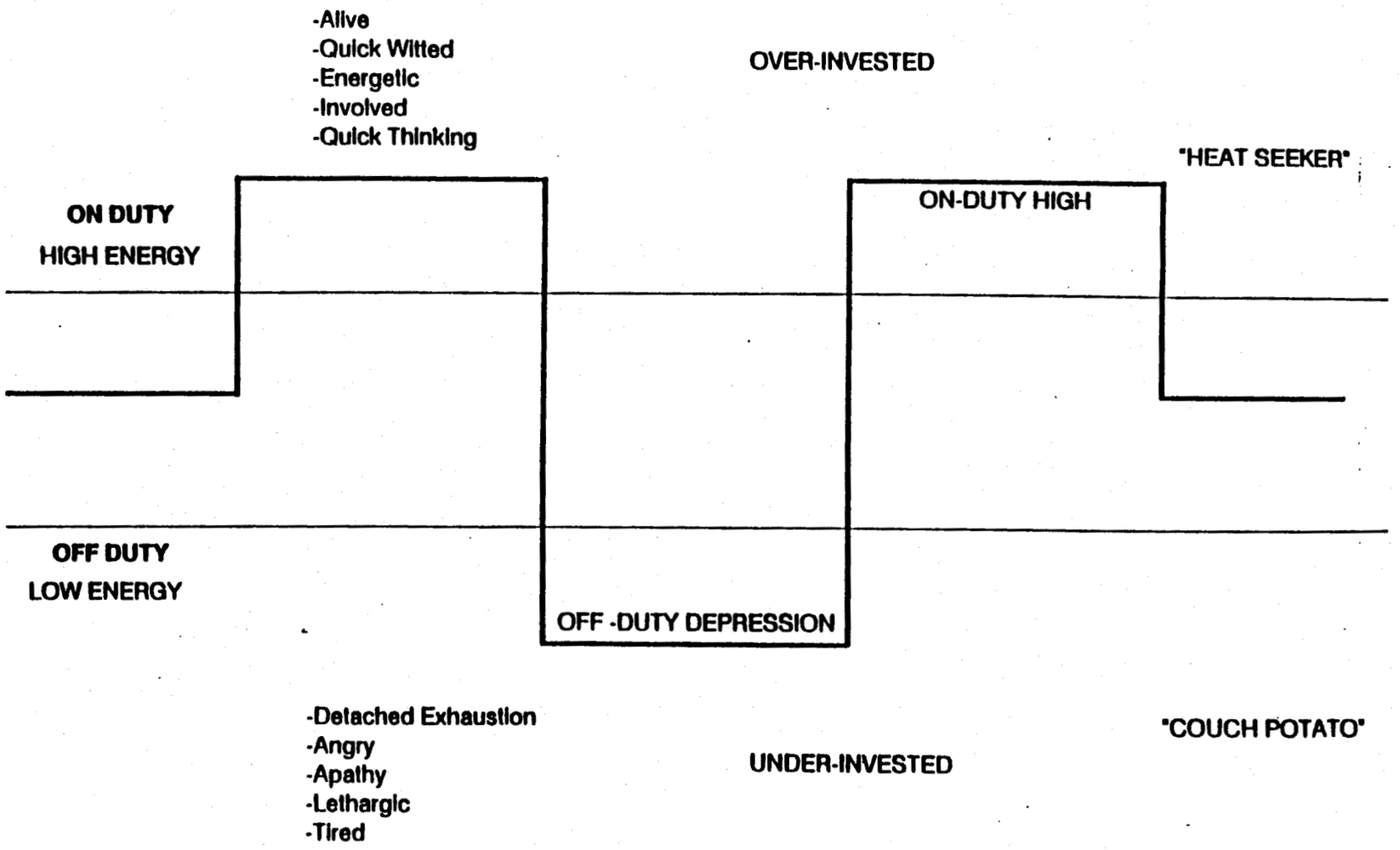
2. _____

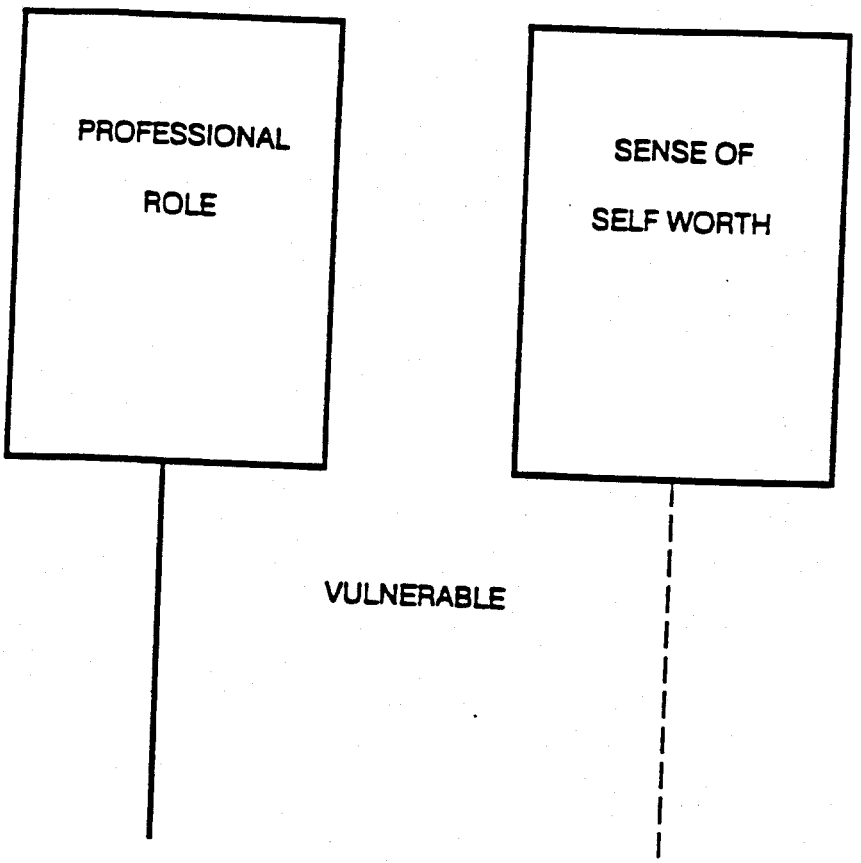
3. _____

4. _____

5. _____

# BIOLOGICAL ROLLER COASTER





| WHAT I DO CONTROL | WHAT I DON'T CONTROL |
| --- | --- |
| *(Survivor)* | *(Victim)* |

# HYPERVIGILANCE: A LEARNED PERCEPTUAL SET AND ITS CONSEQUENCES ON POLICE STRESS

*Kevin M. Gilmartin, Ph.D.*

Over the past decade the journals in the area of law enforcement have shown a significant awareness of the issue of police stress. The literature abounds with accounts of the mental and physical health destroying results that occur from a career in law enforcement.

A direct stressor initiated stress reaction formulation has been used explanatorily. Long lists of potential stressors ranging from public apathy and an ineffective court system, to being witness daily to man's imhumanity have been complied.[1] The basic theme of this manner of conceptualizing police stress is that due to the nature of the job, the officer is bombarded with constant frustration, negativity, and unappreciativeness that leads to an experiencing of the stress reaction and consequently the diseases of adaptation.

The purpose of this paper is to generate a hypothesis that goes beyond the stressor initiating stress formulations and propose that law enforcement creates a learned perceptual set that ultimately cause the officer to alter the social and sociological manner in which he interacts with his environment. This hypothetical perceptual set will be developed as a basic social/physiological format from which the law enforcement officer develops a stress reaction.

Interviewing recruit applicants and individuals attempting to re-enter a career in law enforcement can serve as a potential springboard to explain the law enforcement perceptual set. After approximately fourteen years of interviewing both recruits and re-entry law enforcement officers, the author believes two definite themes of reasons for job choice appear. Recruits give responses explaining their choice of a career in law enforcement along the themes of public service, a meaningful job, and a potential diversity of duties. Officers, who after several years of service leave law enforcement and choose after a period of absence to return, have almost exclusively stated the reason for their return as "cop work gets in the blood". It appears that the veteran officer may be describing a sensation of physiological change that becomes inseparable from the police role.

As a police psychologist with full awareness that the issue of police stress is a reality, the author believes the responses of "cop work getting the blood" might prove crucial in an explanation of the police stress reaction.

The majority of the literature on police stress speaks of the ill-effects of this reaction. The physiologically elevated states are explained as negative events in the officer's life. Yet the clinical reality appears that the stress reaction and the physiologically elevated states are the very short term rewards that either keep people in law enforcement or, once having left, motivate them to seek a career re-entry. It also appears that officers who's careers have been typified by a lack of being exposed to a bombardment of violence, unappreciativeness, and negativity also experience the stress reaction.

The profession of law enforcement emphasizes to its new members to interpret the environment as potentially threatening. Concepts such as officer safety and street survival are created to demonstrate the lethalness of the law enforcement officer's daily work place.[2] These vicarious learning experiences appear to combine with the officer's own first hand experiences in threatening situations to teach an interpretation of the environment as potentially life-threatening and dangerous.[3] A perceptual set of being vigilant of events in one's environment leads to a state of being hypervigilant or over-reactive to potentially threatening situations. At a bio-behavioral level, it is the role of the reticular activating system to scan inputs from the perceptual field and determine which events should be interpreted as threatening and which as neutral.[4] The average citizen travels the streets of his community daily oblivious psychologically and neurologically to the events unfolding before him. Law enforcement officers, on the other hand, are trained and learn their very survival can depend on their interpreting most aspects of their environment as potentially lethal. This perceptual set therefore basically requires teaching the reticular activating system a new set of values for interpreting incoming cues and putting valances of potential danger on events the average citizen would clearly interpret as neutral.

The average citizen has the neurological advantage of stimulus habituation. The capacity to be nonreactive to stimuli whose threshold of perceived potential danger is insufficient to warrant attention. The law enforcement perceptual style considers stimulus habituation to be potentially lethal carelessness. The environment is scanned, and even the most innocuous situations need to be

processed. The sensory process of stimulus habituation is unlearned in favor of the lower threshold of reticular attentiveness. This elevated attentiveness of hypervigilant perceptual style has a law enforcement officer in an elevated physiological state merely by assuming his occupational role.

The reinterpretation of the environment and subsequent reprogramming of the reticular activating system sets into motion the perceptual set of hypervigilance and its physiologicial consequences. As a message of potential danger is experienced by the officer, mild to moderate elevations of the sympathetic branch of the autonomic nervous system will be innervated. This will be interpreted by the officer as a feeling of energization, rapid thought pattern, and a general speeding up of the physical and cognitive reactions. A state that in and of itself is not judged to be unpleasant. A state of social physiological reaction that the rookie street cop learns as inseparable from the police role. This sets the stage for a career long perceptual-attitudinal linkage. It is at this point that "cop work gets in the blood." At a behavioral level, speech is more rapid, humor and wit are present, and a general feeling of aliveness can be felt. At a biobehavioral or physiological level changes are in response to merely a perceptual manner in which law enforcement officers learn to view their environment. There does not need to be present significant specific stressors to induce these changes, merely a perceptual set that becomes an everyday manner of perceiving the world.

The difference between a perceptual theory of hypervigilance and a specific stressor inducing the stress reaction formulation can be demonstrated in the everyday behavior of law enforcement officers. Officers who engage in potentially mundane activities such as watching traffic pass, do so, not from a neutral physiological resting state, but rather from a state of hyervigilance, scanning the environment as potentially threatening and sinister. This generates physiological changes in situations where a non-law enforcement officer might engage in an identical behavior as the officer but experience entirely different physiological reactions. Once a hypervigilant perceptual set becomes a daily occurrence, the officer is altering his physiology daily without being exposed to significantly threatening stressor situations. This learned perceptual set and it's concomitant alteration of the reticular activating system has a social component in the officer's day to day life.

The well known phenomena of officers giving up non-police acquaintances and socially interacting to an ever increasing degree with only other law enforcement types begins leaving the officer without the benefit of testing other social perceptual sets or social roles. The seeing the world through the eyes of a police officer becomes the one style of social interaction that is practiced daily. The subsequent high-levels of autonomic sympathetic branch responses causes a feeling of energization, vitality and a general speeding up of cognitive processes to be directly linked to the perceptual set generated by the police role.

The law enforcement officer who, without benefit of recruit academy stress inoculation training, finds the new perceptual set and it's concomitance physical energy enjoyable, begins investing in his work with an almost recreation seeking attitude. The hypervigilant perceptual set leads to elevated innervation of the sympathetic branch of the autonomic nervous system. This sets into motion a potential hyper-conditionality for traumatic events whether they be experienced first hand or by vicarious learning.[5] This would only increase the effect of any single stressor to place the individual into an adaptation stress reaction. The perceptual set creates highly fertile ground for specific stressor exposure to have major consequences.

The social consequence of a perceptual set of hypervigilance and its consequence of over-interpreting the environment as potentially lethal would be a loss of capacity to discriminate which situations are in themselves genuinely dangerous. The hypervigilant or officer safety conscious officer would be daily reinforcing in clinical terms a "pseudo-paranoid" perception of his environment. The over-scanning of the RAS and the hyper-reactive role of the autonomic nervous system, although a necessary occupational perceptual set, can lead to a pathological interpersonal and intrapersonal mode of interacting if other social roles are not of major importance in the officer's life.

The past decades have seen a decrease in the importance of traditional social support systems such as neighborhood, extended and nuclear families, religion and other non-occupational systems. Workers of all types tend to identify more with the place of their occupation than with the place of their residence.[6] This might prove to present new challenges to the average non-law enforcement manager, however, this narrowing of the social support systems could prove to have lethal physical and social consequences to the law enforcement officer, the officer who loses the benefit of interacting with the world through other roles and social perceptual sets.[7]

The narrowing of the social support systems and the over- identification with work that is currently affecting all workers leaves the law enforcement officer seeing the world only as through the eyes of a law enforcement officer. The perceptual set of hypervigilance and consequently perceived hyper- vulnerability has the officer

arrowing his social circles. And also narrowing his comort zone of where he is able to interact without feelings f vulnerability and reactiveness. This "psuedo-paranoia" eads to the adolescent-like importance of peer pressure n the law enforcement culture. The distrust of any one than those within the law enforcement culture. Absolute trust is reserved for only those within the mmediate peer group. This also generates management difficulties of directing policies to a group of workers who have a hair trigger of atuonomic reactiveness which leads to second guessing and potentially misinterpreting any management directive. An almost adolescent like rebelliousness towards authority.

If one chooses to follow the natural bio-behavioral consequences of a hypervigilant perceptual set away from the police role and into the family situation other predictions can be generated. The officer who has not been oriented through stress training or has not been victimized yet by learning better can suffer significant family disruption by the phenomena currently being discussed. The hypervigilant perceptual role and it's reticular reactivating system consequences causes the officer to spend his work day in the sympathetic autonomic nervous system branch. The feeling of energy, wit, and comradery will be correlated with the work place. As the officer arrives home, the hypervigilant perceptual set is held in elevance in the safety of his/her own home. However, pendulum of homeostasis swings into a parasympathetic state of tiredness, numbness, and an almost detached exhaustion when interacting with the less threatening and more mundane tasks of after work homelife. The hypervigilance and consequent "street-high" of the work place leads to the "off-duty depression" of the parasympathetic swing in an attempt to homeostatically revitalize the body.

As this bio-behavioral switch takes place, on can imagine the potential effects on the family dynamics. The role of detached exhaustion, non-involvement with family activities, and the all too well known "I'll do it later, I'm beat right now" appear as the consequences of the occupational perceptual set of hypervigilance. The physiologically based detachment and exhaustion can be misinterpreted by family members as a lack of interest in family matters or basic rejection of spouse and family.

As one can imagine it is difficult enough to maintain a family with the usual pressures a career in law enforcement creates, such as under-pay, long hours, and shift work. The perceptual set that leads to indifference and exhaustion and only feeling a sense of energy and aliveness when the occupational role is brought about can prove an unmanageable burden to an already strained police marriage.

It has been the author's clinical experience that even if a communication based marital therapy model is initiated it can prove fruitless if the daily pendulous swing of the autonomic nervous system are not addressed. The biological boomerang is energized when either at work or telling "war stories" for vicarious autonomic reactiveness. That energized feeling that seems to build as the "war stories" flow. It is the author's contention that this state of hypervigilence and its physiological consequence is the first domino of a police stress theory. It's impact on society, the family, and the police organization are easily discernable.

The family learns to also over-identify with the work role. Pride in being a police family may become a pathological importance on maintaining the police perceptual set as the primary family identifier. The consequence is a feeling of increasing importance of any variable that iminates from the work place. As the officer and family begin putting more and more of their eggs in the basket marked "police role" a drastic consequence potentially takes place. The realities being that more law enforcement officer's are on the receiving end of orders than on the giving end, police families suffer from the consequences of individuals outside the family having inflated importance in controlling how the family identifies itself. The over importance of the police role to the family, leaves the police family unduly feeling hyper-vulnerable to any changes in variables such as the work assignment, or decrease in the officers status at work. Variables such as a change from a special assignment such as Canine or SWAT can send the hyper- vulnerable police family into crisis if the family support systems are too narrowly linked to the police role.

Financially, families trapped into the sympathetic/parasympathetic pendulum can find themselves using pathalogical buying as a means to include sympathetic arousal into the family role. Officers will "novelty buy" guns, cars, trucks, boats, etc. as a means of short term excitement in the desperate attempt to "feel good at home and get away from the cop work". Yet all that appears to occur is a vicious cycle of novelty buying and short term good feeling leading quickly to the new purchase loosing it's novelty impact. Also the financial affairs of many police families can be devastated by the financial effects of attempting to buy out of the physiological depression secondary to hypervigilance.

From a manager's point of view, the hypervigilant officer feels vulnerable to any change in the work status. The pseudo- paranoia mentioned above leads to intense anxiety and alienation from anyone that increases the officer's vulnerability by controlling his major self-identifier – his police role. The hypervigilant officer is the hyper-vulnerable, and consequently the hyper-reactive to any perceived threat, whether physical in the social environment of psychological in the work place. Each will be over interpreted and cause over reactiveness. Manage-

ment will be perceived by the vulnerable officer through the defense mechanism of projection. Even the most straightforward management directive may be explained by the hypervigilant officer as "conspiracies against the troops." This projection based perception and its interpretive style receives consensual validation due to the levels of peer pressure in the police officer's social realm.

At a societal level, hypervigilance will demonstrate itself in increasing police alienation. A loss of capacity to discriminate which citizens are genuinely threatening to the officer's safety and which are not, will cause the officers to lump all non-police types into the same untrustworthy category. This category, a product of over generalization, will be labeled with whatever "in vogue" term is currently being used in the police culture to describe anyone who is not exactly like "me and my partner officers".

From the therapists perspective in attempting to formulate either an individual or family treatment plan, hypervigilance must be taken into consideration. The detached exhaustion off- duty stated above will generate pathological attempts to create autonomic arousal away from the work place. Promiscuity and abusive drinking can manifest themselves as way of attempting to recreate the energized feeling or "high" the officer knows from his work place, and an avoidance of the depressed exhaustion that occurs upon his return home. Even once a communication pattern has been established, if the family is not educated to the devastating effects of the hypervigilant perceptual set, the emotional rollercoaster ride can break the already strained marriage.

It's been the author's experience treating police families to address the perceptual set and its physiological consequences head-on. Officers are educated on the need to emotionally "decontaminate" from the effects of the street adrenalin through aerobic exercise. Time management is stressed to force the officers to make a commitment to engage in whatever the desired behavior is prior to getting into the state of emotional exhaustion that comes immediately upon arrival home from duty.[8] Most importantly the officer needs to realize the importance of social roles other than the social role of police officer.[9] The officer needs to practice perceptual sets other than those hypervigilance and scanning the environment constantly only to interpret it as potentially threatening of sinister. This testing of other social roles is basically a form of reality testing to show not all non-police environments need cause a feeling of vulnerability and consequently need to be avoided.

In summary, it is the contention of the author that a career in law enforcement produces a perceptual set of hypervigilance. The perceptual set causes the individual to learn to interpret his environment as potentially lethal. Consequently it requires teaching the reticluar activating system to learn new reactive patterns and generate limbic arousal to situations that the vast majority of society would interpret as neutral. This over reactiveness sets into motion a work lifestyle that the officer is potentially always being innervated in mild to moderate sympathetic autonomic arousal patterns. This is consequently interpreted by the officer as a generalized feeling of well-being or energy that is directly linked only to working in the police role. The homeostatically induced counterpart would be a detached exhaustion when not engaged in some off-shoot of the police role. This being the over-identification so apparent in the police culture.

This perceptual set of hypervigilance can be considered the first domino to be knocked over in a theory of police stress and adding salience to the direct stressor inducing stress formulations. The effects of the perceptual set on the family dynamics and management effects were discussed. Brief guidelines for therapy were also put forth.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CHAPTER 23

# The Brotherhood of Biochemistry: Its Implications for a Police Career

by Kevin Gilmartin, Ph.D.

As the field of behavioral sciences has grown over the past decades, significant attention has been given to the study of the stressful effects of life as law enforcement officers. The main theme of these studies concerning police stress revolves around two major approaches. The first approach points out the stress reaction and its potential long-term effects. This involves educating police officers about the stress reaction and revolves around Hans Seyle's concept of the general adaptation syndrome (GAS; the physiological processes through which the body attempts to adapt to ever-changing challenges). The second major approach in teaching law enforcement officers about stress is to present a list of potential stressors or events that precipitate the stress reaction. This list usually becomes somewhat a litany of the daily negative events that officers are exposed to, such as the inhumanity of man toward his fellow man, the inefficiencies of the criminal justice system, sedentary life-style, poor nutritional habits, and so on. While this information is indeed valuable, it appears to miss the major concept of the stress reaction for law enforcement officers. It points out stress as a negative event to be avoided. But in reality, most officers find that in the beginning years of their career, experiencing this stress reaction in mild dosages makes the career exciting and very attractive.

If you asked a large number of law enforcement officers why they chose or stayed with their career, you would probably hear such answers as "Cop work gets in your blood," "It's exciting and a different thing to do each day," "I couldn't stand just working behind a desk," and so on. However, what attracts law enforcement applicants and young cops to the job in the first half of a police career may be their undoing when the novelty has worn off. When police officers state that "cop work gets in your blood," they may unknowingly be describing a very potent physiological change that all police officers experience when first approaching their job. This physiological change appears to be so entrenched in the police role that it might be impossible to separate this physiological change from the role itself. It has been said that police work creates a brotherhood. Today this brotherhood is not exclusively a male domain, but it is a closed social unit that extends membership only to other cops. Cops may not understand the procedures, equipment, or geographical terrain in which other officers perform their duties, but they certainly understand the physiological sensations involved in the job. For example, a cop from Maine and a cop from California accidentally meet in O'Hare Airport and start sharing experiences and telling "war stories." Each officer might have difficulty visualizing the external events taking place in the narrative told by the other (the setting, temperature, type of community the call took place in, and so on), but he or she would have no difficulty in understanding the "internal environment" of the call: how it felt to work that particular call—the physiology of the call. The brotherhood of police is actually a "brotherhood of biochemistry." Cops understand how other cops feel in similar situations because "they've been there." They've experienced similar physiological sensations, and they've made critical decisions in these physiological states. The physiological sensations cops experience on the street are characteristic of the stress reaction. Without these sensations, police work would not be as attractive to young cops. In fact, they might find it boring and mundane.

## Hypervigilance

Consider how the police role is developed in young cops. It begins with the manner in which law enforcement officers are required to view the world. If you take cops in Anytown, U.S.A., and put them behind the wheel of a patrol unit, they are required to view the streets and the community from a different perspective than citizen drivers. Cops realize that "I better pay

attention out here! I could get my butt kicked or get somebody else or myself killed if I'm not paying attention!" This reality forces young officers to take a different view of the world from civilians. When viewing the world while in this new work role, officers experience a new physiological sensation—an increase in alertness, an increased sensation of energy and aliveness. This new perceptual style goes beyond just "paying attention." It includes looking, and watching sections of the community that other people would ignore or consider neutral. In the interest of their own safety, officers have to view all encounters as potentially lethal. This newfound perceptual style, with its emphasis on officer safety, carries with it a parallel physiological and psychological state. As mentioned previously, young officers feel increased sensations of energy, aliveness, and alertness. They find themselves becoming quick-witted in the presence of fellow street cops. Friendships develop quickly, and camaraderie is intensified among people with whom they share potential jeopardy. During the developmental years, young officers experience firsthand the physiological stress reaction, but it is not seen as a negative reaction. On duty, the associated sensation of physiological intensity is viewed as pleasant and enjoyable. They find their job so attractive that it is difficult to leave at the end of a shift. What is unwittingly taking place is that young officers are developing an on-duty style of *hypervigilance*. This style, though necessary for the survival of law enforcement officers, often leads to the long-term destruction of an effective personal life. Officers go on duty, experience increased energy, alertness, quick-wittedness, and camaraderie, and enjoy their tour. However, for every action there is an equal and opposite reaction. Officers who experience an on-duty physiological "high" find that when they get off duty and return home, this hypervigilant reaction stops, as they literally plunge into the opposite reactions of detachment, exhaustion, apathy, and isolation. Thus officers experience the police stress reaction—an emotional ride on a biological roller coaster.

The "biological" roller coaster describes the extreme psychophysiological swings that police officers experience on a daily basis. One can assume that average citizens live on a more even keel, but police officers are denied this stability. Because of the degree of emotional intensity of law enforcement—the increased sensations of alertness required while on duty, followed by reactions of an equal magnitude in the opposite directions while off duty—the police officer's life is characterized by the extremes of highs and lows. This pendulum-like swing occurs daily. Going to work initiates an increased sensation of involvement, energy, and alertness—coming home, a sensation of apathy, detachment and boredom. The biological reason this roller coaster takes place lies in the autonomic nervous system that controls all the body's automatic processes: heart rate, blood pressure, body temperature, and so

on. The autonomic nervous system has two branches that act in tandem. The sympathetic branch (chapter 21) alerts the body to potentially intense situations, causing increased alertness, awareness, and the "fight or flight reaction" (like taking a bunch of "uppers"). The parasympathetic branch controls the body's quiescent or peaceful counterreactions (like taking a bunch of "downers"). This biological roller coaster cycles daily for young officers in the first years of their careers as they polish police skills. It produces high-activity, highly involved police officers, but leaves them with underinvolved, apathetic personal lives. It can be said in no uncertain terms that the first victims of this biological roller coaster are not the officers themselves but their families. The officers alternate between being "heat seekers" at work, where the more intense the call, the more they're drawn to it, and being "couch potatos" at home. Once the police role is unplugged, there remains only a listless detachment from anything related to a personal life.

The "couch potato" phase of the biological roller coaster can be documented easily by interviewing police spouses during the first decade of the officer's career. Although the faces and names change, the stories remain almost identical.

"She's different now that she's a cop. We used to do so many things together, but now she gets off duty and I can't even speak to her."

"He comes home from work, collapses on the couch, turns on the television set—I can talk to him for five minutes and he doesn't even hear me."

"You know, we drove 150 miles last weekend to go visit my mom and dad. I don't think she said two words to me on the whole trip."

"We walk through the mall on his days off and he barely grunts to me, but then he sees two or three of his buddies working off-duty and you can't shut him up: 'Hey, what happened last night? Did you guys arrest that asshole? I heard you come up on the air.'"

As officers begin experiencing the biological roller-coaster ride, they begin heavily investing in the police role. Their family and personal relationships become thin, frazzled, and very fragile. The police wife laments, "I don't know how much longer I can keep this family together. He comes home angry every night: 'Everybody on earth is an asshole.'"

"I swear she'd rather be at work than at home. She starts getting ready for work two hours before she has to be there. Sometimes I think she's married to the job and not to me."

The police family begins reverberating with this biological roller coaster. Police officers' life-styles change drastically.

These elevated sensations while on duty are necessary. Officers do not have the luxury of viewing the world as primarily peaceful and benign.

Officers' very existence depends on their being able to perceive situations from the perceptual set of hypervigilance. They must interpret aspects of their environment as potentially lethal that other members of society see as unimportant. Without hypervigilance, police officers would be seen as "not good cops." However, the tragedy is that while law enforcement officers are trained to react during the upper phase of the biological roller coaster, there has been very little training done or education provided on how to adapt to or avoid the pitfalls of the bottom half of the ride. In the first decade of a police career, the valleys of the roller-coaster ride destroy the emotional support systems and the family support systems—systems that will become increasingly important if officers are to survive the second half of a police career.

## Social Isolation

Unknowingly, law enforcement officers begin cycling around this roller coaster. Work becomes increasingly attractive, relationships and friendships occurring on duty become highly intense, while old relationships that existed prior to becoming a cop are dropped or are maintained only minimally.

For decades, law enforcement officers have deluded themselves concerning this letting loose of old friendships by rationalizations, such as "Only other cops can understand me" and "Everybody else just wants to tell me about that cop who gave him a ticket." However, in reality, young cops often get together and talk about the job and to share "war stories." These gatherings vicariously return officers to the elevated highs of the biological roller coaster. Speaking to the schoolteacher next door or the welder who used to be your friend is "not exciting." Young heat-seeking cops love to tell war stories and hear them from others. Through such dialogues, roller-coaster valleys are avoided, and "cop talk" returns officers to the elevated reaches of energy and alertness, and draws them back into the "brotherhood of biochemistry." The sharing of war stories amounts to little more than "adrenal masturbation."

Young officers become very comfortable only with other police officers, their social isolation from other aspects and relationships in their lives increases, and they become comfortable only within the sphere of this hypervigilant, narrow police-role they all share. Here's how social isolation develops.

At the start of their careers, young cops believe that the world is divided into "good people" and "bad people." The socialization pattern of the police

academy soon has the officers redesigning this dichotomy to "good people" (cops) and "other people." The "other people" soon become "assholes." Young officers begin seeing the world as just cops and "assholes," but soon have a rude awakening when they find that veteran cops sometimes refer to officers from other agencies as "assholes." The social isolation pattern deepens. Now the world is divided into "cops in their department" and "assholes." Social isolation continues to narrow until it's "uniform cops in my district or precinct on swing shift"; everybody else is an "asshole." After a few years, the average cop concludes, "it's me and my partner" and the "rest of you are assholes." Eventually he says, "I'm not so sure about my partner. Sometimes he can be a real asshole."

The longer people are cops, the more unconsciously reactive they become to situations in which they do not feel completely comfortable. The physiological sensation of being in potential jeopardy is experienced in the abdominal area, triggered by a branch of the tenth cranial nerve: the vagus nerve. When cops experience this physiological sensation while dealing with another person, it's easy to project negative values onto the other person immediately and label him or her an "asshole." If asked, cops would probably say "I just had a gut feeling this guy's an asshole." Thus a defensive physiological reaction designed to permit officers to survive becomes a socially isolating event that threatens officers' personal emotional survival.

## The Lives of Cops

After approximately two years on the job, officers are riding this biological roller coaster daily and consider most of the outside world "assholes." While these two reactions are going on, however, officers are typically doing their job, have high on-site activity, are enjoying police work, and in many ways, although still quite naive to the realities of the long-terms effects of a police career, could be experiencing the "golden years" of their own individual law enforcement career. They enjoy going to work, they are highly energized and enthusiastic, enjoy coworkers, and will state "I love my job." This fragile lifestyle and paranoid way of perceiving the world will typically come crashing down on officers in the not too distant future. Officers find themselves staying away from home for longer and longer periods of time. If the shift ends at midnight, cops realize that once they walk through the doors of their house, the exhaustion, apathy, and bottom half of the roller coaster will hit them hard; unwittingly they spend more time away from home. Younger

officers in smaller police departments find themselves going down to the department on their days off just to see what's happening. The economic realities of police management can be quite exploitive of young cops' overinvested, biological enthusiasm. Sometimes the hardest thing about managing young cops is not in getting them to come to work but in getting them to go home. Many small police departments actually could not exist without this overinvestment by young officers and also by nonreimbursed reserve officers whose only payment is a ride on the biological roller coaster. These officers have overlearned the social perceptual style that comes with assuming a police role. The longer they are cops, the more they interact only with other cops, all learning to see the world in only one manner.

Young officers continue to overinvest in their police role. For the first few years, this overinvestment leads to an exciting, enjoyable, dynamic job. Very often, early in their police careers, officers not only isolate themselves from nonpolice friends, but also overindulge in their professional role by listening to scanners while off duty or on days off. One of the potential hazards of this overidentifying and overinvesting in the police role is financial. From the beginning, cops learn the financial realities of a police career: "You're never gonna get rich being a cop." Off-duty work can be an extremely seductive lure for many police families. Officers can provide the necessities and a few extra luxuries of life by working an extra two or three shifts per week, either as security at the local shopping mall or doing point control for construction projects. Although the extra cash certainly helps, the additional time away from home spent in the police role continues the officers' overinvestment and leaves little time for them to develop competencies in other social roles and to build a personal life for themselves and their family.

This overinvestment in the police role goes beyond justifiable pride in the profession. Officers begin linking their sense of self-worth to the police role in what at first glance appears to be a basically benign sense of pride. However, this creates an intense form of emotional vulnerability for average police officers. When you ask a group of cops who controls their police role, young cops often say, "I do." The older, wiser cops respond, "I wish I did."

This link of self-worth to the police role creates a social dynamic that turns many enthusiastic, energized police officers into cynical, recalcitrant employees who resist administrative direction. As their police role is altered by external administrative authorities and the inevitable decline occurs, their sense of self-worth also takes a tumble. Police officers do *not* control their police role and must admit, upon reflection, that it is controlled by administrative authorities. Not until after the first several years of police work do the realities of this type of administrative control hit home. Then there is a "rude awakening." This vulnerability is particularly salient to specialized

police officers—the narcotics agent, canine officer, or detective in some special assignment.

This psychological phenomena of having your sense of self-worth controlled by other individuals leads to very normal feelings of defensiveness and resistance. This linkage explains why police officers, after the first few years, may grow to resent administrative authority, mainly because they are so vulnerable to the changes that can take place in their police role. This resentment and resistance to administrative control leads to an occupational pseudoparanoia, in which officers begin making such statements as "I can handle the assholes on the street but I can't handle the assholes in the administration." Although the streets contain physical danger, the major psychological and emotional threat comes from those who control their police role, with its emotionally overinvested sense of self-worth.

## Emotional Vulnerability

Hypervigilance and the biological roller coaster, combined with the emotional overinvestment in the police role, create emotionally vulnerable individuals. For the first four or five years, officers are overly enthusiastic about the job, eating, sleeping, and breathing police work. But with eight or nine years on the job, they find themselves increasingly resentful, resistant, and hostile toward a police career. However, they have invested so much financially and emotionally in the sense of security a police retirement provides that they can't let go. Former young heat seekers become cynical dinosaurs whose constant lament is: "Just wait until I get my twenty in—then I can get the hell out of here."

Regardless of which theorist is discussing the concept of stress, the crucial elements in defining stress appear to be any given situation where subjects have high demands placed on them and low control over those demands. Police officers, particularly those who do the best job and care the most about their police role, are extremely vulnerable to police stress. The best officers are those most susceptible to the stress of the biological roller coaster. Those officers who practice good officer safety skills and are hypervigilant and observant are the ones most likely to have an elevated sense of involvement on duty. They are also the ones most likely to have the biological roller coaster come crashing down during their off-duty time. They go from "heat seeker" to "couch potato." It's during this off-duty, down time that any significant intervention must take place. However, during this down time, when officers are experiencing apathy and detached exhaustion, they are least likely to implement any change. Life is in neutral. If officers do anything, it will probably be to complain about the job. In breaking the stress

cycle, officers must take control over those aspects of their lives that they can control. Average cops do not control their police role. However, they can control, at least to a larger extent, their own personal life. It is the surrender of their personal life to the biological roller coaster and off-duty depressionlike states that causes the strong vulnerability of the police stress response. Officers find themselves feeling less and less comfortable off duty, even while becoming more and more cynical about the job. The only time they feel alive and involved is at work. So the overinvestment in the police role continues, and they become more and more vulnerable to having this overinvested role taken away from them without a well-developed personal life to cushion the blow. This highly vulnerable emotional state typifies the personal lives of a significant percentage of law enforcement officers. Officers need to recognize the vicious cycle and make appropriate changes in their life-styles.

## Controlling One's Life

It is very difficult for average law enforcement officers to make a realistic appraisal of how much of their personal life they really do control. Their immediate rationalization is to say "I'm a cop twenty-four hours a day." But, in reality, with some planning and proactive effort, they are capable of controlling a significant percentage of their time each day. They can develop separate, noncop personal lives. This is usually not done easily because when officers are off duty, the biological roller coaster robs them of spontaneity or enthusiasm. What do average cops want to do when they get off duty? "Nothing. Absolutely nothing!"

Several ineffective methods of breaking this cycle have surfaced, and in all likelihood the average cop has experimented from time to time with all of them. They focus on getting officers out of the off-duty valleys of the biological roller coaster and back to the more elevated states associated with on-duty status. Some officers heavily invest in special response team assignments, where staying on duty for longer periods of time permits them to experience even more than average levels of hypervigilance. The narcotics officer or SWAT officer is an excellent example of the extreme heat seeker. But such actions are an inappropriate way of attempting to regain control. For married police officers, promiscuity and/or other relationships that are initiated while in the police role permit officers to extend inappropriately the sense of aliveness and energy and to avoid the pitfalls of apathy and detachment at the opposite end of the roller coaster. Gambling, substance abuse, "choir practices"—all are escape mechanisms that go far beyond just permitting officers to "unwind." They allow overinvested police officers to avoid

facing the realization that home, in contrast to the emotional on-duty high of the biological roller coaster, is a place and time of detachment, isolation, and depression, and is to be avoided at all cost.

## Family Impact

As the police socialization process evolves over the years and hypervigilance becomes the normal perceptual set for police officers, the police family does not go unscathed. The family also learns to overidentify with the police role. Pride in being a police family may become of pathological importance in maintaining the police perceptual style as a primary family identifier. The result is that any variable that emanates from the workplace is of increasing importance to the family's well-being and happiness. As the officer and family begin putting more and more of their eggs in the basket marked "police role," a drastic effect looms on the horizon. Because more law enforcement officers are on the receiving end of orders than are on the giving end, police families become vulnerable to the actions of individuals outside the family who have an important role in controlling the family identity.

The overimportance of the police role leaves the police family feeling hypervulnerable to any changes that impact the officer's police role. If there has been overinvestment in the police role and a concomitant narrowing of support systems to only the police culture, changes such as removal from an assignment can send the vulnerable police family into crisis. Police families also fall victim to the couch potato syndrome. They become deficient in planning skills. "We like to be spontaneous" becomes a catch phrase for a lot of police families, even though "spontaneity" might be something the family has not experienced socially in years. Hobbies are forgotten, vacations are not planned, trips away from the police role are not experienced. The cycle of overinvestment in police work, the biological roller coaster, and apathy toward and disregard for a personal life may even cost police officers their families during the first decade of their career. This leaves them without vital support systems and compounds their isolation as the second decade of a police career unfolds.

*Case Example.* Officer John Miller was a sixteen-year veteran of a two-thousand-man police force. During his career, he had served in several capacities, from patrol officer to detective. For the past nine years he had been a canine officer. During this time John earned the respect not only of the street cops but also of his superiors. It was a rare individual indeed who did not speak of John as an officer to be admired and looked up to. John had high job satisfaction, was well respected by other canine officers, and ap-

peared to be heading toward his twenty-year retirement as a police success story. John also had a well-functioning police family.

He had been married for seventeen years. This marriage had produced two children, a son and daughter, fourteen and twelve years old. The family was heavily invested in John's role as a police officer, particularly in his specialty of canine officer. The children had grown up with police service dogs as members of the family. On two occasions over the past decade, the family had traveled, once to California, and another time to the southeastern United States, to bring back prospective canines for the dog unit. These trips occurred as part of the family vacation. The family also had imported a dog from Germany at their own expense. Beyond a doubt this was a police family—a canine-oriented police family. On more than one occasion, the children had been proud to have their father bring the highly trained dogs to their elementary and junior high schools to perform canine demonstrations.

Suddenly John found himself under the supervision of a new captain. The new command officer had certain ideas of his own involving the cross-training of bomb dogs and narcotics dogs. John adamantly opposed this idea. John tried to approach his new captain with tact but was met with an authoritarian narrow-mindedness. The captain ordered John to take his experienced drug dogs and cross-train them as bomb dogs. Again, John tactfully attempted to explain to the captain that once a dog is certified to alert to one narrow range of olfactory sensation, cross-training would confuse the animal and reduce its total efficiency, producing a dog of only limited serviceability. When this approach was rebuffed, John tried to make it clearer by pointing out to the captain that if a cross-trained dog sat down (meaning that he's found something), they wouldn't know whether to evacuate the building or get a search warrant. The captain failed to appreciate the humor in his approach, and John found himself unceremoniously ordered out of the canine unit and returned to uniform patrol, assigned to a part of the city where he had begun work sixteen years prior.

This unexpected transfer hit John quite hard and also his wife and children. The transfer meant that not only was John no longer a member of the specialized canine unit, but that all city-funded equipment, including the dogs, would be turned back to the city for assignment to another officer. John took the transfer hard.

When he started his new assignment as a patrol officer, he did so with cynicism and hostility. This was the first time in sixteen years that John did not enjoy going to work, and he rapidly grew to hate it. His sick leave increased as did the number of citizen complaints. On more than one occasion John found himself receiving verbal discipline from his watch commander (an officer with whom he attended the police academy sixteen

years prior). John's new lieutenant attempted to perform intervention and supervisory counseling by stating "John, I know that the manner in which you were handled at Special Operations [canine] was maybe not the best way. This is field operations and it's a new deal over here. I need you as a leader. We have a lot of young cops out here and I'm gonna need your seniority and your leadership."

To this John responded, "Lieutenant, you can count on me being here. I have four years to go till I retire, but don't count on me for anything else."

John's behavior continued to deteriorate, evidenced not only by a lack of adequate investigation for field calls, but also by a general decline in his performance as a police officer.

While deterioration was taking place work, John's family also was beginning to suffer. His wife and children bounced back from the transfer much sooner than John did. His wife advised John, "You have four years to go here and then we can do what we want to do. Let's just finish it out." To which John responded, "I'm not gonna make four years with these assholes."

Several months after John's transfer from canine, he encountered an old police friend who had retired and become chief of police in a small rural department in the same state. When John and his old friend began commiserating over old times, his friend advised him, "If you come to work for me in my department you can start working your dog the day you arrive." John was rather enthusiastic about this job proposition even though it meant a 40 percent reduction in pay and relocating almost 250 miles away in a small rural community. John's wife took the news of a potential move with a marked lack of enthusiasm.

"John, we've lived in this city almost our whole life. Our children were born here. Our parents are here, and our home is almost paid off. Let's just do four more years with the department then decide what we want to do. I don't think we can take a 40 percent cut in pay and still make ends meet."

Thus John and his wife began several months of confrontation over his accepting the chance to work with a dog again in the new town. Now not only was the workplace exceedingly unhappy for John, but for the first time in seventeen years of marriage, home had become a place of confrontation and tension. After several months of constant debate at home over whether or not to relocate to the new city, and simultaneously operating under closer and closer administrative scrutiny due to his deteriorating police performance, his wife finally gave in, saying "If the only way I can keep this family together is to move to that town, then I guess we just have to go."

John and his wife sold their home, where they had lived for sixteen years, transferred the kids to a school district of questionable quality, and attempted to re-create a new life in an isolated part of the state away from

friends and family. The state in which the family lived had statewide certification for peace officers and a statewide public safety retirement system, so his retirement rights were intact. John continued to work toward his last four years of a police career.

Shortly after arriving in his new department, John found the grass was not always greener on the other side. His old friend the chief required all officers to undergo a field training program. John was assigned a field training officer who had approximately two years of police experience. Although John was typically an easygoing and open-minded individual, he found the young officer's habit of personal editorializing about officer safety more than he could bear on a daily basis. John soon began getting into confrontations with this young officer. This was reflected in his daily evaluations and eventually brought John to the attention of his old friend, the chief.

The chief attempted to counsel John by saying "John, look. Just go through the field training program. Learn how we do business here, and as soon as you're through the program, we'll start working on your getting a canine unit up on the streets."

To this, John responded. "I thought I was gonna work a dog as soon as I got here." The chief advised him at this point that his canine unit would not be funded until the next fiscal year—approximately seven months away. Feeling angry and betrayed, John confronted the chief. "You brought me way the hell up to this Godforsaken spot by telling me I could work the dog. Now you're saying I can't have one for seven months. That's b.s."

Soon John was given the choice of conducting business the way the chief wanted or finding employment elsewhere. John went home and advised his wife that they were leaving the town after only two months. His wife responded positively, believing that they were returning to their old city where John had rehire rights inasmuch as he had given notice to his former employer.

John responded, "I'm never going back there to work for those assholes even if I only had four days, not just four years." John quit his job and found employment in a twenty-man police force, again at the opposite end of the state. This time he traveled to his new employment without his family; his wife elected to return to the city where his police career had begun. John found himself divorced, two hundred miles away from his children. At first he saw them every other weekend, but as the months passed he visited less and less frequently. John became involved in a live-in relationship with a dispatcher who worked in his new department.

After a year and a half working as a canine officer in the new department, a new mayor and city council were elected. The day they were sworn into office, they terminated the chief of police and the entire police force,

including John. Now, at forty-one years of age, with eighteen years toward a twenty-year retirement within the state, John found himself with high blood pressure and impaired vision, and unable to pass a required preemployment physical for state law enforcement officers.

Two years away from retirement eligibility, John went to work as a security guard in a power plant 300 miles away from the city where he practiced law enforcement for sixteen years. He began to drink excessively and became a hostile, cynical, and emotionally broken man.

John's case can be considered a tragic consequence of the police stress cycle and a prime example of how vulnerable a police officer becomes if he welds his sense of self-worth to his police role—a role he himself does not control. Obviously John lost perspective along the way by overinvesting in his role as a canine officer. More important, he also lost a wife, a day-to-day relationship with his children, a satisfying police career, and ultimately his retirement. How in a little less than two years did a satisfied, enthusiastic, happily married police officer become an angry, cynical, depressed, alcohol-abusing individual who, in all likelihood, will never realize a police retirement and who, without professional counseling, will not be able to put the pieces of his life back together?

By studying John's case, average cops can learn the tragic consequences of law enforcement overinvolvement, the consequences of the "brotherhood of biochemistry." It's important to step back from John's case and point out where he made mistakes that average cops unfortunately often replicate with little, if any, awareness of their own vulnerability.

If you were a friend of John's, what would you have advised him to do along his downward spiral and career-ending decisions? Would you have told him to just go along with the captain and cross-train the bomb and dope dogs, knowing that it would yield a dog that was unserviceable? Would you have told him to just bear it the next four years? Do it by "standing on your head" if you had to, just complete your four years? It won't do any practical good for John, or any other police officer, to point out that the captain who ordered the training was "an asshole" or that the chief of the small town who promised John an immediate position as canine officer and then reneged, was also "an asshole." It won't help to blame the mayor, city council, and all the registered voters who ousted the chief and all his officers, for John's misfortune.

Somewhere during this tragic cycle, John should have taken control of his life and assumed personal responsibility. John is like a large number of other law enforcement officers heavily invested in the police role—highly vulnerable because he had placed all his eggs in the basket marked "canine officer"—in a basket held by someone else. In John's case the basket was held

by a captain who, in all likelihood, was not highly competent. Nonetheless, when the basket fell, John and his family sustained the damage—not the captain.

What would you have told John? Would it have helped to tell John to start putting some eggs in a basket marked "John and family"? Maybe John, his wife, and the children could have started an independent canine training service. Perhaps John could have channeled his enthusiasm into other aspects of life that the police department did not control.

John was a victim of police stress because he, like other victims, had no control over his fate. Police officers who overinvest in their police role, no matter how benevolent their intentions, run the risk of becoming another "John." How often have competent, enthusiastic officers had a positive productive career changed by a transfer, a demotion, a loss of status or prestige in the department? Whom do those officers turn to? Because of the job's biological roller coaster, they have failed to develop a personal life. Where do the officers escape to? Where do they feel in control? It's obvious that the police department controls the police role. If officers have abdicated a personal role, where do they find emotional serenity, peace, and tranquility? They don't. Instead, with other burned-out cops, they find camaraderie and shared cynicism and hostility toward the police department. Although John's case is a tragedy, it's by no means an isolated example.

## Overcoming the Brotherhood

The first step in helping officers to achieve emotional survival is to teach a "proactive life-style." "Render onto Caesar the things that are Caesar's," but take the reins of your life fully in hand and develop a personal life. For most police officers, this requires a written, preplanned personal master calendar that the family keeps posted someplace visible and central to the family. Often it is put on the refrigerator with magnets. This preplanned master calendar permits the family to put *in writing* several things each week that they can look forward to. These activities do not require significant expenditures. Bowling, walks, physical exercise, or even quiet time to read can give officers control over at least one aspect of their lives. Usually it's this block of time, the off-duty time, that young officers throw away so haphazardly. Many officers will view the suggestion of attempting to develop a proactive personal life with uncertainty and rationalize away any possibility of doing so by statements such as "Yeah, every time you plan something, some jerk down at

the department's gonna call you back," or "I took a vacation once and when I came back I was transferred." Many times these rationalizations are true, but does this require a police family to surrender control of its own time? If they make the fatal mistake of giving up control, they're surrendering to the role of victim.

Police officers who plan together with their families have a proactive, self-controlled life-style that gives them something to look forward to each day, no matter how small the event. While a certain percentage of these plans are going to be canceled by call-outs, court dates, and overtime, the majority will take place if officers plan them.

Without proactive planning for a personal and family life to break the stress cycle and roller-coaster ride, many police families find themselves not looking forward to "doing things" but rather to "buying things." These police families find themselves purchasing new cars, guns, and other "large-ticket items." It sure feels good to buy a new car! Every sense, every process is stimulated. The feel of the seats, the steering wheel, the smell of the car is all very stimulating—somewhat like the upper highs of the biological roller coaster. However, these buying highs are short-lived. After the novelty wears off, the payment lingers on. Police families who do not plan things to do typically tend to buy impulsively. Thus the biological roller coaster has some very definite drawbacks in the world of impulse economics. The second major element to emotional survival for a police family is to recognize and satisfy the intense need for physical exercise. Selling physical fitness programs to cops certainly is not one of the easiest undertakings. Many an older street cop responds to the suggestion of jogging with cynical statements, such as "If they want me to run, why did they give me a patrol car?" However, physical fitness is an officer's number-one means of breaking the deleterious impact of the biological roller coaster. The downward side of the ride and the resultant off-duty depression is the body's way of attempting to metabolize adrenaline-related stimulants that are produced during the on-duty "high." Fuels that are not metabolized through exercise will typically lead to explosive outbursts of anger and hostility at home. "The flying toaster and small appliance syndrome" is the label given to these outbursts of anger that occur in police families due to the combination of both sedentariness and unresolved anger and hostility.

The old military expression "The more you sweat in peace, the less you bleed in war" suggests that regularly scheduled exercise is one way of beating the cycle of stress-related depression. It also gives police officers the capacity to practice biological "officer safety" effectively on a daily basis, thus maintaining a balanced sense of alertness on duty.

The extreme physical and emotional swings initiated by the biological

roller coaster result in shortened life expectancy. Repeatedly, studies demonstrate that police are more susceptible to injury and death from stress-related breakdown than from any other factor. In the civilian population, 55 percent of all deaths are attributable to heart disease. Among police officers, the three leading causes of nonaccidental disability retirements are heart and circulatory disease, back disorders, and peptic ulcers.

Police work can not only be survived but can offer a rewarding career of service to others. However, individual officers must assume responsibility, through self-motivation, to seek the necessary attitudinal change. It is essential for police officers to have a systematic program of physical exercise, not only to break the stress-related cycle, but to provide what cardiologists label "cardioprotective resistance."

Cops need to have a self-initiated regular period, approximately thirty to forty-five minutes per day, of aerobic exercise—rhythmic and repetitive exercise that places emphasis on the exchange of oxygen and carbon dioxide and not on the development of musculature (like weight lifting). Cops who exercise feel a greater sense of self-satisfaction and control over their own destinies. There are days when officers come home from work and don't feel fit to rejoin the human race. Anger, hostility, and the desire to just "sit in front of the tube and pop a cold one" dominate all other thoughts. Taking a half hour to work out physically increases their sense of self-worth, self-esteem, and physical well-being. Average cops may agree with the benefits of physical exercise, but their problem is "How do I find time to do it? I'm already stretched thin." This is where they should go back to step one in our tips for officer emotional survival and schedule a time *in writing* on the calendar.

Biking, jogging, walking, and swimming not only permit officers to have some energy left for a personal life but also lead to lower physiological thresholds under stress that produce better decisions in those life-and-death situations police officers have to face.

The third element of emotional survival that police officers and their families need to build revolves around the development of other alternative, nonpolice roles. Police officers who, for the first several years of their career could not get enough of police work, unfortunately become those who do not have a personal life, nor do they know how to develop one. The novelty of cop work has worn off, yet there's no well-developed, balanced personal life to fall back on to recharge the batteries. The contrast between the following two case histories emphasizes the value of developing a personal, balanced life-style.

*Case Example.* James Martin was a nineteen-year veteran on the day he was killed in the line of duty. When officers were dispatched to his residence to

notify his wife and two teenage daughters, they were met with the predictable reactions of emotional devastation that comes with the news of hearing that your loved one will not be returning. The officers on this particular call, after providing whatever support they could to the family, found it necessary to use the telephone. When they approached the telephone, they found taped on an index card under the kitchen telephone the message, "This is a career, not a crusade." Months later when the officers followed up to see how the family was doing, the index card was still taped below the telephone. They asked the officer's widow what the card meant. She responded: "He loved being a cop and he was very good at it, but he had seen so many of his friends become obsessed with police work and how it cost them their families. We vowed never to let that happen. He loved putting bad guys in jail and he loved being a cop, but he also loved being a husband and a father. We always found time to have our time together. We might have had our Christmases on December 26 or Thanksgiving dinners on Saturday, but we always had them. We never surrendered being a family. I miss him very much. But I can look back and say we had a good life together."

It's obvious that this family planned for time together and that the officer had developed other interests. Although this officer tragically lost his life in the line of duty, he left behind an emotional legacy of two children and a wife who not only share the pride of having been a police family but the love of having been a functioning, caring family unit. Police work does not always need to take control of family time.

*Case Example.* Not all stories have the same ending, however. The author (KG) while visiting another city to conduct police training, was approached by the police chief of a nearby small law enforcement agency and asked to become involved in a situation concerning one of their officers who was terminally ill. Initially the author thought the request was to provide some psychological assistance to the officer. However, the chief advised that the difficulties were not with the officer himself, but with his son. The problems revolved around the fact that the son, who was twenty-three years of age, had not spoken with his father since he was eighteen, when he left the house under significant family strain. The chief further advised that he himself had approached the young man and found him totally unwilling to even consider speaking with his father, who wished to make peace with his son. The chief angrily expressed his feeling that the son was being unreasonable ("This kid's some kind of an asshole").

The author was requested to approach the son to negotiate some sort of peace between him and his terminally ill father. The following day, the author met with the young man, telling him that he (the author) was there in his capacity of police psychologist to talk with him about his father. The boy

interrupted: "You're here to tell me my dad's dead, aren't you?" The author's response was "No, I'm not. But you really ought to go see him." This impulsive, highly directive statement resulted in an angry response. Immediately the young man shouted, "You have no right to come here and tell me what the hell I ought to do. You don't know anything about the situation. Why don't you just leave!" When the author requested him to explain why he was so unwilling to see his father and attempt to reach some form of final understanding, the young man stated: "Do you know how many times my father ever came to watch me play football in high school or wrestle? I'll tell you. Not once! Do you know how many times he attended a Cub Scout meeting or a Boy Scout meeting or a Little League game? Not once! The only thing I can remember about my father when I was growing up was that he was never home, and he was always angry. If I stepped out of line, I was told that I was going to grow up to be just another one of the little assholes that he sees everyday."

The young man ventilated his hostility, adding that he saw no reason to go into town to visit his father. He said he felt sorry for his mother and would come back to town to help her after his father passed away. The author attempted numerous strategies to get this young man to rethink his position.

For two hours the son continued to express his feelings that the time for creation of some relationship between him and his father had long passed. It became obvious that this young man remained adamantly entrenched in his position and was not going to contact his father. When the chief of police was advised that the officer's son would not go to see his father, the chief expressed anger and hostility toward the young man. The chief described the officer who was dying, saying "I've known him for over twenty years. He's one of the best cops I know, just a fine human being. I'll give you an example of what kind of man he is. There's not a family in our town here who, at Thanksgiving, goes without a food basket, and that's because he almost single-handedly coordinates this program. At Christmas he receives the names of needy families from the schools and welfare offices, and he sees that each family has a food basket and each child has a toy under the Christmas tree. He's active in our bicycle safety program and in the school resource program." As the chief was speaking, it became obvious to the author that he was describing an entirely different man from the one the son had. The chief was describing a life that he had shared with this officer at the upper reaches of the biological roller coaster where the officer was involved—participating in activities and enthusiastically sharing his life with those around him. The officer's son, however, was describing a life spent at the lower reaches of the biological roller coaster—an apathetic, disinterested, emotionally detached, angry father. It was apparent that the chief of police and the officer's son

were speaking about two entirely different people psychologically. The tragedy of this second case history is that the son never did travel to the hospital. The officer died, and the son probably looks back on his deceased father with a very different emotional legacy from those of the children of our officer whose professional and personal credo was "This is a career, not a crusade."

## Summary

If law enforcement officers are to survive the "brotherhood of biochemistry," they must look at both their on-duty and off-duty life-styles and take charge of the events in their lives that they can control. Proactive goal-setting, an active aerobic exercise program, and nurturing and developing other roles in life besides the hypervigilant police role should enable officers to manage their life-style more effectively. To survive police stress, officers need to know what they can control and to surrender what they cannot control. Their emotional and physical well-being requires them to take a realistic review of their day-to-day life-style and to make whatever alterations are necessary to ensure a well-balanced, healthy personal life.

# EFFECTIVE PEER SUPPORT . . .
## Knowing How To Listen

In law enforcement, the verbal skills honed from the earliest part of a career usually revolve around interrogation and fact-finding listening. An officer's first function is not to be an empathetic listener, but to obtain information that facilitates public safety. In Peer Support, the officer needs to learn a new listening skill based on empathy and sharing. These skills can be broken down into three areas: (1) Making contact, setting the stage and developing rapport; (2) Facilitative and empathetic listening, and (3) Taking action and problem-solving.

### I. MAKING CONTACT, SETTING THE STAGE AND DEVELOPING RAPPORT.

The first step in being an effective Peer Supporter/Counselor is meeting with the co-worker in what can be a stressful, embarrassing or anxiety-laden situation. It is quite important that the Peer Counselor is able to create a non-threatening, safe and non-judgmental setting in which the individual can trust another person and feels comfortable to share personal and many times very difficult information. There are certain skills that the Peer Counselor will need to use whenever meeting with a fellow worker. These all into two general categories: non-verbal skills and verbal skills.

A. Non-Verbal Skills

1. It is quite important that the setting in which you meet the counselee is as comfortable and as private as possible. In all likelihood, the Peer Counselor will not be meeting in a formalized office with a scheduled appointment. Coffee shops, restaurants and patrol cars are where the lion's share of peer support takes place. It is important for the Peer Counselor to respect the privacy of the individual seeking his/her services. The counselor needs to be flexible enough to accept any reasonable setting that the counselee feels comfortable within. It is important, if at all possible, that you are able to sit face-to-face with the client; although obviously, that is not always possible. The emotional comfort and feeling of safety is by far the most important variable that the Peer Counselor needs to consider. In choosing the setting, however, it is important that the Peer Counselor take into consideration basic safety issues, particularly if the counselee is dealing with issues such as suicidal behavior. It is also best if settings be selected that cannot be misconstrued or misinterpreted by others or the counselee.

2. In developing rapport, the non-verbal cue of eye contact is quite important to consider. Maintaining eye contact is a significant variable. It conveys interest, concern and understanding. This does not mean that all subcultures interpret eye contact in similar terms. The Peer Counselor has to be sensitive to the nuances of any given situation. Appropriate eye contact does not mean riveting one's eyes on the counselee to the point of creating emotional discomfort. It is quite important that the Peer Counselor be aware of his/her non-verbal behavior. Avoid staring at irrelevant objects, looking out windows or focusing in on issues other than what the counselee is attempting to

communicate. The non-verbal behavior of sitting in a chair, leaning slightly forward and creating the appropriate amount of eye contact can non-verbally communicate to the counselee that your message is important, I want to hear it and I'm here to help.

3. It is quite important that non-verbal and semi-verbal feedback be given while actively listening the counselee. This can be given by nodding one's head, making such semi-verbal statements as "Um-hum" or "I understand", and sharing appropriate facial expressions.

4. Many times from the earliest part of a law enforcement career, interviewing goes along with documentation. As a Peer Counselor, it is quite important that you don't take notes or fidget with irrelevant objects. The counselee should be the focus of the Peer Counselor's attention. When people are in crisis it is quite understandable that they are hyper-sensitive to criticism or rejection, and the Peer Counselor, even by a momentary irrelevant yawn, sigh, looking out a window or fidgeting with an object on a desk, can communicate the message that "whatever you're trying to tell me isn't that important to me." This can be quite devastating to a person who is utilizing the Peer Counselor possibly as a first contact or a last resort.

B. Verbal Behaviors

1. It is important when making contact in a peer support setting that, from the initial contact, the Peer Counselor establish what the realm of liability is for the given setting. Many law enforcement agencies have blanket confidentiality and privileged communication for the Peer Counselor;. However, each particular governmental entity views this variable from a different perspective. Many law enforcement agencies require that confidentiality not be maintained for acts such as crimes where the officer is either confessing or has knowledge of, drug usage or alleged acts of dangerousness to self or others. Almost every state presently has mandatory reporting laws for all health care professionals in areas such as child abuse and child molestation. The Peer Counselor needs to be fully cognizant of the limitations of that confidentiality.

As the session begins, confidentiality issues should discussed and stressed by the Peer Counselor. Usually people in crises are hyper-sensitive, and particularly in work places where individuals work closely together, intimate knowledge of another person can have devastating effects.
It is important that the Peer Counselor have certain verbal skills or "opening lines" that facilitate the conversation beginning. Many law enforcement agencies have found that their hostage negotiators make excellent Peer Counselors in that they are practiced in the ares of effective listening skills as well as approaching people in difficult situations to create rapport. Some Peer Counselors report that the following statements start the ball rolling.

1. "I've known you for ten years, John, and I don't think I've ever seen you dragging as much as you are today, something happening on the home front?";

2. "I heard about your difficulties. If you ever want to grab a cup of coffee and visit, I'd sure be willing to listen.";

3. "The lieutenant said that you've been having a tough time lately. He asked me to look in on you. I'm here if there is anything I can do.";

4. "I hear that fatal out on the interstate was pretty tough. Why don't we get together and talk about it.";

5. "You really look down, like you need someone to listen. Why don't we go after shift and run it down."

Obviously, these comments have to be appropriate to the given setting. The main purpose is to emphasize to the client that you're caring, empathetic and want to help. It is important that once rapport is established and the client feels comfortable, that you learn, as stated above, not only what to listen to, but how to listen. Many people confuse being quiet and waiting your turn to speak with listening. By far the most important skill in a Peer Counselor is **"learning to listen."**

## II. FACILITATIVE AND EMPATHETIC LISTENING

A. For the person coming to a Peer Counselor, many times it's difficult to share emotionally sensitive and personal material. Learning to listen, to gently probe and to provide feedback is exceedingly important. The listener needs to be actively engaged in facilitating the counselee in sharing the material without barraging them or interrogating them. One of the first skills in this area is parroting. This often refers to selecting one word that appears to be central to a given sentence or thought and reflecting it back to the counselee. Typically, it's a word that carries some emotional valance, but not always.

For example:

Counselee: "I was really down today. It's been a year since Jim was killed."

Counselor: "A year?" or "Really down?"

The purpose of parroting is to clarify either the emotion being expressed or the content of the material.

B. Reflection of Content

This technique is similar to parroting except instead of selecting a single word and echoing it to the counselee, the Peer Counselor chooses a "Reader's Digest version" or gist of the material and gives it back to the counselee to show that they are following what the person is saying and that they understand what is being expressed. This has the purpose of facilitating and keeping the flow of information and sharing taking place.

For example:

Officer: "I don't know. I didn't think it would be this hard. I put my mother in a nursing home because she just can't take care of herself any more. Dad's been gone about five years. I go over to the house, she's not eating, the house looks like something down in shanty town anymore. And I don't think mom can take care of herself. I thought that at least at the nursing home she'd be taken care of and fed, but damn I really feel like shit putting my mother in that place."

Counselor: "Sounds like you're feeling really down about what you felt you had to do for your mom."

When first looking at this technique, it seems awfully artificial and simple minded; however, when it's done effectively it provides the officer who is attempting to share a difficult piece of emotion with the feedback that you are following what they're saying and that you're on the same track. As this technique is practiced, it doesn't seem as contrived to the Peer Counselor and becomes second nature. It's important that the reflection of content be done in a natural and non-disruptive manner. Many times the material presented is emotionally-laden either with tears or anger.

Officer: "Things at home just haven't been going real well over the past two years. I thought we'd be able to work them out. But I think my husband is screwing around with one of the female officers on his shift. I've been married to him for ten years, we're both cops and I know what it's like. I haven't screwed around on him, but I'm getting all kinds of anonymous phone calls right now and it's driving me crazy."

Counselor: "You really feel your husband is seeing somebody else? That's a tough thing emotionally to look at."

In reflecting the content of a given statement, it's important that brevity be used and the purpose is only to keep the officer flowing in the sharing process and giving feedback that you're not getting out in left field and misunderstanding what they're sharing with you. The reflection of content is only an aid to help the officer communicate, it's not an end in itself. It's always important as a Peer Counselor to remember "you're going to need your ears a lot more than your tongue."

C. Reflection of Emotion

In mastering this skill, it's important that the Peer Counselor reflect not back only the content of what is shared, but the emotion that goes along with it. This requires some interpretation on the Peer Counselor's part, and many times serves the purpose of helping the officer clarify how they're actually feeling about an emotionally confusing and volatile subject.

Officer: "I've been a cop for fifteen years now. I have at least five years to go to retire. I'm 43. I never see my kids any more. And I've been divorced for two years. There is times I just say to hell with it and really don't give a shit if I see the sun shine the next day."

Counselor: "You really sound depressed and like you're feeling there isn't much purpose in your life right now."

Many times in the reflection of emotion the sharing is at a deeper level than the simple parroting mentioned above. More than the words are listened to and the empathy and sharing processes develop by one officer learning to listen and genuinely care to the emotional message being given by another. Many people think that the reflection of emotion is at the heart and center of the skill package possessed by a good Peer Counselor. It's quite important at this point that the Peer Counselor not be judgmental nor advise the officer that his/her feelings are wrong or in any way inappropriate. Every human being is entitled to his/her feelings. Whether or not we would agree with them is irrelevant. There is no quicker way for a Peer Counselor to destroy rapport and terminate the sharing process than by injecting his/her individual values or emotions into a situation and permitting them to override the emotions being shared by t he counselee. Some key volatile phrases to be avoided at any cost are: "you shouldn't feel that way"; "those feelings aren't really the way it is"; "that's not right".

This is particularly important for the Peer Counselor to tune into, especially in law enforcement environments where personalities, politics and cliques exist as a way of life. By projecting one's own perspective on a situation can either diminish rapport or jeopardize the overall well-being of the officer.

For example:

Officer: "There are times I feel like just reaching up and choking out Lieutenant Smith. He's one of the biggest asshole's I know. For the past five years he's been screwing with me. Every shitty assignment that comes up, I get. I think he's a backstabbing S.O.B. and if I could get out of this detain I'd do it in a second."

Peer Counselor should **NOT** under respond in this manner:

"All you really got to know Smitty he's not that bad a guy. He's like most of us. He's got his good points and his bad point, but once you get to know him he's a pretty decent fellow."

This editorializing by the Peer Counselor on his/her personal beliefs about Lt. Smith is a sure way to give the message that "I don't agree with you and your message and your feelings about Lt. Smith are invalid." It's quite important that the Peer Counselor create an atmosphere in which "unconditional, positive regard and acceptance" is present. This is not meant by any means to say that the Peer Counselor agrees with the feelings of the officer but only that he/she accepts them. Officers many times will "fish" for unconditional acceptance by utilizing such verbal techniques to check out the Peer Counselor's feelings by saying things like "I don't know if you'll agree with me or not but I really think Smith is an asshole" or "I know you might be a friend of his, John, but this is how I feel" or "this might not be right, but this is how I feel." It's very important that the Peer Counselor not inject his/her feelings or attitudes into these situations, particularly in smaller law enforcement agencies where everybody seems to have some opinion or feeling on everyone else.

There are very few times in our life where we have relationships with people where we have "unconditional acceptance or positive regard." It doesn't occur usually on the first setting and is beyond just simple trust. As a Peer Counselor, you'll hear material that is of the most personal and intimate nature. To be effective, you need to communicate "whatever you'd like to share with me, I'm willing to accept it." That's a skill and an attitude that only gets developed after practice. In law enforcement, it's exceedingly important that the Peer Counselor learn to separate his/her personal attitudes and agendas from "unconditional, positive regard."

A good example of this not occurring would be as follows:

Officer: "You know, I think those assholes in the administration do nothing but sit around and jerk us around. It's been so long since those white shirts have done any real police work, I think all they want to do is kiss the butt on the City Council. I'm so fed up with those jerks."

Peer Counselor response should **NOT** be along the lines of:

"Yeah, I know what you mean, I agree with you. Chief Adams is such a jerk. The only reason he got the job was he and the mayor are golfing buddies."

Whether or not as a Peer Counselor you have any given feelings towards administrative personnel, policies or directives, those are kept to one's self and are not injected to contaminate the peer support role. Many times Peer Counselors lose the importance of these situations and use their positions to editorialize or inject themselves into departmental policies, procedures or labor/management disputes. That is **NOT** the role of an effective Peer Counselor.

D. Open-Ended Questions

It is quite important that the Peer Counselor learn to engage verbally with the officer by not barraging or interrogating with close-ended questions that are responded to by one or two word answers, but rather to develop the skill of gently probing and asking open-ended questions that require expanded answers. This, again, permits rapport to be established and facilitates the flowing and sharing process. These "open-ended" questions are usually the most effective for keeping the officer sharing and the communication process going.

Officer: I don't know if they told you about it but I was the officer that was talking to that man last night when he blew his brains out. I've seen lots of dead people in the last eight years, but this is the first time I've ever seen somebody die right in front of me."

Counselor: "Could you tell me more about what happened?"

The benefit of open-ended questions is it permits the person the chance to not only provide more information, but also to facilitate ventilation and expression of the emotions that go along with the information they're sharing. Many times this can be facilitated by just asking the officer "how do you feel about that?" or "how does that sit with you?"

E. Here and Now

This particular technique means keeping the officer gently focused on what is being spoken of at the present time. Many times this is called immediacy. Law enforcement officer particularly will share information, but will intellectualize and editorialize as they're speaking about personal material and need to be gently brought back to the here and now and asked about how they feel about a given subject. Often times initially this is met with denial on the officer's part that they're having any real feelings about it and the Peer Counselor would need to use gentle confrontation to point out that the officer has some emotions, not just information to share.

Example:

Officer: "You know I worked that multiple fatal the other night. It ended up being a triple. One of them was a kid. When I got to the scene, it looked like somebody threw a hand grenade in the cab of that truck. I knew the mother was dead as soon as I got up to it, but I wasn't sure about the child. We got the jaws of life out there and were cutting away for about fifteen minutes before we could get in and the paramedic pronounced them both at the scene. It was one of the worst ones I've had to work."

Counselor: "It sounds like it was a pretty rough call."

Officer: "No, it's nothing that you don't see every day in this line of work."

Counselor: "It sounds like you're having a tough time with it. Sounds like you feel maybe a little guilty that you weren't able to do more for the kid."

Officer: "Maybe, I don't know. You know, working the fatals with kids is always real tough."

Counselor: "Yeah, sometimes they really get to you."

Officer: "I guess it was tougher than I thought it was. I went home last night and really just had this need to call my ex-wife and check on how my kids were doing."

Counselor: "Yeah, I guess it's tough since the divorce not having your kids."

Officer: "You know, I'll tell you, sometimes I feel like a real shit since the divorce. Like I'm screwing my kids up or something. I really love them but I only get to see them on weekends. I wonder if I'm going to screw them up."

Counselor: "I guess you really miss your kids and you really love them."

As you can see in the above example, traumatic or difficult situations many times "piggy-back" or bring out other areas of emotional conflict. To this officer, the multiple fatal accident had not only emotionally traumatic issues to be dealt with, but it brought out emotional pain and difficulties that the officer was possessing in other parts of his personal life. This is where practicing the reflection of content skill mentioned above and being able to follow the emotions that the officer is putting out is critically important.

F. Don't Jump to Conclusions

Many times officers will "test the waters" with a Peer Counselor. This can be a conscious as well as an unconscious maneuver on the part of the officer until unconditional acceptance is created. Officers will come in speaking about "safe problems" such as anger at the boss, "job stress" and "anger", seeing how the Peer Counselor responds. If the Peer Counselor immediately jumps on one of these subjects and believes that is the only reason the officer has sought out the Peer Counselor, the real message can be missed. Sometimes it's the second or third meeting between the officer and Peer Counselor before the "real problem" is put forward. After the "safe" subjects are spoken about and rapport is created, only then can the officer trust enough to put forth the "risky" emotions. Subjects such as spouse infidelity, suicidal thinking, drug usage, child abuse or sexual difficulties will only be approached once the Peer Counselor proves his/her self to be a genuine,

empathetic and accepting listener. There is no faster way to terminate the effectiveness as a Peer Counselor than to stop listening or attempting to structure the conversations with the officer on what the "Peer Supporter thinks is important". It is always important to remember that the officer is of central importance in the peer support situation. It is his/her needs that are being responded to, not what the Peer Supporter thinks his/her needs are.

# ACTIVE LISTENING

## RESPONSE STYLES

| | | |
|---|---|---|
| Evaluate | - | judge, criticize |
| Teaching | - | preach, give information |
| Supportive | - | reassure, encouragement, lecture |
| Probing | - | asking questions, parroting |
| Clarifying | - | paraphrasing, reflecting, questions |

1. First three styles are most frequently used.
2. Last three styles are most frequently helpful.
3. All response styles are helpful at various times.
4. Which style you decide to use depends on what the person needs at the moment.
5. If you use one response style 40% of the time, you will be seen using that style all the time.

## ACTIVE LISTENING

PURPOSE: To show interest and encourage the speaker to continue talking.

HOW: 1. You stop talking
2. Attentive body posture
3. Appropriate head nods ("ah-ha", "ummm...")
4. Think about what they are saying, not about what you are going to say next.

FOUR ACTIVE LISTENING SKILLS:

1. Questions
2. Parroting
3. Paraphrasing
4. Reflecting

## QUESTIONS

PURPOSE: To get more information and to control the conversation. Various types of questions can be asked for a variety of results.

HOW: 1. To get specific details, ask closed questions.
2. To get lots of information, ask open questions.
3. "Why" is the hardest question and may put the person on the defensive.
4. "What" and "how" can replace a "why" question.
5. Asking simple questions put people at east ("Where do you work?"; "Do you have children?").
6. It helps to ask the person's permission to ask questions. It shows respect. When necessary, tell the person that some of the questions may be difficult.
7. You can ask questions as a report taker, or you can ask the same questions as a concerned helper (by body posture, voice tone, etc.).
8. The person asking questions has control of the conversation (helping someone in crisis to get questions answered helps them restore their control.

EXAMPLE:

Officer: "How did you get in his car?"

Victim: "Well, I was late for work so I was hitching a ride and he picked me up."

Officer: "Okey, then what happened?" (open question)

Victim: "Well he drove to an empty lot and I got scared..." (victim tells story)

Officer: "I need to find out some specific things. These questions may be difficult for you. IF you get upset we can take a break, okay?"

Victim: "Okay."

Officer: "Can you tell me, was the gun a revolver or an automatic?" (closed question)

**PARROTING**

PURPOSE: To find out specific information without asking lengthy questions.

HOW: Repeat one word that you want the person to expand on.

EXAMPLE:

Victim: "As soon as I came home, I noticed the broken window and the T.V. missing and that's when I called the police."

Officer: "Broken window?"

Victim: "Yes, it's the window over here in the kitchen. It makes me so angry that it happened again."

Officer: "Again?"

Victim: "Yes, last month Detective Brown caught my neighbor's boy .....

Client: "Yes, I was hurt. I was angry and hurt. These are people I worked hard for. It's been three months and I'm still angry with them."

Helper: "So you're kind of between a rock and a hard spot. If you don't work, you don't pay the rent. If you do work, you risk being hurt again."

Client: Exactly. What if the same thing happens?

**PARAPHRASING**

PURPOSE: To clarify for you and for the speaker. Speaker hears what they are saying to examine if this is what they mean.

HOW: 1. Repeat back a summary of what the person said.
2. Check out if what you understood is correct.
3. If it is correct, help them to continue talking: "tell me more".
4. If you didn't understand, ask them to explain again (they will possibly automatically correct you and you can then go on).
5. It helps to think about what they are and tare not saying while they are talking (what is the music behind the words?). Also, don't think about what you will say next.

EXAMPLE:

Client: "I lost my job, my wife is always yelling at me, and I just can't seem to get it together."

Helper: "You lost your job and there are problems between you and your wife; with all this pressure, it seems really hard to get things back to normal."

Client: "Exactly. Except things with my wife are just like they've always been, so I guess that is normal. I guess the main problem is not finding work."

**REFLECTING**

PURPOSE: To help person clarify and identify their feelings. This helps to diffuse so you can go on to problem solving.

HOW: 1. Listen for feeling words (hurt, angry) and repeat these words back.
2. Check out if this is the feeling they are experiencing and what other feelings they may have.
3. Use metaphors to turn abstract emotions into concrete ways of expressing them.
4. When you guess a feeling, allow the person to say "no, I don't feel angry; I feel hurt.". You don't have to reflect the "correct" feeling to be helpful.
5. Watch body language.

EXAMPLE:

Client: "Ever since I lost my job I don't seem able to motivate myself."

Helper: "So, you're feeling discouraged."

Client: "No, I'm not discouraged, I just don't trust employers."

Helper: "So you were really hurt when they fired you."

# ATTENTIVE SKILLS

A. Pay attention to your present experience (perception - sensing).

B. Look and really see; listen and really hear.

C. Share experience (express perceptions and sensing).

D. Risk saying positive things (love, affection, etc.) as well as negative things (anger, criticism, etc.).

E. Avoid intellectualizing to avoid feeling or experiencing.

F. Avoid asking questions unless sincerely seeking information (most questions are for manipulating people).

G. Don't ask "why", ask "what". ("Why" puts people on the defensive. "What" directs them to their experience.)

H. Don't gossip about someone who is present - speak directly to that person.

I. Notice to whom you are speaking (you may be "broadcasting" without really speaking to anyone).

J. Claim responsibility for your own behavior.

K. Don't lay your thing on somebody else (don't interpret things for others).

L. Don't be "helpful" by trying to do something for somebody that the persons needs to do for him/herself.

M. Allow another person to "cop-out" if they really want to (don't push anyone to do anything they don't want to do).

N. Respect the confidences (secrets) of the group.

# LISTENING TO OTHERS

1. STOP TALKING - you can't listen while you're talking.

2. EMPATHIZE WITH THE OTHER PERSON - try to put yourself in his/her place so that you can see what he/she is trying to get at.

3. ASK QUESTIONS - when you don't understand and when you need further clarification.

4. DON'T GIVE UP TOO SOON - don't interrupt the other person; give them time to say what they have to say.

5. CONCENTRATE ON WHAT THEY ARE SAYING - actively focus your attention on their words, ideas and feelings related to the subject.

6. LOOK AT THE OTHER PERSON - face, mouth, eyes and hands all will help communicate.

7. SMILE AND NOD APPROPRIATELY - but don't overdo it.

8. LEAVE YOUR EMOTIONS BEHIND (if you can) - try to push your worries, your fears and your problems outside the meeting room. They may prevent you from listening well.

9. CONTROL YOUR ANGER - try not to get angry at what the person is saying; your anger may prevent you from understanding words or meanings.

10. GET RID OF DISTRACTIONS - put down any papers, pencils, etc. you may have in your hands; they may distract your attention.

11. GET THE MAIN POINTS - concentrate on the main ideas and not the illustrative material. Examples, stories, statistics, etc. are important, but are usually not the main points. Examine them only to see if they prove, support or define the main ideas.

12. SHARE RESPONSIBILITY FOR COMMUNICATION - only part of the responsibility rests with the speaker. You as the listener have an important part. Try to understand and if you don't, ask for clarification.

13. REACT TO IDEAS, NOT TO THE PERSON - don't let your reactions to the person influence your interpretation of what is said. Ideas may be good even if you don't like the person.

14. DON'T ARGUE MENTALLY - when you are trying to understand the other person, it is a handicap to argue mentally as they are speaking. This sets up a barrier between you and the speaker.

15. USE THE DIFFERENCE IN RATE - you can listen faster than someone can talk, so use this rate difference to your advantage by trying to stay on the right track, anticipate what the person is going to say, think back over what has been said, evaluate development, etc. Rate difference: speech rate is about 100 to 150 words per minute; thinking is about 250 to 500 words per minute.

16. LISTEN FOR WHAT IS NOT SAID - sometimes you can learn just as much by determining what the other person leaves out as you can by listening to what is said.

17. LISTEN TO HOW SOMETHING IS SAID - we frequently concentrate so hard on what is said the we miss the importance of the emotional reactions and attitudes related to what is said. A person's attitudes and emotional reactions may be more important than what is said in so many words.

18. DON'T ANTAGONIZE THE SPEAKER - you may cause the other person to conceal ideas, emotions and attitudes by antagonizing in any of a number of ways: arguing, criticizing, taking notes, not taking notes, asking questions, not asking question, etc. Try to judge and be aware of the effect you are having on the other person. Adapt.

19. LISTEN FOR PERSONALITY - one of the best ways of finding out information about a person is to listen to then talk. As they talk, you can begin to find out likes and dislikes, motivations, value systems, what they think about everything and anything, what makes them tick.

20. AVOID JUMPING TO ASSUMPTIONS - they can get you into trouble trying to understand other persons. Don't assume that they use words in the same way you do; that they didn't say what they meant, but you understand what they meant; that they are avoiding looking you in the eye because they are telling a lie; that they are trying to embarrass you by looking you in the eye; that they are distorting the truth because what they say doesn't agree with what you think; that they are lying because they have interpreted the facts differently from you; that they are unethical because they are trying to win you over to their point of view; that they are angry because they are enthusiastic in presenting their view. Assumptions like these may turn out to be true, but more often they just get in the road of your understanding and reaching an agreement or compromise.

21. AVOID CLASSIFYING THE SPEAKER - it has some value, but beware! Too frequently we classify a person as one type and then try to fit everything said into what makes sense coming from that type of person. S/he is a Republican. Therefore, our perceptions of what they say or mean are all shaded by whether we like or dislike Republicans. At times, it helps us to understand people to know their politics, their religious beliefs, their jobs, etc., but people have the trait of being unpredictable and not fitting into their classification.

22. AVOID HASTY JUDGEMENT - wait until all the facts are in before making any judgments.

23. RECOGNIZE YOUR OWN PREJUDICE - try to be aware of your own feeling toward the speaker, the subject, the occasion, etc., and allow for these prejudgments.

24. IDENTIFY TYPE OF REASONING - frequently it is difficult to sort out good and faulty reasoning when you are listening. Nevertheless, it is so important a job that a listener should make every effort to learn to spot faulty reasoning when he/she hears it.

25. EVALUATE FACTS AND EVIDENCE - as you listen, try to identify not only the significance of the facts and evidence, but also their relatedness to the argument.

## POLICE COMMUNICATION
## (at its finest)

A police officer on routine patrol stops a citizen for running a stop sign, the conversation between them goes like this:

Officer: Sir, may I see your drivers license and registration?

Citizen: Officer, what's the problem?

Officer: Sir, you didn't stop for that stop sign back there at the intersection.

Citizen: There wasn't anybody coming.

Officer: But you didn't stop.

Citizen: I slowed down.

Officer: But you didn't stop!

Citizen: What the hell is the difference?!

Officer: Sir, would you please step out of your vehicle.

(The officer proceeds to hit the citizen over the head with his night stick.)

Officer: Now sir, would you like me to slow down or stop?

# FIVE PECULIARITIES OF HUMAN COMMUNICATION

There are five characteristics of human communication that hinder our ability to effectively communicate with and understand other people.

## 1. WORDS MEAN DIFFERENT THINGS TO DIFFERENT PEOPLE

Look up 500 different words in a dictionary and you are likely to find over 2,500 different meanings and/or definitions for those words. In order to effectively communicate, both the speaker and the listener must share a mutual understanding of the words that they use.

## 2. PEOPLE OFTEN CODE THEIR MESSAGES

Most of us have been trained from early childhood to express ourselves indirectly; to code our messages. Decoding is always guesswork and the real meaning of the message is often lost.

## 3. THE PRESENTING PROBLEM MAY NOT BE THE MAJOR CONCERN

People are often reluctant to come directly to the point. Frequently, the things people want to discuss the most are the things that they hide most carefully. Sometimes it's called, "beating around the bush." Solving minor problems while the real, issues are not even addressed is a big source of ineffectiveness in government, industry, schools, families, and other institutions.

## 4. FILTERS DISTORT WHAT PEOPLE HEAR AND SAY AND EMOTIONS ARE BLINDING

Our own expectations, experiences, values, biases, self image, beliefs, ideas, etc. are filters that distort how we hear another person's message. In addition, people are often unaware of their emotions or how they effect their communications with others. Emotions can literally put some people out of control and prevent them from communicating with others.

## 5. LISTENERS ARE EASILY DISTRACTED

People can listen much faster than they talk. When we listen we have a lot of spare time which we usually waste. Poor listeners get off the track and find that they can't catch up with the speaker's ideas.

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# EFFECTIVE PEER SUPPORT DURING CRISIS

## KNOWING HOW TO LISTEN

In law enforcement, many times the verbal skills honed from the earliest part of a career revolve around interrogation and fact-finding listening. The law enforcement officer's first function is not to be an empathetic listener, but to obtain information that facilitates public safety. In Peer Support the officer needs to learn a new listening skill based on empathy and sharing. These skills can be basically broken down into three areas A,B,C.:

**A.** **Achieving Contact**, setting the stage and developing rapport
**B.** **Boiling Down the Problem**: Facilitative and empathetic listening
**C.** **Cope with the Problem**: Taking action and problem-solving.

# ABC MODEL OF CRISIS INTERVENTION

## Achieve Contact

* introduce yourself
* ask permission
* create rapport

## Boil Down The Problem

* presenting problem may not be the issue
* use skills - parrot, paraphrase & reflect
* focus on NOW
* avoid defensiveness
* "What are you most concerned about?"
* most of your time should be spent here

## Cope With The Problem

* client has the solutions
* what do YOU want to happen
* has this happened before, what did you do then
* what are YOU willing to do
* reinforce ideas, give strokes
* how can I be helpful - give resources
* "Yes but, ..." - go back to B

# ACHIEVING CONTACT

MAKING CONTACT, SETTING THE STAGE AND DEVELOPING RAPPORT

The first step in being an effective Peer Supporter is meeting with the co-worker in what can be a stressful, embarrassing and anxiety-laden situation. It is quite important that the Peer Counselor be able to create a non-threatening, safe and non-judgmental setting in which the individual feels comfortable to share personal and many times very difficult information to trust with another human being. There are certain specific variables that the Peer Supporter will need to take into consideration whenever meeting with a fellow worker. These basically fall into two general categories: non-verbal skills and verbal skills.

A. Non-verbal Skills

1. It is quite important that the setting in which you meet the client is as comfortable and as private as possible. In all likelihood, the Peer Supporter will not be meeting in a formalized office with a scheduled appointment. Coffee shops, restaurants and patrol cars are where the lion's share of peer counseling takes place. It is important for the Peer Supporter to respect the privacy of the individual seeking his/her services, and would need to be flexible enough to accept any reasonable setting that the client feels comfortable within. It is important, if at all possible, that you are able to sit in a face-to-face mode; although obviously, patrol cars or lunch counters do not permit this to take place. The emotional comfort and feeling of safety is by far the most important variable that the Peer Supporter would need to consider. In choosing the setting, however, it is important that the Peer Supporter take into consideration basic officer safety issues, particularly if the client is dealing with issues such as suicidal behavior. It is also best if settings be selected that cannot be misconstrued or misinterpreted by others or the client.

2. In developing rapport, the non-verbal cue of eye contact is quite important to consider. Maintaining eye contact is a significant variable. It conveys interest, concern and understanding. This does not mean that all sub-cultures would interpret eye contact in similar terms and the Peer Supporter would need to be sensitive to the nuances of any given situation. Appropriate eye contact is not also to be interpreted as riveting one's eyes on the client to the point of creating emotional discomfort. It is quite important, however, that the Peer Supporter be cognizant of his/her non-verbal behavior and avoid staring at irrelevant objects, looking out windows or focusing in on issues other than the client and the message that he or she is attempting to communicate. The non-verbal behavior of sitting in a chair, leaning slightly forward and creating the appropriate amount of eye contact can non-verbally communicate to the client that "your message is important, I want to hear it and I'm here to help."

3. It is quite important that non-verbal and semi-verbal feedback be given while actively listening to the client. This can be given by nodding one's head, making such semi-verbal statements as "Um-hum" or "I understand", and sharing appropriate facial expressions.

4. Many times from the earliest part of a law enforcement career, interviewing goes along with documentation. It is quite important as a Peer Supporter that notes not be taken, fidgeting with irrelevant objects not take place and that the client be the focus of the Peer Supporter's attention. When people are in crisis it is quite understandable that they are hyper-sensitive to criticism or rejection and the Peer Supporter, even by a momentary irrelevant yawn, a sigh, looking out a window or fidgeting with an object on a desk, can communicate the message that "whatever you're trying to tell me isn't that important to me". This can be quite devastating to a person who is utilizing the Peer Supporter possibly as not only a first contact, but also a last resort.

B. Verbal Behaviors

1. It is quite important when making contact in a peer counseling setting that from the initial contact the Peer Supporter establish what the realm of liability is for the given setting. Many law enforcement agencies have blanket confidentiality and privileged communication for the Peer Supporter; however, each particular governmental entity would view this variable from a different perspective. Many departments require in the law enforcement area that confidentiality not be present for acts such as crimes where the officer is either confessing or has knowledge of drug usage or alleged acts of dangerousness to self or others. Almost every state presently has mandatory reporting laws for all health care professionals in areas such as child abuse and child molestation, and the Peer Supporter would be required to establish this situation as confidential, but at the same time be fully cognizant of the limitations of that confidentiality

2. It is quite important as the session begins that the confidentiality be stressed by the Peer Supporter. Usually people in crises are hyper-sensitive and, particularly in work places where individuals work closely together, intimate knowledge of another person can have devastating effects.

3. It is important that the Peer Supporter have certain verbal skills or "opening lines" that facilitate the conversation beginning. Many law enforcement agencies have found that their hostage negotiators make excellent Peer Supporters in that they are practiced in the area of effective listening skills as well as approaching people in difficult situations to create rapport. Some Peer Supporters report that the following statements start the ball rolling:

    1. "I've known you for ten years, John, and I don't think I've ever seen you dragging as much as you are today, something happening on the home front?";

    2. "I heard about your difficulties. If you ever want to grab a cup of coffee and visit, I'd sure be willing to listen.";

    3. "The lieutenant said that you've been having a tough time lately. He asked me to look in on you. I'm here if there is anything I can do.";

    4. "I hear that the fatal out on the interstate was pretty tough. Why don't we get together and talk about it.";

    5. "You really look down, like you need someone to listen. Why don't we go after shift and run it down."

Obviously, these comments would need to be appropriate to the given setting with the main point to emphasize to the officer that you're caring, empathetic and want to help. It's important that once rapport is established and the officer feels comfortable, that you learn, as stated above, not only what to listen to but how to listen. Many people confuse being quite and waiting your turn to speak with listening. By far the most important variable in a Peer Supporter is **"learning to listen."**

# Boil Down the Problem

B. FACILITATIVE AND EMPATHETIC LISTENING

A. For the person coming to a Peer Supporter, many times it's difficult to share emotionally sensitive and personal material. Learning to listen, to gently probe and to provide feedback is exceedingly important. The listener needs to be actively engaged in facilitating the client in sharing the material without barraging them or interrogating them. One of the first skills in this area is parroting. This often refers to selecting one word that appears to be central to a given sentence or thought and reflecting it back to the client. Typically, it's a word that carries some emotional value, but not always.

For example:

Client: "I was really down today. It's been a year since Jim was killed."

Peer Supporter: "A year?" or "You're Really down?"

The purpose of parroting back a term is to clarify either the emotion being expressed or the content of the material.

B. Reflection of Content

This technique is similar to parroting except instead of selecting a single word and echoing it to the client, the Peer Supporter chooses a "reader's Digest version" or gist of the material and gives it back to the client to show that they are following what the person is saying and that they understand what is being expressed. This has the purpose of facilitating and keeping the flow of information and sharing taking place.

For example:

Officer: "I don't know. I didn't think it would be this hard. I put my mother in a nursing home because she just can't take care of herself any more. Dad's been gone about five years. I go over to the house, she's not eating, the house looks like something down in shanty town anymore. And I don't think mom can take care of herself. I thought that at least at the nursing

home she'd be taken care of and fed, but damn I really feel terrible putting my mother in that place."

Peer Supporter: "Sounds like you're feeling really down about what you felt you had to do for your mom."

When first looking at this technique, it seems awfully artificial and simple minded; however, when it's done effectively it provides the officer who is attempting to share a difficult piece of emotion with the feedback that you are following what they're saying and that you're on the same track. As this technique is practiced, it doesn't seem as quite as contrived to the Peer Supporter and becomes second nature. It's important that the reflection of content be done in a natural and non-disruptive manner. Many times the material presented is emotionally laden either with tears or anger.

Officer: "Things at home just haven't been going real well over the past two years. I thought we'd be able to work them out. But I think my husband is cheating on me with one of the female officers on his shift. I've been married to him for ten years, we're both cops and I know what it's like. I haven't screwed around on him, but I'm getting all kinds of anonymous phone calls right now and it's driving me crazy."

Peer Supporter: "You really feel your husband is seeing somebody else? That's a tough thing emotionally to look at."

In reflecting the content of a given statement, it's important that brevity be used and the purpose is only to keep the officer flowing in the sharing process and giving feedback that you're not getting out in left field and misunderstanding what they're sharing with you. The reflection of content is only an aid to help the officer communicate, it's not an end in itself. It's always important as a Peer Supporter to remember **"<u>you're going to need your ears a lot more than your tongue</u>."**

C. Reflection of Emotion

In mastering this skill, it's important that the Peer Supporter reflect back not only the content of what is shared, but the emotion that goes along with it. This requires some interpretation on the Peer Supporter's part, and many times serves the purpose of helping the officer clarify how they're actually feeling about an emotionally confusing and volatile subject.

Officer: "I've been a cop for fifteen years now. I have at least five years to go to retire. I'm 43. I never see my kids any more. And I've been divorced for two years. There is times I just say to hell with it and really don't give a damn if I see the sun shine the next day."

Peer Supporter: "You really sound depressed and like you're feeling there isn't much purpose in your life right now."

Many times in the reflection of emotion the sharing is at a deeper level than the simple parroting mentioned above. More than the words are listened to and the empathy and sharing processes develop by one officer learning to listen to and genuinely caring about the emotional message being given by another. Many people think that the reflection of emotion is at the heart and center of the skill package possessed by a good Peer Supporter. It's quite important at this point that the Peer Supporter not be judgmental nor advise the officer that his/her feeling are wrong or in any way inappropriate. Every human being is entitled to his/her feelings. Whether or not we would agree with them is irrelevant. There is no quicker way for a Peer Supporter to destroy rapport and terminate the sharing process than by injecting his/her individual values or emotions into a situation and permitting them to override the emotions being shared by the client.

**Some key volatile phrases to be avoided at any cost are:**

"you shouldn't feel that way"

"those feelings aren't really the way it is"

"that's not right".

This is particularly important for the Peer Supporter to tune into, especially in law enforcement environments where personalities, politics and cliques exist as a way of life. Projecting one's own perspective on a situation can either diminish rapport or jeopardize the overall well-being of the officer.

For Example:

Officer: "There is times I feel like just reaching up and choking out Lieutenant Smith. He's one of the biggest idiots I know. For the past five years he's been making my life miserable every chance he gets. Every garbage assignment that comes up, I get. I think he's a backstabbing S.O.B. and if I could get out of this detail I'd do it in a second."

Peer Supporter should **NOT** respond in this manner: "Al, you really got to know Smitty; he's not that bad a guy. He's like most of us. He's got his good points and his bad points, but once you get to know him he's a pretty descent fellow."

This editorializing by the Peer Supporter on his/her personal beliefs about Lt. Smith is a sure way to give the message that "I don't agree with you and your message and your feelings about Lt. Smith are invalid." It's quite important that the Peer Supporter create

an atmosphere in which **"unconditional, positive regard"** and **"Acceptance"** are present. This is not meant by any means to say that the Peer Supporter agrees with the feelings of the officer, but only that he/she accepts them. Officers many times will "fish" for unconditional acceptance by utilizing such verbal techniques to check out the Peer Supporter's feelings by saying things like " I don't know if you'll agree with me or not but I really think Smith is a jerk" or "I know you might be a friend of his, John, but this is how I feel" or "this might not be right, but this is how I feel." It's very important that the Peer Supporter not inject his/her feelings or attitudes into these situations, particularly in smaller law enforcement agencies where everybody seems to have some opinion or feeling on everyone else.

There are very few times in our life where we have relationships with people where we have "unconditional acceptance or positive regard." It doesn't occur usually on the first setting and is beyond just simple trust. As a Peer Supporter, you'll hear material that is of the most personal and intimate nature. To be effective, you need to communicate "whatever you'd like to share with me, I'm willing to accept it." That's a skill and an attitude that only gets developed after practice. In law enforcement, it's exceedingly important that the Peer Supporter learn to separate this/her personal attitudes and agendas from "unconditional, positive regard." A good example of this not occurring would be as follows:

Officer: "You know, I think those morons in the administration do nothing but sit around and jerk us around. It's been so long since those white shirts have done any real police work, I think all they want to do is kiss the butt on the City Council. I'm so fed up with those jerks."

Peer Supporter response should **NOT** be along the lines of : "Yeah, I know what you mean, I agree with you. Chief Adams is such a jerk. The only reason he got the job was he and the mayor are golfing buddies."

Whether or not as a Peer Supporter you have any given feelings towards administrative personnel, policies or directives, those are kept to one's self and are not injected to contaminate the peer counseling role. Many times Peer Supporters lose the importance of these situations and use their positions to editorialize or inject themselves into departmental policies, procedures or labor/management disputes. That is **NOT** the role of an effective Peer Supporter.

D. Open-Ended Questions

It is quite important that the Peer Supporter learn to engage verbally with the officer by not barraging or interrogating with close-ended questions that are responded to by one or two word answers, but rather to develop the skill of gently probing and asking open-ended questions that require expanded answers. This, again, permits rapport to be established

and facilitates the flowing and sharing process. These "open-ended" questions are usually the most effective for keeping the officer sharing and the communication process going.

Officer: "I don't know if they told you about it but I was the officer that was talking to that man last night when he blew his brains out. I've seen lots of dead people in the last eight years, but this is the first time I've ever seen somebody die right in front of me."

Peer Supporter: "Could you tell me more about what happened?"

The benefit of open-ended questions is it permits the person the chance to not only provide more information, but also to facilitate ventilation and expression of the emotions that go along with the information they're sharing. Many times this can be facilitated by just asking the officer "how do you feel about that?" or "how does that sit with you?".

E. Here and Now

This particular technique means keeping the officer gently focused on what is being spoken of at the present time. Many times this is called immediacy. Law enforcement officers particularly will share information, but will intellectualize and editorialize as they're speaking about personal material and need to be gently brought back to the here and now and asked about how they feel about a given subject. Often times initially this is met with denial on the officer's part that they're having any real feelings about it and the Peer counselor would need to use gentle confrontation to point out that the officer has some emotions, not just information to share.

Example:

Officer: "You know I worked that multiple fatal the other night. It ended up being a triple. One of them was a kid. When I got to the scene, it looked like somebody threw a hand grenade in the cab of that truck. I knew the mother was dead as soon as I got up to it, but I wasn't certain about the child. We got the jaws of life out there and were cutting away for about fifteen minutes before we could get in and the paramedic pronounced them both at the scene. It was one of the worst ones I've had to work."

Peer Supporter: "It sounds like it was a pretty rough call."

Officer: "No, it's nothing that you don't see every day in this line of work."

Peer Supporter: "It sounds like you're having a tough time with it . Sounds like you feel maybe a little guilty that you weren't able to do more for the kid."

Officer: "Maybe, I don't know. You know, working the fatals with kids is always real tough."

Peer Supporter: "Yeah, sometimes they really get to you."

Officer: "I guess it was tougher than I thought it was. I went home last night and really just had this need to call my ex-wife and check on how my kids were doing."

Peer Supporter: "Yeah, I guess it's tough since the divorce not having your kids."

Officer: "You know, I'll tell you, sometimes I feel like a real jerk since the divorce. Like I'm screwing my kids up or something. I really love them but I only get to see them on weekends. I wonder if I'm going to screw them up."

Peer Supporter: "I guess you really miss your kids and you really love them."

As you can see in the above example, traumatic or difficult situations many times "piggy-back" or bring out other areas of emotional conflict. To this officer, the multiple fatal accident had not only emotionally traumatic issues to be dealt with, but it brought out emotional pain and difficulties that the officer was possessing in other parts of this personal life. This is where practicing the reflection of content skill mentioned above and being able to follow the emotions that the officer is putting out is critically important.

F. Don't Jump to Conclusions

Many times officers will "test the waters" with the Peer Supporter. This can be a conscious as well as an unconscious maneuver on the part of the officer until unconditional acceptance is created. Officers will come in speaking about "safe problems" such as anger at the boss, "job stress" and "anger", seeing how the Peer Supporter responds. If the Peer Supporter immediately jumps on one of these subjects and believes that that is the only reason the officer has sought out the Peer Supporter, the real message can be missed. Sometimes it's the second or third meeting between the officer and Peer Supporter before the "real problem" is put forward. After the "safe" subjects are spoken about and rapport is created, only then can the officer trust enough to put forth the "risky" emotions. Subjects such as spouse infidelity, suicidal thinking, drug usage, child abuse or sexual difficulties will only be approached once the Peer Supporter proves him/herself to be a genuine, empathetic and accepting listener. There is no faster way to terminate the effectiveness as a Peer Supporter than to stop listening or attempting to structure the conversations with the officer on what the "Peer Supporter **thinks** is important." It is always important to remember that the officer is of central importance in the peer support situation. It is his/her needs that are being responded to, not what the Peer Supporter thinks his/her needs are.

# Cope with the Problem

It is extremely important at this phase that the Peer Supporter realize that he/she does not possess the answer to the problem as the Peer Supporter, but rather the answer is for the client to generate. This can be an extremely difficult concept for many law enforcement type individuals who are used to **"Arriving at the scene and handling other peoples problems".** The course of action is for the client to develop and agree to pursue. This is particularly important because as much as an empathetic Peer Supporter can try and assist and support, **"the problem is still the clients to handle".** A negative or resistant client proves this to a Peer Supporter every time he/she would say, "I tried what you suggested, but it didn't help" or "I talked to him and it didn't help at all". This leads directly to the "Yeah But" game, where the client can try to "put the monkey on the Peer Supporter's back" Any solutions or course of action to solve any problem has to come from within the client with support from the peer. Successful Peer Support means respecting the co-worker's ability to take responsibility for his/her own decision making. Obviously in extreme cases the Peer Supporter would assume a more directive approach. This however is typically not the best solution.

**Remember:**
Client has the solutions
What do YOU want to happen
Has this happened before?, what did you do then?
What are You willing to do?
Reinforce ideas and be supportive
How can I be helpful-suggest resources

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# MAJOR DIMENSIONS OF POST-TRAUMATIC STRESS

## INTRUSION:

Intrusive Thoughts
Intrusive Tactile Sensations
Intrusive Sensory Experiences: Smells, Sounds
Sleep Disturbance
Concentration Problems
Recurrent Themes
Nightmares
Perceptual Distortions

## AROUSAL:

Increased Heart Rate or Blood Pressure when recounting experiences
Spontaneous Emotionality:
Anger
Sadness
Guilt
Blame

## AVOIDANCE:

Events Associated with Incident:
Place
Time
People
Weather
Temperature
Anniversary Occasions
Potential any close emotional relationship or experience

# POST TRAUMATIC STRESS DISORDER

An event that is outside range of usual human experience (markedly distressing to almost anyone).

Re-experiencing event

a. intrusive thoughts
b. flashbacks, hallucinations, repetitive play
c. distressing dreams
d. intense psychological distress (events/symbolize)

Numbness/Avoidance

a. thoughts associated
b. hobbies
c. amnesia
d. estrangement/detachment
e. reduced affect
g. foreshortened future

Physical Arousal

a. sleep disturbances
b. lack of concentration
c. startle reaction (hypervigilance)
d. irritability
e. physiological reactions

Long Term Crisis Reactions

1. Not all victims/survivors have
2. Many experience over long period of time
3. Usually trigger events set off
   a. sensorial
   b. anniversaries
   c. Criminal Justice System
   d. media - similar event

4. "Second Assault" (actions of others)

   a. Criminal Justice System
   b. media
   c. family/friends
   d. clergy
   e. medical personnel

   Can't prevent, but can decrease intensity.

Care Givers

1. PTSD/Long Term Crisis

   a. immune - super human
   b. couch potato
   c. family/friends
   d. schedules

2. Burn Out/Stress

   High achievers burn out & Low achievers get stressed

   a. enthusiasm
   b. stagnation
   c. frustration
   d. apathy

What Helps Others And You . . . Assistance during the first one to three hours of crisis is more significant than help provided later

I. Safety/Security

   a. safe now (if they are)
   b. nurture, don't rescue
   c. take control, then give it back

II. Ventilate/Validate

   a. describe event
   b. describe where you were
   c. describe reactions/responses
   d. validate normal responses/coping reactions

   **"Normal reaction to an abnormal situations"**

III. Predict/Prepare

a. predict trigger events
b. prepare for reactions
c. prepare for dealing with reactions

IV. Education

a. re-establish/maintain hope
b. homework - read/write
c. develop skills (i.e. relaxation, communication, etc.)

V. Helpful Responses

a. "I'm sorry it happened to you."
b. "It wasn't your fault."
c. "Your reaction is normal."
d. "Things can never be the same, but it can get better."
e. Be honest.

# POST-SHOOTING TRAUMA

By Roger M. Solomon, Ph.D.
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The emotional aftermath for an officer who uses fatal force in the line of duty can be traumatic. Though it is difficult to estimate how many officers have left law enforcement in the wake of such trauma, most experts agree that we have lost many good officers in the years following a shooting. However, not every officer involved in a shooting experiences a traumatic reaction. About one-third have a mild reaction, one-third have a moderate reaction, and one-third have a severe reaction (Solomon and Horn 1986; Stratton et al. 1984).

Each officer experiences the emotional aftermath of a shooting in his own way, depending on many factors, such as perceived vulnerability or how life-threatening the incident was; amount of control over the situation; one's expectations concerning shooting situations; proximity (how close or far from suspect); how bloody or gory the shooting was; reputation of the suspect (e.g., murderer vs. scared teenager); perceived "fairness" of the situation (e.g., shooting a person who used the officer to commit suicide is perceived as unfair and produces anger in the officer); legal and administrative consequences; amount of stress in one's life and level of adjustment; personal coping skills; and amount of support.

The following description of the emotional aftermath of the use of deadly force is a general model that applies not only to post-shooting trauma, but to the aftermath of any critical incident (any situation where one feels overwhelmed by his sense of vulnerability and/or lack of control over the situation).

## Phases of the Emotional Aftermath

The traumatic experience starts when a situation puts the life of an officer or another person in danger, and the officer makes the decision to use deadly force. Many physical, psychological and emotional phenomena occur during the brief moments of peak stress, many of which are confusing to the officer.

For example, it is quite common to experience perceptual distortions. About four out of five officers involved in a shooting will experience time distortion (Solomon and Horn 1986). Usually, time slows down and events appear to occur in slow motion. For other officers, time accelerates. Auditory distortions are experienced by about two out of three officers involved in a shooting. For most, sound diminishes. An officer may not hear all the rounds going off or may not be aware of how many rounds were fired. Other officers experience intensified sound—gun shots sound like canons. Visual distortions occur about half of the time. Officers may experience tunnel vision and a heightened sense of detail.

It is important that investigators know how common, and normal, these perceptual distortions are. If an officer's report of how many shots were fired is inaccurate because he did not hear all the rounds go off, if he cannot give a good description of the suspect's clothing because of tunnel vision, or if he says it took five minutes for the shoot-out to conclude when other evidence indicates it only took forty-five seconds, it does not necessarily mean the officer is lying or trying to cover something up. He was probably experiencing the normal, perceptual distortions that commonly occur during moments of peak stress.

The *shock disruption* phase starts when the shooting ends. An officer may experience a few minutes of shock symptoms such as tremors, shaking, crying, nausea, hyperventilation, and so on. These are stress come-down reactions that sometimes occur when a high-impact situation is over, and are not signs of weakness.

Initially, an officer may be dazed, inattentive and upset. There may be a feeling of disbelief or difficulty comprehending the reality or significance of what just happened. It may be difficult to concentrate and to remember details. For a few hours up to a couple of days, the officer may be on an "adrenaline high" and over-stimulated, leaving him tense, anxious, agitated or irritable. This adrenaline high may make it difficult to sleep during this phase.

It is important to remember that the officer will be very sensitive to others' reactions, particularly in regard to whether the department will stand behind him. Being critical (e.g., "What did you do?") can magnify the trauma whereas a supportive response (e.g., "Are you OK?") goes a long way toward calming the officer.

Commonly, part of the shock reaction is that one's emotions concerning the incident, and awareness of these emotions, becomes blunted. An officer may feel emotionally detached and numb, with anxiety occasionally breaking through. There is a tendency to feel one is running on "automatic pilot"—just going through the motions. Indeed, we do not experience the full emotional impact of a critical incident immediately afterwards. Psychological defenses, such as denial, automatically arise to shield overwhelming emotions temporarily. This shock disruption period may last a few minutes, a few hours, a few days, or a week or longer; it is different for each individual, but usually it lasts two to three days. This is why it is important to give an officer administrative leave right after a shooting and not let him go back to the street even if he says he feels all right. He may be experiencing this "denial" of emotion. For obvious reasons, an officer should not be on the street when the emotional impact hits.

Sooner or later, the emotional impact of the situation does hit. The adrenaline high wears off, with the officer perhaps experiencing an emotional and physical letdown, and emotions stemming from the incident surface. This is the next phase, *impact*, which usually occurs within three days, although some officers experience a delayed reaction six months to a year after the incident. During this phase, the officer confronts feelings of vulnerability and mortality stemming from the incident. The more vulnerable an officer felt during the incident, the greater the emotional impact of the situation. Feelings of vulnerability often stem from a perception of lack of control over the situation. An officer may have felt forced to use a weapon when a suspect would not comply with verbal commands, and he may feel angry that he was put in a position of vulnerability where there was no other choice but to use deadly force.

Officers may experience many kinds of reactions during this phase that, although normal, make some officers feel they are losing emotional control or "going nuts." Some of the more common reactions an officer may experience are

- Heightened sense of danger/vulnerability
- Fear and anxiety about future encounters
- Anger/rage
- Nightmares

- Flashbacks/intrusive thoughts of the incident
- Sleep difficulties
- Depression
- Guilt
- Emotional numbing
- Isolation and emotional withdrawal from others
- Sexual difficulties
- Stress reactions (e.g., headaches, indigestion, muscle aches, insomnia, diarrhea/constipation)
- Anxiety reactions (e.g., difficulty concentrating, excessive worry, irritability, nervousness)
- Family problems.

It is important for officers to realize these are *normal reactions to an abnormal situation,* not signs of pathology.

The next phase, which in most cases starts soon after the emotional impact hits, is the *coping* phase. An officer starts understanding, working through, and coming to grips with the emotional impact of the situation. The emotional intensity tends to wax and wane over time, peaking after a couple of weeks, and then starts decreasing. There is often a lot of soul searching during this time. An officer goes over the situation repeatedly and wonders if the right action was taken or if there was anything else that could have been done. If the officer allows himself to work through the emotional impact, and does not try to suppress it and pretend it is not there, he will reach the final phase: acceptance.

The *acceptance resolution* phase is usually reached within anywhere from two to ten weeks, but can take longer. It may even be months before this phase is reached, depending on the situation, the legal/administrative aftermath, the amount of support and the officer's coping skills. Upon reaching the acceptance phase, the officer understands and accepts what happened and what had to be done. There may still be occasional nightmares, flashbacks and the like, but the officer understands the underlying emotions and is dealing constructively with them. With proper support and coping skills, an officer becomes even stronger. Indeed, after coming to grips with one's vulnerability, there is not a whole lot else in life to overcome.

**Situational Reminders**

Even after reaching resolution, and returning to duty, there may be situational reminders that trigger the emotions felt right after the incident. The anniversary of the incident may also trigger these emotional reactions. Going through a critical incident is like "crossing a fence" or losing one's innocence. One knows he is vulnerable, that he may not be able to control a situation, and deadly force may again have to be used. One has to come to grips with this reality; there is no jumping back over the fence.

An officer can get "stuck" going through the trauma process. Some of the signs of getting stuck, that is, not dealing well with the incident, are

- Continuation and intensification of post-incident (impact phase) symptoms
- Excessive stress and anxiety reactions
- Being continually obsessed with the incident
- Increased absenteeism, burn out/drop in productivity
- Increase in anger and irritability
- Overreaction or being over-aggressive
- Underreaction
- Risk taking
- Increase in family problems
- Alcohol/drug abuse.

If an officer who has been in a shooting develops a pattern of work problems (e.g., use of excessive force) he did not have before the incident, it may be a sign of trauma. It is important to refer the officer for some help and not merely administer discipline.

Not all officers experience a traumatic reaction after a shooting. One-third of officers involved in a shooting experience only slight reactions. Are these officers cold-blooded, insensitive people? No. There are several reasons why these officers have little reaction. First, these officers were mentally prepared for the eventuality of a critical incident. They anticipated what can happen, thought it through, and accepted the reality of what they might have to face. Second, some officers are able to maintain an objective, detached point of view and accept the reality of police work and the police role. Third, as a result of coming to grips and working through feelings of vulnerability resulting from previous involvement in critical incidents, an officer may experience little emotional reaction after a shooting. After successfully working though one critical incident, it is often easier to go through another.

On the other hand, if emotional reactions from a previous critical incident have not been worked through, but rather are suppressed, a subsequent critical incident becomes more difficult to deal with. Officers who have a traumatic reaction and suppress their emotions may develop long-term emotional problems, such as post-traumatic stress disorder.

**Administrative Factors and Recommendations**

The investigation of any police use of deadly force is necessary; the hard questions have to be asked and their answers found. However, the stress of the administrative/investigative/legal aftermath can compound the stress of a shooting. It is not unusual for the officer to perceive he is being treated like a suspect and that he is being abandoned by the department. For example, his gun and leather is taken away, which to many officers is like field stripping his identity and giving the message that he did something wrong. He is read his rights, isolated until he can be interviewed, and an old buddy—now a detective—comes to interrogate him. Suddenly, he is the prime suspect in a homicide investigation. There is seldom face-to-face communication with high-ranking administrators, leaving the officer with the impression that the people for whom he works do not care about him. To complete the humiliation and finalize the officer's impression that he is alone and that no one is on his side, the officer is suspended, with or without pay, pending investigation. The term *suspension* implies that the officer was wrong. If the officer has not experienced trauma as a result of the incident itself, it is quite likely that such treatment will precipitate it. Another consequence of such treatment is that it results in alienation from and distrust of the department (Reiser and Geiger 1984; Solomon and Horn 1986).

Although the process described may be appropriate and necessary, there is no good reason to treat an officer in an unsupportive, impersonal manner. There are many constructive things the administration can do to reduce stress and support the officer that do not interfere with or compromise the investigation. The following guidelines have been extensively field tested and found to alleviate much of the stress associated with the aftermath of a shooting, to enable the officer to feel supported, and to reduce the amount of overall trauma. These guidelines have been approved by the IACP Police Psychological Services Section.

1. At the scene, show concern and understanding. Give mental and physical first aid.

2. After obtaining necessary on-scene information, provide a psychological break by getting the officer away from the body and at some distance from the scene. The officer should be with a supportive friend or supervisor and return to the scene only if necessary. This break should be of a nonstimulating nature with discretionary use of drinks containing caffeine, as the officer is already pretty "up."

3. With some officers it is important to explain what administrative procedures will occur during the next few hours and why. This will help the officer realize that the investigation of the incident is standard operating procedure, not a "witch hunt."

4. When the gun is taken as evidence, replace it immediately or as soon as is feasible. This guideline can be modified depending on the circumstances and the officer's level of stress.

5. The officer should be advised to consider retaining an attorney to safeguard his personal interests.

6. Before undergoing a detailed interview, the officer should have some recovery time in a secure setting where he is insulated from the press and curious officers.

7. Totally isolating the officer breeds feelings of resentment and alienation. The officer can be with a supportive friend or a peer who has been through a similar experience. (To avoid legal complications, the incident should not be discussed prior to the preliminary investigation.) It is crucial to show the officer concern and support at this time.

8. If the officer is not injured, the officer or department should contact the family (via phone call or personal visit) and let them know what happened before they hear rumors and receive phone calls from others. If the officer is injured, a department member the family knows should pick the family up and drive them to the hospital. Make sure the family has support (e.g., call friends, chaplains).

9. Supportive face-to-face communication with a high-ranking administrator goes a long way toward alleviating fear of departmental reaction. Administrators are often reluctant to say anything to the officer for fear that their comments may be misconstrued as an endorsement of the officer's action. The administrator does not have to comment on the incident; what is important is to show concern and empathy for the officer.

10. The officer should be given some administrative leave—not a "suspension" with pay—to deal with the emotional impact. Usually three days is sufficient, though more or fewer days may be appropriate. Some officers prefer light duty to administrative leave. Depending on the officer and the circumstances, it may be best to avoid the double-bind situation of the officer going back to work prior to the legal or departmental resolution of the shooting by keeping the officer off the street until the shooting is resolved (e.g., after investigation, grand jury, coroner's inquest, district attorney's statement, etc.).

Other officers at the scene of the shooting should be screened for their emotional reactions and given the rest of the shift off or leave, as necessary, on a case-by-case basis. Often, other officers at the scene (e.g., the officer who shot and missed, the officer who did not shoot, etc.) may experience trauma, sometimes more than the officer who shot the suspect. Supervisors, after a little training, can conduct such screening.

11. For the officer(s) who fired a weapon, there should be a mandatory (to defuse stigma), confidential debriefing with a knowledgeable mental health professional prior to returning to duty. The debriefing should take place as soon after the shooting as is practical, ideally within 24 hours and no later than 72 hours. Fitness to return to duty and/or any need for follow-up sessions should be determined by the mental health professional.

Everybody at the scene, including the dispatcher, should have a debriefing with the mental health professional (which can be done in a group) within 72 hours. Anyone at the scene could experience a significant emotional reaction. The officer(s) who did the shooting may not want

to be included in the initial group debriefing because actually shooting the suspect and going through the investigation create different issues. Follow-up sessions for other personnel may be appropriate.

Peer support team members (officers who have previously been involved in similar situations and received special training) are an asset in assisting the group debriefings and providing follow-up support.

12. The opportunity for family counseling (spouse, children, significant other) should be made available.

13. If an officer's phone number is published, it may be advisable to have a friend, family member or telephone answering machine screen phone calls.

14. An administrator or supervisor should tell the rest of the department, or shift, what happened so the officer does not get bombarded with questions and rumors are held in check.

15. Expedite the completion of administrative and criminal investigations and advisement of the outcomes to the officer.

16. Consider the officer's interests in media releases.

17. Allow a paced return to duty, e.g., riding with a fellow officer the first day or two, or working a different beat or shift if desired.

**Peer Support**

A very effective resource in dealing with critical incident trauma is having a peer support team composed of officers who have been involved in shootings and other types of critical incidents.

Research has shown that peer support is extremely effective in reducing trauma (Solomon and Horn 1986). A critical incident support team is not only theraputically effective, it is cost effective since the department is using its own people. It is important that team members receive specialized training in dealing with critical incident/post-shooting trauma and have professional supervision and backup.

It must be emphasized that not every officer involved in a shooting is going to have a traumatic reaction. It is just as damaging to over-support as it is to under-support. What is important is to demonstrate an attitude of caring for those officers who have put their lives on the line and to treat them as human beings, not suspects.

# Peer Supporter Role in Traumatic Situations

**The following is meant to be a guide for the Peer Supporter working with a co-worker who has experienced a trauma**

## BEING INVOLVED IN A TRAUMATIC INCIDENT

Because of your recent involvement in a traumatic incident, we want to make the following information available to you and your loved ones. We encourage you and those close to you to read and discuss this information.

Traumatic incidents are events which occur outside the range of typical human experience and are significantly distressing to almost anyone. They include such things as a serious threat to one's life, shooting someone in the line-of-duty, serious accidents (auto, airplane, train, etc) serious threat or harm to one's family, the sudden destruction of one's home or community, or witnessing serious injury or death. People who are involved in traumatic incidents experience a wide range of ***normal*** reactions and emotions.

Following a incident, people frequently re-experiencing the event through nightmares, daydreams, flashbacks and/or recurring intrusive thoughts. Wanting to avoid things that remind one of the trauma, feelings of social isolation, or being different from other people and a general lack of interest in the world are also typical; as are tension, anxiety, difficulty in falling asleep, irritability, outbursts of anger, trouble concentrating, or being exceptionally jumpy. After a traumatic event, those involved may or may not experience these reactions and emotions.

It is important for you to realize that your police role ***does not*** automatically immunize you from experiencing these reactions and emotions.

Intrusive thoughts about the traumatic incident can be followed by a host of "what if and if only " versions of the event. If you find yourself doing this, consciously challenge the "what if" and remind yourself that is not what happened. Force yourself to look at the reality of the situation, not what might have been. Remember, there is nothing you can do to change what has already occurred. If you believe you should have done something differently, use it as a learning experience for future, rather than a point to continue "what ifing" about.

The following are some of the typical reactions people experience after a traumatic incident. This is not to suggest that you will experience any of these. Depending upon the circumstances of your incident and your personality, you may or may not experience these reactions. If you have experienced or do experience any of these, remember they are entirely normal.

1. SHOCK

   This generally begins during the actual event and can last for few days or even a few weeks. Shock can be experienced by feelings of confusion, disorganization and an inability to perform simple, routine tasks. It can also be seen in the form of denial, that is refusing to believe that the event is really happening. Although officers, often unconsciously, revert to the techniques they were trained during life threatening situations, denial is commonplace. Officers frequently feel a sense of disbelief when the have to fire their weapon at a perpetrator, and find it difficult to believe that this is actually be happening to them.

2. ANGER and/or ANXIETY
this can be seen through trembling, crying, or feelings of tension, anxiety or outrage. Anger is often aimed at administration, particular policies (such as authorized weapons or ammunition), staffing problems, city leaders, etc.

3. FLASHBACKS & INTRUSIVE THOUGHTS
You may relive what happened at unpredictable times of the day or night for some time after the traumatic event. The flashbacks and intrusive thoughts can come in the form of a nightmare or simply as a vivid waking experience.

4.. TIME DISTORTION
This is a very common event. During the actual event your perception of time may have been altered so that time seemed to slow down. You may feel like everything was in slow motion. Each and every detail may have passed by slowly and can be remembered vividly. People sometimes feel like they are simply observing rather than participating in the event. Then experience tunnel vision where they focus on one aspect of the incident, often to the exclusion of everything else.

5. AUDITORY BLOCKAGE
Not hearing the shots being fired, having the gun sound like a "cap gun," hearing muffled "pops" rather than shots, not having your ears ring, not hearing the siren from approaching backup units, not hearing a helicopter land, etc. etc, are all normal reactions that have been experience by officers during traumatic incidents.

6. "WHAT IF or ONLY IF"
After being involved in a traumatic event, people will frequently go to great lengths to invent different scenarios, ignoring the actual facts and outcome of the trauma. "If only I'd been five minutes earlier..." "If only I had reacted more quickly..." "If only I had suspected what he intended to do..." If not dealt with, this can last indefinitely, as the officer imagines more and more elaborate "what if or if only" stories. "What if and if only" scenarios go hand in hand with intrusive thoughts and flashbacks. The more thoughts and flashbacks the person has, the more "what if and if only" versions they tend to create.

7. FEAR OF LOSS OF EMOTIONAL CONTROL
You may begin to feel that you are "losing it", that your are never going to get over the initial shock of the incident and that you are going to be emotionally crippled for life. This is a common and normal reaction.

8. HEIGHTENED SENSE OF DANGER
This often occurs after a shooting incident. Relatively innocuous situations seem to have a greater potential for danger than they ordinarily would. Feelings of paranoia and anxiety are often greatly increased.

9. SORROW AND GUILT
Even if there was absolutely nothing else you could have done, you may still feel sorrow and guilt at having done what you had to do under the circumstances. These feelings of guilt and sorrow are very common. NO matter how irrational they may be, you may have a tendency to say to yourself "If only I had done....."

10.. EMOTIONAL NUMBING
This is a common defense against trauma. You may experience an apparent lack of feeling that is designed to protect you from feeling anything. You may begin to feel that life, at this point, is too terrible to risk confronting it head-on. It may seem easier to suppress all feelings and live "at the surface" so to speak.

11. INTENSIFICATION OF EXISTING PROBLEMS
For example, if you were having marital problems prior to the traumatic incident, or were beginning to deal with losing some of your youthful vigor, the incident might intensify these problems and force you to deal with them sooner than you might have done ordinarily.

12. TEMPORARY IMPOTENCE
Occasionally there is a temporary loss of sexual drive and/or virility. This may further tend to traumatize you and should be seen as a not uncommon side effect.

13. EATING PROBLEMS
This usually manifests itself in the form of a lack of appetite and is similar to the lack of appetite for sex.

14. PSYCHOSOMATIC SYMPTOMS
These could manifest themselves in physical symptoms which are caused by the psychological stress resulting from the traumatic incident. Included are such things as ulcers, asthma, high blood pressure, backaches, heart problems, etc. **It is extremely important that you get medical check-up if you experience physical symptoms.**

15. SURVIVOR GUILT
You may develop guilt feelings of the death of your partner or other officer by thinking "I'm responsible because I did (or did not do)....." when in reality you did what you had to do, or could do, or what anyone else would have done under the circumstances.

16. SELF-MEDICATION
People who experience recurring thought intrusions, flashbacks and anxiety can find ways to self-medicate in an attempt to alleviate the symptoms or stop the hurt, confusion, or numbness. When this happens, alcohol and drug usage can become a serious problem. A less obvious but very common method of self-medication comes in the form of thrill seeking. Some people try to get relief from their unpleasant symptoms through an adrenaline rush, such as suddenly pursing high risk activities (such as parachuting, driving motorcycles or rock climbing), getting into high risk and dangerous situations, or get involved in other destructive behaviors (gambling, prescription drug abuse, sexual promiscuity, etc). These forms of self-medication can prove to be disastrous to both the individual and to a close relationship such as a marriage.

We have attempted to describe some of the normal reactions to abnormal situations. Again, we must remind you . . . you may experience one, none or a combination of them. Please understand, there are ***common and normal.*** If you can relate to any of these, it does not mean you are "losing it" or "can't handle it." Although they may not readily talk about it, officers from around the country who have become involved in traumatic incidents experience these same responses.

You know that all incidents like the one you were involved in require a criminal and/or administrative investigation and inquiry. This takes place in all similar incidents and you are not being singled out. You may read things in the newspaper, see things on TV or hear things on the radio that upset you. Take it with a "grain of salt." Media reports are frequently inaccurate, biased or sensationalized. They do it with everyone else and you can expect they will do it with you.

Your co-workers may say things about the incident that upsets you. Remarks, such as "Good shooting deadeye!" "Why did you have to fire so many shots ?" " Can't you shoot?" "I'm glad you got that SOB!" etc., etc., etc. may bother you after an incident. Friends, acquaintances, neighbors, etc might avoid or not talk with you after you incident. This can be quite disturbing. In most cases your co-workers, friend and acquaintances are not trying to be insensitive or get to you, they don't understand what you are going through, they don't know what to say or are very uncomfortable. Try not to take these remarks personally.

We have put this information together to help you and your loved ones deal with the aftermath of a critical incident more effectively. This information is designed to supplement the debriefing you received.

# Critical Incident Stress Debriefing (CISD)

## Initial Phase . . . Nature and Limitations of a Critical Incident Stress Debriefing (CISD)

1. Team Member Introductions (Name & Background)

2. Purpose
   a. Not Therapy
   b. Discussion about an event
   c. Information and strategies of normal reactions to abnormal situations

3. Reassure Positive Outcomes . . . talk does help

4. Ground Rules and Limitations
   a. Confidentiality . . . what is said in the group, stays in the group
   b. Not a performance critique, but rather a discussion about reactions
   c. Avoid discussing what could compromise the investigation or what could incriminate yourself
   d. No people that do not belong
   e. Participation . . . may choose not to speak during debriefing, but must let team know if help is needed
   f. No breaks
   g. No notes or recorders
   h. Turn off radios, pagers, cell phones, etc.

## Introductions and Fact Phase . . . Factually Recreate Event

1. Introduce yourself and tell the group where you were, what you were doing and what your role was

2. Speak only for yourself

3. Upon your arrival, what did you . . . see, hear, smell?
   a. Deal with senses
   b. Acknowledge, validate and reassure

## Thought Phase . . . Exploring First Thoughts About the Event

1. Time of "Oh my God" or "Aw Shit"

2. Sample Questions
   a. What was your first thought upon arriving at the scene?
   b. When did you realize you were thinking about the event?
   c. Did you ask yourself how this could of happened?
   d. Who were you most concerned about?
   e. Did you feel the need to blame anyone or anything?

3. Acknowledge, validate and reassure

## Reaction Phase . . . Exploring Difficult/Uncomfortable Experiences About the Event

1. Picture of the "replay button" image (Generational examples: Pearl Harbor, JFK, Challenger ect.)

2. Feelings about this

3. Sample Questions
   a. What mental picture do you have of the scene?
   b. What was the most uncomfortable or difficult aspect of this incident for you?
   c. In what way has being involved in this event changed your life?

4. Draw feelings from the mental picture

5. Acknowledge, validate and reassure

6. Offer possible reactions (shock, fear, guilt, anger, sadness, relief, etc)

7. How they felt then and how they feel now

## Symptom Phase . . . Exploring Personal Responses

1. Sample Questions
   a. How did you know this event was different for you than other events?
   b. What did you experience then?
   c. What have you experienced since?
   d. What are you experiencing now?

2. Acknowledge, validate and reassure

3. Explore physical, emotional, cognitive and behavioral symptoms

4. Prompt from symptom checklist (next page)

5. Legitimize both personal and group symptoms

## Teaching Phase . . . Normal Reactions to Abnormal Situations

1. Stress reactions and what can be done to relieve them

2. Invite questions

3. Provide related information
   a. Possible after-effects
   b. Eat, sleep, exercise, talk and normal routines
   c. Spend quality time with family, friends, etc.
   d. Avoid sugar, caffeine, alcohol and drugs

## Wrap-Up

1. Questions

2. Reassurances

3. Plan of Action

4. Anyone with strong symptoms or need to talk further should let team know for follow-up, we are available for one-on-one support

5. Is there anyone who needs to say anything to anyone else before we leave?

6. Summary statements from team
   a. Re-emphasize confidentially issues
   b. Start comments with junior-most team member
   c. Handouts if you have them

# Suggestions for Using Empathic Listening Behaviors

➢Imagine yourself in the other person's position (empathize).

➢Be aware of the other person's body language. What is it telling you?

➢Be aware of your own body language and what it may be telling the other person. Encourage the other person by maintaining eye contact and other non-verbal behaviors that indicate you are listening.

➢Relax and listen for feelings as well as content. Use your intuition to read between the lines.

➢Be patient . . . allow the other person to express their thoughts in their own way. Don't give in too quickly to your discomfort with silence.

➢Do not be afraid to interrupt to clarify or summarize what you have heard.

➢Do not jump ahead to complete the other person's sentence . . . you may be making an erroneous assumption

➢Be aware of your emotional response to what you are hearing . . . it will affect how well you understand and how you respond.

➢Focus your energy and attention on what is being said to you, not on what you want to say next . . . remember, real listening is not waiting for your turn to talk, it is seeking understanding before being understood.

➢Pause a few seconds before giving feedback or answering a question . . . take time to think about what was said.

# Symptom List

| PHYSICAL SYMPTOMS | EMOTIONAL SYMPTOMS | COGNITIVE SYMPTOMS |
|---|---|---|
| Loss of Appetite | Anxiety | Memory Loss |
| Fatigue | Fear | Anomia (inability to name objects) |
| Nausea/Vomiting | Grief | Decision-Making Difficulties |
| Muscle Tremors | Guilt | Problem-Solving Difficulties |
| Twitches | Depression | Confusing Trivia with major issues or items |
| Shock Symptoms | Hopelessness | Difficulty Concentrating |
| Profuse Sweating | Irritability | Loss of Attention Span |
| Chills | Anger | Calculation Difficulties |
| Dizziness | Overwhelmed | Flashbacks |
| Gastro-Intestinal Upset | Identification with Victims | Suicidal Thoughts |
| Sleep Disturbances | Moodiness | |
| Breathing Difficulty | Frustration | |
| Heightened Startle Responses | Suspiciousness | |
| Restlessness | Apathy | |
| | Sadness | |
| | Confusion | |

## REVISED IMPACT OF EVENT SCALE

On _____ experienced _____.

Below is a list of comments made by people after stressful life events. Please check each item, indicating how frequently these comments were true *DURING THE PAST SEVEN DAYS*. if they did not occur, please make the "not at all" column.

| | | NOT AT ALL | RARELY | SOMETIMES | OFTEN |
|---|---|---|---|---|---|
| 1 | I though about it when I didn't mean to. | | | | |
| 2 | I avoided letting myself get upset when I thought about it or was reminded of it. | | | | |
| 3 | I tried to remove it from memory. | | | | |
| 4 | I had trouble falling asleep or staying asleep because of pictures or thought about it that came into my mind. | | | | |
| 5 | I had waves of strong feelings about it. | | | | |
| 6 | I had dreams about it. | | | | |
| 7 | I stayed away from reminders about it. | | | | |
| 8 | I felt as if it hadn't happened or wasn't real. | | | | |
| 9 | I tried not to talk about it. | | | | |
| 10 | Pictures about it popped into my mind. | | | | |
| 11 | Other things kept making me think about it. | | | | |
| 12 | I was aware that I still had a lot of feelings about it but didn't deal with them. | | | | |
| 13 | I tried not to think about it. | | | | |
| 14 | Any reminder brought back feelings about it. | | | | |
| 15 | My feelings about it were kind of numb | | | | |

Intrusion subset = 1,4,5,6,10,11,14; avoidance subset = 2,3,7,8,9,12,13,15

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# The Healing Process

Although the healing precess is very individual and personal, there are some common experiences that most people go through. While this process is natural and normal, it can also be very painful and difficult. Moving through the healing process means acknowledging a painful reality and integrating it into your life in a meaningful way. That may require a lot of time and patience. The following points summarize what we know about the healing process:

1. ***Make a connection between the event and your response.*** The response to trauma may be immediate or delayed, mild or intense. It may include numbness or a strong connection with another event that caused feelings of loss or helplessness. It is crucial to have the support of others and, at the right time, to make the connection between your pain and the event itself. Try to keep from sealing off and suppressing you reactions and feelings.

2. ***Find a safe environment for emotional sharing.*** A very natural human response is to deny or "wall off" the painful reaction to the event. While you may need privacy to deal with events and feelings in your own way and on your own time, you also need to talk about these feelings . . . either with a family member, friend, colleague, or with a counselor or trauma specialist.

3. ***Make an effort to think the event through, either in a group or individually.*** It is important to be able to acknowledge your feelings of sadness, anger, fear, confusion, guilt, etc. If others went through the trauma also, talking about it together can help all of you make sense of what may have been a senseless event.

4. ***Ask the questions that do not have easy answers.*** For example: "Why does it always have to happen to the good guy?" "How could someone do this?"

5. ***Allow memories of painful events in the past to surface, even if you feel that you have already dealt with them.*** Trauma brings back memories of trauma. Although it may seem unfair, an incident can make you remember and sometimes re-experience events that do not usually intrude into your everyday life . . . this is normal. By consciously remembering and re-experiencing these painful events, the memories will eventually recede into the background. The mistake is to push them down again too fast and too soon.

6. ***Examine for yourself, as an individual as well as a member of the group, what this event means for you.*** An example: "As a result of this, we recognize how important we are to one another and how little time we spend communicating. We need to examine our values more closely." This helps encourage acceptance of a new, more difficult reality and the beginning of being able to move on with life.

The healing process does not always proceed in a straight line. You may seem to be recovering, but then something . . . the anniversary of the event or hearing and a similar incident . . . can cause a setback. If you keep these points about the healing process in mind, you will be better equipped to eventually work through the pain.

**Critical Incident Impact and the Law Enforcement Family**

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A critical incident, can be described as "any situation faced by emergency service personnel that causes them to experience unusually strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later" (Mitchell, 1983). For a peace officer, a critical incident can be one that s/he experiences directly (eg shooting a suspect), witnesses (eg death or injury to a child; fellow officer shot or injured) or even one that technically "did not really happen" (eg peace officer almost shot a teenager with a toy gun; peace officer was shot at by a suspect but not hit).

The impact of being involved in a critical incident is fairly well documented. During the incident, a person may experience extreme shock and disbelief which can be immobilizing. A large number of individuals experience unusual sensory perceptions such as time distortions, visual distortions (tunnel vision, unusual clarity), and auditory distortions ("not hearing" loud noises). Equally likely are a number of different affective experiences such as anger, terror, despair, and physiological phenomenon that indicate extreme autonomic nervous system activity.

In the days and weeks that follow a critical incident, the list of possible reactionary symptoms is long and includes examples from the physical/somatic realm as well as emotional, behavioral and cognitive symptomatology. Critical incident reactions can also be significantly delayed, appearing several weeks or months after the event. Lastly, critical incident reactions can linger, developing into a full-fledged Post Traumatic Stress Disorder.

To a certain extent, the role of a peace officer involves constant contact with critical incident stress, either dealing with the critical incidents of citizens or handling critical incidents in which the peace officer is a participant in some way. In order to understand the impact of critical incidents on law enforcement personnel, it is important to understand the world of law enforcement. While peace officers have all the "normal" concerns and reactions that could be expected after being involved in a critical incident, there are a series of unique stressors within the world of law enforcement that can further complicate the experiencing of a critical incident.

In order to understand the impact on law enforcement families, it is important to examine the direct as well as indirect influences of a critical incident on the family. The peace officer is directly impacted by the critical incident. S/he then brings home that impact. The spouse and children can also be directly impacted by the incident, doubling the potential repercussions. Lastly, as the peace officer attempts to deal with either general job stress or a specific critical incident, s/he often makes certain adaptations or adopts coping methods that may, in themselves, cause additional problems within the family.

The remainder of this paper will discuss the world of law enforcement as it impacts the peace officer and his/her family and will highlight the unique stressors or reactions which can occur when a critical incident "hits" such a family. Lastly, possible consequences will be discussed as well as treatment issues both within and outside of the law enforcement world.

## I. Direct impact on the peace officer

### A. World of the peace officer

The stressors involved in law enforcement have been thoroughly summarized in previous articles (Kroes, Margolis & Hurrell, 1974; Alkus & Padesky, 1983; Ellison & Genz, 1983). Any glimpse into the world of law enforcement would have to address obvious stressors such as concerns regarding physical safety, but should also touch on a number of additional concerns which have been identified by peace officers as equally if not more upsetting than the issue of physical danger. Since departments must provide around the clock service, peace officers deal with the stressor of shift work. Shift work translates into sleep deprivation, irregular days off, holiday work, and schedules that often do not mesh with social requirements of family and friends. Peace officers deal with stimulus extremes. A peace officer may experience hours of boring patrol, but always with the expectation that at any moment s/he may be called upon to act in a life or death situation. Due to the recent budgetary problems experienced by many departments, peace officers report concerns re inadequate coverage, increased workload, old and poorly functioning equipment, and slow backup time. Due to the changing political climate, many peace officers no longer feel supported by their supervisors or their Department. These are just some of the stressors that impact a peace officer.

B. Critical incident

Into this picture now comes a critical incident. Peace officers are, of course, normal human beings. They are subject to all the normal distortions and reactions that occur during this type of incident as well as reactions that occur after the incident. Solomon and Horn (1986) asked peace officers to describe their most common reactions to a critical incident, the top ten of which included a heightened sense of danger, anger, nightmares, withdrawal, anxiety, sleep difficulties, intrusive recall, emotional numbing, depression and alienation.

There are aspects of the world of law enforcement, however, which significantly add to the negative experience of a critical incident for most peace officers. Some are not unique to law enforcement, but combined, they can significantly increase the likelihood of damage.

1. Responsibility/Performance - Individuals involved in a critical incident often question their actions and criticize themselves for how they handled the incident. For peace officers, this process is magnified. Peace officers are trained to "handle" emergencies. They hold themselves accountable for the well being of others. A peace officer will mercilessly examine his/her own actions for errors. Peace officer standards of performance, however, can be unrealistic and/or inappropriate. An officer will often hold him/herself accountable for the outcome of a critical incident, even if many of the variables were beyond his/her control. This process is exacerbated by peers who engage in Monday-morning quarterbacking and by the normal process of investigation that occurs when an officer is involved in a critical incident (Reiser & Geiger, 1984). His/her every decision and action is scrutinized by the department as part of a routine investigation and as a means of ascertaining that proper policy and procedures were followed. In addition, the incident is examined in order to obtain feedback with an eye towards improving tactics and the training of subsequent personnel. While this process may be necessary and helpful to the law enforcement agency, it is often perceived by the peace officer as "an accusing finger" which magnifies every error and which can greatly exacerbate

feeling of inadequacy or guilt.

2. Job implications - If a normal citizen is involved in a critical incident, the only job implications are usually the need for time off to recover from the incident. For a peace officer, a judgement call which the Department disagrees with can result in disciplinary action or termination. Given the current political environment, some peace officers report concerns that they could "do everything right" and still be disciplined (Reiser & Geiger, 1984).

3. Financial risk - Even when a peace officer has been departmentally and criminally cleared after a critical incident, s/he can still face civil litigation. A peace officer's personal property, house, etc. often become the target of lawsuits brought to bear because of the officer's handling of an on-duty critical incident.

4. Retaliation - Peace officers are readily identifiable and may face threats of retaliation after a critical incident. This threat becomes even more problematic in a rural setting, where the officer's residence is known.

5. Personalizing - Again, if the setting is rural, the likelihood that the officer knows the victim or suspect is increased. The greater the potential of identification with the victim, suspect or even the community, the greater the degree of traumatic impact.

6. Media coverage/Family & friends - While critical incidents are news, the actions of the average citizen during a critical incident are usually not of special note. If a rape is reported, whether or not the victim fought or how she fought is usually given little coverage. However, if a critical incident involves a peace officer, every action is scrutinized and evaluated in the media. The media coverage is often in error in their description of at least some aspects of the incident, however, the peace officer is not allowed to make a statement to correct any errors. The officer is often the target of great public hostility (Hageman, 1978). Friends and sometimes even family can be equally judgmental.

7. Criminal justice system - After the incident is over, the peace officer has very limited input into the subsequent actions of the justice system. A suspect who fired at the peace officer may be pled down to a lesser crime. The suspect who caused the death of a little girl to which the officer supplied CPR may be let go on a technicality.

8. Cumulative trauma - For most individuals, a critical incident is a relatively rare event. For peace officers, they can become almost routine. Added to that is the negative impact of the stressors identified earlier as part of the world of law enforcement. Over time, cumulative trauma from routine stressors plus the impact of critical incidents can have a significant negative effect on the peace officer (Williams, 1987).

9. Fear of repeat/additional trauma - For most individuals involved in a critical incident, the chances of a repeat incident are low. But a peace officer, who must go out into the same environment again and again, cannot pretend that subsequent

incidents will not occur. If anything, statistically, peace officers who are involved in a shooting, for example, are slightly more likely to be involved in a subsequent shooting.

## II. Direct Impact on the Peace Officer's Family

A. World of the peace officer spouse and children

The spouses and families of law enforcement are directly and negatively impacted by many of the same stressors identified by peace officers themselves. Many spouses and children face an ongoing fear that their peace officer family member will be injured or killed in the line of duty. The fear waxes and wanes depending upon a variety of factors including the overall rate of violence in the community and the media's reflection of that violence. In addition, family members must also deal with shift work, on call, irregular days off and working on holidays (Engler, 1980). Peace officers miss birthday parties, soccer games, Christmas morning and are often not available for family emergencies. Sexual intimacy may be nonexistent if both the peace officer and the spouse work and the shifts do not match (i.e., the peace officer works swing shift and the spouse works days with each having different days off). Female spouses report that they often feel vulnerable sleeping alone when their peace officer spouse works the graveyard shift. Spouses also report concerns related to firearms in the house, same sex partners and "uniform junkies" who are attracted to peace officers because of the aura of danger or authority (Coughlin, Hern & Ard, 1978; Reiser, 1982).

B. Critical incident

Spouses and children are, of course, human too and will have all the normal responses that families members have to being touched by a critical incident. Again, however, there are aspects of being a part of law enforcement that can exacerbate the experience of the critical incident.

1. Danger - Any critical incident, even a near miss, greatly increases the fear level of family members (Reese, 1982). Since many law enforcement relationships tend to be more traditional with a male peace officer who is the only bread winner, the threat of loosing the peace officer becomes all the more frightening. The family members are also very aware that the peace officer must go back "out there". This can generate even more fear and even anger at the peace officer for insisting on remaining in the field of law enforcement.

2. Secondary trauma - Hearing about a critical incident can become, in itself, traumatizing. While family members do not actively experience the critical incident, hearing about the incident, even indirectly, can be sufficient to cause secondary trauma (Mantell, 1986; Hartsough, 1991).

3. Job implications/Financial risk - Each spouse is intimately aware that his/her financial security and the security of any of the couple's children rests squarely on the shoulders of the peace officer. A misjudgment or even just a bad piece of luck

can result in the spouse and children facing financial ruin. And, unlike the peace officer, the spouse has absolutely no control over increasing or decreasing the level of risk.

4. Retaliation - Fear of retaliation can be just as real for the spouse and children as for the peace officer. Since the media often announces the name of involved officers, the spouse or children may feel particularly vulnerable after a peace officer has been involved in a critical incident involving a suspect. After all, they have no training, no firearm to protect themselves should an attempt at retaliation occur.

5. Media coverage/Family & friends - Just as the peace officer is impacted by negative media coverage or the reactions of those around him/her, family members can also be negatively impacted (Gilmartin, 1986). The son of a peace officer may be called the son of a murderer by peers at school. A spouse may end up defending the actions of his/her peace officer spouse to a neighbor. Peace officers report that police work is not something they do, it describes who they are. Family members become part of that identity.

## III. Indirect Impact Through Peace Officer Adaptations

A. Adaptations and coping skills

The field of law enforcement has been referred to as a pressure cooker of stress. Peace officers tend to make a number of adaptations in order to survive this environment. While these adaptations or coping methods may protect the peace officer at work, they often have negative side effects both at home and on the job.

1. Machismo - Many peace officers subscribe to the "macho image" or a John Wayne personality type (Trompetter, 1986; Garner, 1979). This image includes emphasis on a traditional masculine role, suppression of affect, over reliance on physical prowess and an inability to admit to weakness or ask for assistance.

2. Emotional over-control/suppression - Numerous authors have described the tendency of peace officer to engage in emotional detachment, emotional blunting or emotional repression in response to the environment of law enforcement (Bibbins, 1986; Hill, 1981). Eventually the peace officer can become uncomfortable with any experience or display of affect (Stratton, 1975). Alcohol is often used to aid in "not feeling" (Bibbins, 1986; Pendegrass & Ostrov, 1986).

3. Authoritarianism/rigidity - Peace officers live in a para-military world with a chain of command, orders and potential disciplinary actions. Some officers can unintentionally bring home the chain of command. This may result in the peace officer "giving orders" to both spouse and children and expecting family members to follow "appropriate chain of command" at home (Daviss, 1982; Honig & White, In press).

4. Us-them - Peace officers often come to expect to be lied to and can become very

cynical and suspicious (Davidson & Veno, 1980). Some officers then bring this attitude home and may "cross examine" a child about his or her activities or become preoccupied with the idea that a spouse is having an affair (Potter, 1978). Peace officers have become known for their solidarity and can sometimes come to the point where the only person they trust is a fellow cop. Everyone else becomes one of the "them". Family members are often caught in the middle. While they are not a "them", they are also not a cop.

5. Overprotectiveness - Since peace officers are exposed to a great deal of victimization and violence, they often become unusually protective and restrictive towards their families (Honig & White, In press). In addition, they may decide to further "protect" their family by not sharing the trials and tribulations of the job or any concerns or reactions related to it (Madamba, 1986).

B. Critical incident

It is easy to see how the impact of a critical incident, filtered through the adaptations and coping skills identified above may serve to exacerbate a critical incident reaction. A critical incident results in a plethora of emotional reactions including such "unacceptable" feeling as fear, anxiety, sadness and guilt. But a peace officer does not feel (suppression of affect) and a peace officer handles his or her own problems (machismo). Consequently, a peace officer experiencing emotional difficulties may not reach out for assistance (Stratton, Parker & Snibbe 1984). If a single or small emotional reaction is uncomfortable, the strong emotional reactions common during and after a critical incident are often seen by peace officers as so foreign and extreme as to constitute evidence of a total mental breakdown (Fisher, 1986). A peace officer may not feel s/he can go to a spouse for assistance since that would violate the rule of protection of the family. The result can be emotional withdrawal from family members, decreased communication, inhibited expression of affection and intimacy and marital distancing. Being cut off from potential support can then further exacerbate the critical incident reaction.

A peace officer may also not feel comfortable going to an outsider such as a civilian friend or religious leader since they are both members of the "them". In addition, for some critical incidents where investigations or lawsuits are still pending, a peace officer may be instructed not to discuss the incident. Some peace officers may not even feel they can go to a fellow officer, thereby taking advantage of police solidarity as a source of support. The peace officer may feel that fellow officers will judge him/her or will conclude that s/he is "losing it", thereby confirming the officer's worst nightmare.

## IV. Consequences

1. Psychological/physiological consequences - The consequences of being involved in a critical incident can be transitory or chronic, mild or extreme. According to Mitchell (cited by Janik, 1991), 20% of individuals involved in a critical incident reported acute psychological or physical symptoms. Stratton, Parker & Snibbe (1987) stated that 60% of their sample of officers involved in a shooting reported that the incident had a substantial impact on their subsequent lives. Solomon &

Horn (1986) reported that reactions can be divided into mild (37% of their sample), moderate (35%) or extreme (28%). Lipson (1986) found that these reactions can be long lasting with significant symptoms still in evidence six months after a major critical incident. Jerry Vaughn, former executive director of the International Association of Chiefs of Police (cited by Horn, 1991) claims that 70% of peace officers involved in a lethal critical incident will leave the force within 5 years.

2. Relationship consequences - It is difficult to identify what portion of law enforcement marital problems arise out of critical incident stress directly. While some studies do indicate a high degree of marital difficulties among law enforcement couples in general (Kroes, 1976; Blackmore, 1978), few have addressed the direct impact of a critical incident. Foreman (1991) maintains that law enforcement families already exhibit ongoing signs of Post Traumatic Stress. However, both Wittrup and Blau (cited in Mitchell, 1991) reported significant marital and family disruption after a peace officer was involved in a shooting. Singleton & Teahan (1978) found that being involved in a physically threatening situation at work resulted in greater conflict for the peace officer at home. Solomon & Horn (1986) found that 27% of their sample of peace officers who had been in a line of duty shooting reported at least moderate family problems after the shooting. Hartsough (1991) also supports the idea that critical incident stress has a definite "ripple effect" which impacts the family of public safety personnel. This can be particularly problematic since if both peace officer and spouse are significantly negatively impacted, each will be deprived of their most valued support resource, ie their relationship partner.

3. Parent-child consequences - Again it is difficult to separate out pre-existing parent-child problems related to overprotectiveness, authoritarian style, decreased trust and emotional suppression from the impact caused by a critical incident. However, it is obvious that as the peace officer becomes more overwhelmed by the critical incident, s/he may perceive the children as one more demand. The peace officer may experience difficulty addressing the child's feelings of fear, anxiety and possibly resentment and anger. The peace officer may not be seen as approachable by his/her child (Southworth, 1990). As the peace officer withdraws, positive interaction between parent and child becomes less and less likely. Lastly, the officer may become even more rigid and overprotective after a critical incident confirms his/her fears about the world.

## V. Interventions

A. Internal - There are a number of actions that can be taken from within the field of law enforcement that can significantly mitigate the impact of critical incidents.

1. Selection - The first step involves screening out pathology in order to guarantee that potential peace officers face the stress of critical incidents with no known deficits. In addition, selection techniques should include interviews with candidates' spouses in order to ascertain the spouse's awareness of potential relationship stressors and the need for spousal support.

2. Spousal orientation - Orientation of spouses is essential and usually covers job requirements, firearm safety, policy and procedures (including shooting policies and procedures), law enforcement stress, and potential relationship impact of a career in law enforcement.

3. Education - On going seminars, workshops and trainings can be presented to both peace officers and their spouses on topics such as surviving a critical incident, stress management, communication skills, parenting, etc.

4. Critical incident debriefings - Mandatory critical incident debriefings of peace officers can significantly reduce critical incident reactions (Bohl, 1991). Including family members in a second or separate debriefing can significantly decrease later negative impact on the family.

5. Counseling - Psychological services available to the peace officer as well as family members can aid in early detection and treatment of any critical incident trauma.

6. Supervisor training - Educating supervisors and assisting them in the early detection and appropriate referral of individuals who begin to demonstrate critical incident reactions can catch potential problems before they escalate.

7. Research - Ongoing research on the effect of critical incidents on peace officers and their families will better enable health professionals to protect law enforcement families from the impact of a critical incident and will also assist in treatment planning should negative impact occur.

8. Management consultation and education - It is an ongoing task to educate law enforcement management regarding the impact of critical incidents in order to assist them in making decisions pertaining to trainings, services offered, policy and procedures and various other interventions to assist law enforcement officers and their families.

B. External - As outside mental health professionals involved with law enforcement personnel, it is essential that the professionals have a working knowledge of the world of law enforcement through ride-a-longs, trainings, etc. (Garrison, 1986). It is also important that the professional understand the basics of critical incident stress and critical incident debriefing procedures as well as be familiar with the special issues impacting law enforcement personnel. The special issues may be external such as media perception or internal such as concerns re being "crazy" or emotionally out of control. Lastly, it is extremely important that professionals respect the concerns re confidentiality and potential job implications that a peace officer will bring into treatment and that all personal preconceptions and biases about "cops" be dealt with prior to treating members of law enforcement.

## VI. Summary

Law enforcement personnel may be exposed to or involved in a variety of critical incidents, sometimes on a routine basis. These incidents include not only those personally experienced but also those witnessed and even those that "almost" happen. While personnel may differ in the degree of impact a critical incident has on them, most experience at least some transitory reactions. The reactions can be immediate, occur after a few days or even occur months later and can disturb the peace officer's emotional, physiological, cognitive and behavioral functioning. Law enforcement personnel are by no means immune to the impact of critical incidents.

Peace officers deal with many stressors as a routine part of their job. Concerns regarding personal safety, shiftwork, stimulus extremes and equipment and personnel shortages are a few of the most commonly mentioned stressors. When a peace officer is involved in a critical incidents, s/he deals with all the usual job stressors, plus all of the normal critical incident repercussions. In addition, there may exist additional potential repercussions, many of which are unique to law enforcement. Peace officers face responsibility for others, performance concerns, job implications, financial risks, fears of retaliation, identification with victims or the community, unfavorable reactions from the media, friends and family, disappointment with the criminal justice system and concerns about "going back out" into the same environment to face the risk of repeat traumatization. The peace officer is directly impacted by the critical incident and can bring this impact home to his/her family.

Peace officer families also experience the stress of a career in law enforcement. Family members deal with "normal" law enforcement hassles such as the fear of losing a family member, having a firearm in the house, and shift work. In addition, spouses report concerns related to "uniform junkies", opposite sex partners and being left alone at night. Just as there are unique additional stressors for the peace officer involved in a critical incident, there are additional stressors for the peace officer's family as well. Families deal with increased fear for the personal safety of the peace officer, secondary trauma through listening to the retelling of traumatic events, financial risk, fears of retaliation and unfavorable reactions from the media or friends and family. Family members face some of the same concerns as the peace officers and are also directly impacted by the critical incident.

Many peace officers make certain adaptions and develop specific coping methods to succeed in the field of law enforcement. Peace officers tend to be more macho and authoritarian/rigid, to believe that emotions should be strictly controlled or suppressed, tend to try and protect the family from the outside world and tend to become suspicious and mistrustful of others. While these coping methods may, at times, help protect law enforcement personnel from the stress of a career in law enforcement, they can also become problematic in themselves. Further damage can occur when a critical incident is filtered through these adaptions and coping methods, since many of them interfere with intimacy and obtaining social support or assistance.

Critical incidents can negatively impact a peace officer's physical health and his/her mental and emotional well being. In addition, critical incidents can damage marital and parent/child relationships. It is therefore crucial that each law enforcement agency become aware of the potential for damage and come to the aid of the family in whatever way possible. Law enforcement agencies can be of assistance through proper selection procedures, spousal orientation, education, critical incident debriefings, counseling, supervisor training and through

research. Mental health professionals, experienced in critical incident trauma and familiar with the world of law enforcement, can be of assistance by educating law enforcement agencies about critical incident trauma and by providing the services described above. The target of these interventions must be not only the peace officer but his/her family as well.

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# Co-Workers and Their Families

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# COWORKERS AND THEIR FAMILIES

Public safety work is more than an occupation, more even than a career or a profession. The role of police officer, firefighter, or EMS provider becomes for many the central element in the identity of both the worker and his or her family. While the untimely death of a public safety employee is clearly most tragic for the direct survivors of the fallen worker, it can also be a profoundly disturbing and unsettling event for surviving officers, firefighters, and medics -- and for those who live with and care for them: the public safety officer's family.

People react very differently to different types of stress. Much of the stress inherent in the work of professional public safety personnel comes in the form of *challenges*. These stressors are elements of their jobs which, while often very taxing and sometimes even frankly harrowing, are also at the very core of their attraction to these callings. Those challenges call on the public safety responder to reach his or her highest levels of performance and to win control of situations and circumstances many people would never even approach. Success in meeting such challenges is the greatest reward the occupations can bring.

Beneath these intense challenges, however, is also an ever-present element of danger. While the death of a public safety official forces his or her family and friends into the painful and tragic process of dealing with loss, one of

the most profound emotional stressors humans must face, surviving workers and their families must also confront the harsh reality of threat -- the potentially intense and pervasive stress of confronting the closeness of harm and the limits of one's ability to always escape it.

The implications of threat are radically different from those of loss, both for surviving public safety employees and for their families. For workers and families alike, the pervasiveness of danger and risk in the line of duty is usually met by denial and suppression; when the realization of these factors cannot be avoided, rationalizations like "it can't happen to me" form the primary defense. Line of duty deaths, serious injuries, or similar critical incidents render those defenses woefully inadequate, and leave the surviving officers and their families face-to-face with the proximity and the extent of their peril.

The well-managed agency should be aware of the impact of threat on officers and their families, not just after a critical incident but throughout an employee's career. The extreme personal, organizational, and family upheaval which can follow such tragedies is not simply the result of the event itself, but comes even more from its capacity to magnify and intensify the stresses confronting workers and their families on a daily basis. Sound and progressive approaches to management, command, and supervision in every aspect of the organization's operation ultimately lead to more effectiveness in the agency's efforts to help personnel

and their families rebound from the stress of a major incident in their department.

Some of the most important factors in helping personnel and families to cope are also among the elements progressive agencies have identified as most important in achieving their organizational goals. Clear articulation of agency missions and values in terms that its personnel can understand and apply, and the reliable application of those values at all levels of the department's operation builds an atmosphere of openness and trust in which people come to know what expectations are held of them and what they can expect in return. Command procedures which are well developed and consistently used for the routine as well as the critical incident create an environment in which roles and responsibilities are known and understood. They also provide a framework through which post incident understanding of the events which transpired, the decisions which were made, and the outcomes which resulted can be effectively developed. Employee assistance programs and similar vehicles, when coupled with strong management endorsement and effective peer and supervisory referral, can be instrumental toward ensuring that the relationship between work, the agency, the employee, and the family remains cohesive and constructive, and that problems on or off the job are effectively addressed before they come to threaten the delicate balance these important and unusual jobs demand.

Impact of Critical Incidents on Public Safety Workers and Their Families

Most individuals have developed approaches to managing the impact of stressful situations which enable them to deal effectively with the inescapable difficulties of daily living. Each of these approaches, however, may be severely challenged in the wake of the critical incident. Dramatic increases in perceived threat are quite understandable as both workers and those they love attempt to process what has happened and what it means to them. For example:

1. Predictability of life events ordinarily provides a major source of comfort and structure. This sense of regularity, which forms the basis of one's sense of safety and security, is often the first victim of the critical incident for both the worker and the family.
2. Control of the circumstances surrounding one's life and the events which mark its course is a critical component of one's sense of autonomy and security; this sense of control is particularly important to public safety workers and their families who must constantly face the sense of threat which underlies each encounter. Critical incidents have the potential to make that important perception seem to evaporate, leaving the threat which lies beneath it frighteningly exposed.

3. Perspective comprises a major avenue for the reconciliation of uncontrollable events. Whatever faith or convictions one may hold, however, are likely to be severely shaken by tragedy of the proportions these events present. Challenges can readily dissolve into threats, leaving even those persons ordinarily known as optimistic and positive feeling cynical and angry.

4. Strategies for addressing stressful events, especially approaches developed well in advance and extensively rehearsed, allow one to react effectively even when seemingly overwhelmed by the unexpected nature of the intensity of the situation. This helps prevent the sense of paralysis which often accompanies highly charged circumstances, and helps to "jump start" one's movements toward effective coping and response.

5. Social support can help provide an environment in which those who share important elements of the experience and its impact can assist one another in restructuring beliefs and expectations thrown into question by the incident and its aftermath. Those who have weathered similar events can be particularly helpful in assisting affected workers and their families to predict the feelings and events they face, to identify effective strategies and reassert control over those aspects of their circumstances which can be meaningfully altered, and to develop the perspectives needed to accept those

aspects which cannot be predicted, controlled, or changed. More importantly, the process of rebuilding should also work to strengthen the bonds which hold the workers, their families, and the organization together.

## Helping Workers and Their Families to Cope

Efforts to support the process of readjustment are delicate matters which demand careful and creative agency responses. No two situations are ever entirely alike, nor do any two agencies ever entirely share the subtle elements of history, tradition, and roles on which effective interventions must be built. To effectively meet the unique demands of any individual circumstance, crucial questions of what should be done, when any particular approach should be undertaken, or by whom it should be led, require the combined professional judgements of executive staff, personnel and labor leadership, and their established sources of psychological consultation. The success of the approaches taken rests not in the techniques selected, but rather in the commitment of the agency and its personnel to the process of recovery.

### Before an Incident

1. The most important factors in preparing personnel for the impact of critical incidents are not inherently psychological in nature; they represent instead exactly those things a good executive would expect to do to

build a sound agency and strong performance. Personnel should be trained -- especially through situational rehearsal and hands-on simulations -- for the roles and tasks they will be required to perform. This provides prediction, strategy, and therefore control.

Similarly, management practices which state clearly the values and missions of the organization and make explicit how those values direct daily decisions help frame the perspectives through which personal reactions to major incidents can be transformed from paralyzing threats into career-affirming challenges. Command practices which are w ell integrated into daily functioning, but readily expanded to envelope the unfolding of serious events, ensure that there will be confidence in the decision making process, hence restoring the sense of control as the incident develops and providing perspective for its examination and processing once the incident is over.

2. Research has also shown that no single factor better prepares personnel to withstand intense and prolonged stress than good physical conditioning, and that no single factor better dissipates that stress or better promotes rapid and complete recovery than moderate physical exercise. Wellness and physical training programs are valuable for more than simply injury prevention and sick-leave utilization; they are the backbone of the employees' mental conditioning as well.

3. The only true predictor of serious long-term consequences for personnel surviving a critical incident has been their psychological well-being at the time the event occurred. Most personnel experiencing such events find them distressing and difficult to reconcile, and most report struggling with their reactions. But the vast majority also find ways to turn threat into challenge, and take away from the event important lessons regarding the strength of heart and commitment which define the professional public safety responder. Whatever problems the individual may have at the time, however, can easily be exaggerated by the stress of the critical incident.

Since exposure to traumatic events is an inescapable part of public safety occupations, selection of personnel should strongly examine factors which might unduly dispose prospective employees toward difficulties in dealing with the events they may encounter. Similarly, since critical incidents may occur at any time, supervisors must also be able to recognize signs of psychological stress in daily functioning, and to assist employees in seeking appropriate vehicles through which to resolve issues which might increase their stress load and render them more vulnerable to traumatic impact in their assignments. An active and effective employee assistance program, especially one with a strong peer

component and the visible support of all levels of the organization, can be indispensable in achieving this critical human resource goal.

4. Public safety families are constantly influenced by the twists and turns of their loved one's activities and career. Special attention should be given to helping them to learn about the jobs their loved ones do, the organizations for which they work, and the ways in which they work together. "Spouse Academies", family workshops, and similar programs have proven valuable in helping families become a more active and aware part of their loved one's career, and hence a stronger and more reliable source of support. Social events and informal activities designed to build a strong relationship between agencies and the families of the personnel are also a strong part of the traditions of many departments, and have long helped to build a sense of trust and belonging which proves invaluable in times of stress and need.

Many agencies or labor organizations have formally structured Spouse Associations which provide an established vehicle for these activities. Support groups can also prove beneficial in helping persons who share similar circumstances, experiences, and concerns exchange information, perspectives, and strategies in an atmosphere of constructive social support. Such interaction allows spouses to address the too often

abrupt and frightening transitions of career growth faced by their public safety mates in an atmosphere of "veteran to rookie" support, not unlike that which aids their spouses, and helps to ensure that important but sensitive issues such as loss, threat, and grief are not left undiscussed and unresolved.

5. Keeping individual personnel and their families a part of the agency's public image is also valuable in building strong bonds throughout the organization. The most meaningful moments in a career, both for the public safety worker and his or her family, often come when the department has gone to the effort to publicly express its pride in a particular act or effort. Too often, supervision is seen as a threatening element in its own right, always ready to catch the employee doing something wrong -- it takes no more effort to catch people doing things right, and the rewards can last a lifetime. Posthumous expressions of pride are exceptionally hollow if similar demonstrations were never believed to be a part of the victim's living relationship to his or her organization.

*As the Incident Unfolds*

1. Command presence is vital to maintaining confidence that both the formal organization which must manage the incident and the informal organization which provides the framework for social support will function as they

should under the adverse circumstances of the critical incident. In organizations with well developed Incident Command Systems, the chief or similar executive officials may never assume command of the operation per se, but their presence makes the important statements that the incident has their full attention and concern and, even more importantly, that the welfare of their personnel outweighs any other issue or obligation.

2. The unfolding incident may demand the ongoing functioning of coworkers despite the tragic impact of losses during the working stages of the event. Indeed, additional personnel may be required to complete the operations, and they too will be called upon to carry out their roles under the shock and stress of a comrade's death. Special attention should be given to supporting the efforts of these personnel to carry out their professional obligations safely and assuredly under these difficult circumstances.

Officers assigned to staging, rehabilitation, and safety functions within the Incident Command System need to be prepared to address stress related aspects of these roles. Staging should be away from the immediate scene, and those personnel preparing to enter the scene should, whenever possible, be given discrete, time-limited assignments with clear objectives, and should be thoroughly briefed -- preferably including

diagrams, photos, or other concrete data as may be available -- regarding what they will see and what their assignment must accomplish. Once an assignment is completed, the rehabilitation sector officer should ensure that the stressfulness of the assignment is acknowledged, that personnel have the opportunity to add information to the command picture of the unfolding event, and that they are made aware that further support will follow as the incident is completed and the organization begins to process the total experience. The officer assigned the safety function should also be keenly aware that the stress of a coworker's involvement can increase the risks of overexertion, accident, and injury; these factors should be assessed on an ongoing basis for all involved personnel.

3. Protocol issues are also important to coworkers and their families. The death of a fellow public safety employee leaves a profound sense of helplessness among people whose entire lives are dedicated to helping; the traditions, rituals, and protocols of mourning and respect give personnel the opportunity to stand together as a unit in honor of their lost comrade, and to express proudly and publicly the bonds which hold them together. These activities and events are not simply ceremonial, they are key moments in setting the framework for recovery and growth.

4. Accurate information is critical at these moments, especially regarding what is being done for the immediate families of the victims, how they are reacting, and what efforts other coworkers and their families can add to their support.

5. Most importantly, the actions of the agency's chief executives set the tone and the pace for the entire organization. The chief executive and his staff should make every effort to assume the roles of officers and gentlemen, and to communicate to everyone in their agency -- including the families of their personnel -- their personal investment in what has happened and what will be done to make certain that the loss is not in vain.

*After the Incident*

1. Structured sessions to assist the organization in processing the impact of the event may prove beneficial as a method of "jump starting" the support systems which underlie any strong organization. These sessions should first help personnel to construct a shared picture of how the incident occurred, what their colleagues were thinking and doing, and ultimately how they as individuals and their organization as a whole are reacting and feeling about the events. The most important goal, however, is to move from this process into concrete actions that individuals and the organization will take to recover, learn from the

experience, honor its lost members, and collectively move forward.

Several good structures have been proposed to assist organizations in conducting this process, sometimes called critical incident stress debriefing. The important element to note, however, is that the process must remain internal to the particular organization and responsive to the needs and concerns of that specific group and event. It is not the session itself that leads to recovery, it is the process it begins within the personnel attending and the organization they serve.

2. Families of surviving personnel, even those nct directly involved in the particular incident, have needs and concerns of their own which should also be addressed. Their issues and their methods of dealing with them, however, are very different from those of their public safety worker. Sessions for these members of an organizations' broader family are equally important, and should receive the same attention in planning, attendance, and follow-up as do staff debriefings.

Command staff should be present at these sessions to explain the circumstances of the event, answer families' questions, and most importantly to hear and respond to their concerns. It is recommended, however,

that this session be reserved for the families alone, since many will be unwilling to discuss their deeper concerns when their public safety member is present.

3. The agency must be prepared to make at least some visible and immediate responses to concerns these sessions bring forward. Remember that the crisis to these personnel and their loved ones centers on threat, and that this can only be addressed by concrete actions to make their world somehow safer. While nothing can be done to totally prevent tragic loss in dangerous occupations, even the symbolic effort to make a concrete gesture toward that end does much to help translate the stress from threat to challenge again.

4. No event involving tragic loss is over quickly or completely. These events become a part of the organization's history and tradition, and an even more important part of the personal history of each coworker close to the incident or the colleague lost. Coworkers, supervisors, and commanders need to remain sensitive to the importance of these moments in the career of a public safety worker, and to take the effort to honor the memory of those lost at appropriate moments in the agency's future. Keeping the memory alive is important not just to the immediate survivors, but to all those who will carry on their traditions in the years to come -- families as well as employees.

5. While most persons will recover from the impact of the events with minimal formal intervention, certain individuals may find that the particular loss has touched elements within themselves which require more specialized attention. Coworkers and supervisors should help them to acknowledge their need for further assistance, and encourage them to seek the help they need without fear of disapproval or reprisal. Employee assistance programs should be especially prepared to address the unique problems presented by these reactions, and to quickly assist employees in working through their recovery.
6. Spouses and families are even more likely to seek personal assistance in processing the impact of these events. Public safety workers and their supervisors should be sensitive to their needs as well, and similarly ready to encourage their use of EAP's and other agency resources to speed their recovery and assist in their efforts to grow beyond the tragedy.

## Some Final Thoughts

The strength of any public safety agency is in the depth of pride and commitment its personnel bring to their jobs every day; the strength of the agency's personnel lies in the strength of those who stand behind them -- their loved ones and family members. The well-managed agency realizes the importance of taking every measure at its

disposal to ensure that these strengths are maintained and built upon in everything the agency does, and that when a tragedy occurs these strengths are brought to bear to move the organization and its members from loss and threat to a renewed commitment to the challenges which define their strength and their spirit.

The best measures to achieve these ends are those which are central to any sound management strategy... Well-managed incidents, conducted by the well-trained, well-conditioned, and well-adjusted members of a well-run organization provide the best protection from daily stresses; the well-developed responses of a well-integrated agency -- including its families as well as its employees -- provide the best framework for recovery from tragic loss. But beneath it all lies a depth of commitment to values and bonds which hold a proud profession together. When those values are expressed at all levels of an organization and in all the agency seeks to do, its personnel and those they love enjoy a foundation no tragedy can every destroy.

# AFTERBURN:

## the victimization of police families

*By Andrew H. Ryan, Ph.D., Chief Psychologist, South Carolina Criminal Justice Academy, Office of Human Services & Assessment, Columbia, South Carolina*

We know you are a different breed—not only in our minds but in your own. We know you are exposed to the things of which nightmares are made, and that you have become the primary victim of violent crime. We know that your family is victimized by these events, as well. The research tells us that you have chosen one of the five most stressful professions, and that many of you do not survive the career for many reasons previously considered unrelated to the events of your job. Too often, the services that could make a difference are either unavailable or unapproachable, as the nature of the profession tends to dissuade its members from seeking help. It is your story that this article addresses, with a focus on how we can better serve and protect our most valued commodity—the police family.

The story began when a police officer responded to a call where a woman had threatened homicide and suicide. She had just learned that her child was terminally ill, and did not want the child to suffer.

It was a typical South Carolina day in the midst of mosquito season. She chose as her setting for this crisis the woods near her parents' home, where she grew up. Having exhausted all her coping skills, she saw no other way to ease the pain.

When the officer arrived, she turned her gun on him, initiating an eight-hour standoff. Additional officers called to the scene took armed defensive positions, while the first officer negotiated for the lives of the woman and her child. Able to provide a solution where there were no solutions earlier, he saved her life, the child's life and, possibly, his own and those of his fellow officers—all without a shot being fired.

I would like to report that the story had a happy ending, but the reality is that it was not the end, but the beginning . . . the beginning of an "Afterburn."

### *Whom Can You Talk To?*

When he went home that night and tried to relate the story to his wife, she did not want to listen; she said she could not bear to relive the story she had already seen on TV. As her husband recounted the details of the woman's plight, she became overwhelmed and ran into the bathroom, locking the door and running water to drown out his words. The officer's overwhelming need to talk led to a breakdown in the open communications of the family.

In no other profession can you save a life in the line of duty, exchange high fives with your peers, receive media recognition as a hero and then, almost within hours, have the aftermath of the event leave emotional scars on you and your family. The total effects on your family and friends are immeasurable.[1]

The "AFTERBURN" training program for law enforcement, recently presented as a national teleconference, stresses a multidisciplinary approach to addressing the needs of police officers and their families following the officer's involvement in or exposure to violent crime.[2] If we are to provide meaningful assistance, we will need the combined resources of mental health professionals, the clergy and law enforcement, as well as the attention of our politicians, to prioritize and coordinate the services.

The fields of victimization and psychotraumatology have dramatically expanded in the past 20 years. Initially, the focus was on the individual who suffered direct or threatened physical, emotional or psychological harm as a result of a serious or violent crime. Today, although these victims are still the primary focus, the secondary victims of crime are recognized as being in need of similar services.

Traditionally, violence involved physical force with the intent to harm another, and the plight of the victim was understood in terms of physical violation. However, injury to victims of violence involves not only physical violation, but psychological violation as well. The aftermath of violence for victims must be understood by considering threats not only to their bodily integrity but also to their psychological integrity. Victims may be forced to cope with the possible loss of physical functioning, financial stability and even the possible breakdown of the cognitive structures that are instrumental in providing psychological stability.[3]

One way to begin to understand the reactions—and thus the needs—of primary and secondary victims is to recognize that anxiety and fear are the predominant emotional responses of victims of violence. Coping with violent victimization involves coming to grips with the ensuing cognitive disorganization precipitated by the experience. For victims of violence, intense anxiety—with all its emotional, physiological and behavioral manifestations—reflects a disruption in their worldview and beliefs about society. The key to their recovery process is in the re-establishment of an integrated worldview. A police officer's exposure to violent crime may have an even more powerful effect on the police family, as family members are more likely to personalize the event and identify with the officer as the victim.

### *The Heavy Badge*

Although the average police badge weighs only 2 ounces overall, with larger models running to perhaps 4 ounces, Dr. Gary Aumiller notes that when that badge is pinned on, it carries a weight unknown to most law enforcement officers. The true weight of the badge is not found in the gym or measured on a scale, and cannot be overcome by muscle. This weight requires a strength and conditioning for which few officers are trained.

The heaviness of the badge makes law enforcement officers different from other professionals; it is pinned not just on a chest, but on a life style. These life style difficulties can act to victimize not only officers, but their families as well. Over the course of the

past 15 years, police psychologists have identified 10 areas that make the badge heavy and the police family different:

1. Law enforcement officers are seen as authority figures.
2. The wearing of a badge, uniform and gun makes a law enforcement officer separate from society.
3. Law enforcement officers work in a quasi-military, structured institution.
4. Shiftwork is not normal.
5. Law enforcement work encourages camaraderie, which can be a double-edged sword.
6. Officers have a different kind of stress in their jobs, described by some police psychologists as "burst stress."
7. Law enforcement officers have a job that requires extreme restraint under highly emotional circumstances.
8. The law enforcement officer works in a fact-based world, with everything compared to written law.
9. The "at-work" world of the officer is very negative.
10. The children of law enforcement officers may have a more difficult adjustment to adulthood.[4]

Being a law enforcement officer is more than what is taught at the academy or on the job. The work has many effects that need to be overcome so as not to affect the officer's personal life and victimize his family.

## *What About the Kids?*

As Ellen Kirschman has written, "If families are at-risk for 'catching' trauma, children are the most vulnerable family members because they are still learning how to manage their emotions. Children and adolescents, however mature they appear, usually don't possess the social or psychological sophistication to understand what has happened to them or to their families when traumatic stress occurs."[5] The family is a child's "safe harbor," and it is within the family environment that children learn to deal with stressful events. We must provide these children with a sense of normalcy, understand their emotions and why they are reacting the way they do, not hide the truth from them and, most of all, know when to get them professional help.

## *The Family*

Exposure to violent crime, others' pain and suffering, and man's inhumanity to man all potentially impose a heavy toll on the police officer as a primary victim and family members as secondary victims. The impact of violent crime can be severe; a significant number of officers involved in a critical incident will show transitory post-traumatic stress symptoms. Significantly, secondary victims also feel the emotional pain and, without assistance, will become emotionally depleted over time.

The consequences of this victimization do not manifest themselves solely on the job, but throughout the officer's life. He may also be asked to return to the job of helping before he has healed himself. Depression, anxiety and anger—all of which are normal symptoms among victims of crime—can alter one's approach to life. Unfortunately, the police officer is not afforded the luxury of suffering through the pain; he must endure and go back to serving other victims. So, too, the police family must go on as if nothing has changed.

In reality, of course, much has changed. The family dynamics have been altered and may never be the same. What, then, is the percentage of family members with the same symptoms?

The importance of assessing and treating the spouses/mates of trauma survivors has been successfully argued by many researchers.[6] Additionally, the author has found no significant dif-

ferences in levels of depression, post-traumatic stress disorder (PTSD), communication, attitudes toward police issues and stress symptoms between police officers and their wives.[7]

The same argument has also been extended to the entire family of the officer. For example, Brende and Goldsmith discuss the "ripple effect" of traumatic events, in which the officer's entire family is affected by the traumatic event.[8] Such "post-traumatic family victimization cycles" require proper intervention, and include therapy considerations such as identifying intra-family alienation, defining a healing community, resolving shame and secrets, and breaking the repetition cycle.

These findings lend some support to the argument that officers' families may be secondary victims of trauma and should no longer be ignored by police psychologists and support personnel.

Couples and families are being recognized more and more as desired units of treatment and support following a traumatic event. Therefore, it is imperative that all service providers—especially police psychologists—look beyond the immediate officer-victim's needs to recognize the needs of his spouse/mate and children. It is important to note that treatment of these couples and families may require special interventions that go beyond traditional couples or family therapy to focus more on multidisciplinary psychoeducational and self-help principles.

Brooks discusses several "pitfalls" of past family therapy with Vietnam veterans, which may provide some insight into treating officer families.[9] Specifically, family therapy for Vietnam veterans has often consisted of a linear view that focuses on "what the family can do to help"—implying that the veteran's military experience is the cause of the family disruption. Similarly, guidelines for "communicating with the veteran" are often presented to the family. Brooks asserts that this linear view is also evidenced in "spouse/mate support models" for PTSD intervention, which clearly locate causality for problems with the veteran and his Vietnam experience. Similarly, communication problems are considered to lie with the veteran; when responsibility is partly on the spouse/mate, it is only in the sense that she is not responding to the veteran's deviant behaviors. In summary, this view has been one of "veteran as problem/family as victim."

Service providers and police psychologists working with law enforcement families need to heed this warning. Moreover, many law enforcement intervention programs take this same linear view with the police officer and his family. Immersion into a culture where one is surrounded by other officers, coupled with an expectation that he should be able to suppress his feelings and distance himself emotionally, may lead the officer to resist involvement in family therapy. Police psychologists must not only recognize the need for couples and family therapy following a trauma, but also consider the unique contextual variables associated with the police culture and the effect this may have on treatment.

A final consideration in the service to police families comes from an area familiar to many of us in law enforcement—the need for peer teams. The officer's extended family—the other officers within the agency—are a valuable commodity in that the police have been taking care of themselves for years. This tradition should not be discouraged. Rather, it should be used to expand the network of support and referral services. Together, teams work to prevent the negative impact of acute stress, as well as accelerate the recovery process in a person or group that has experienced a critical incident.

In light of the known effects of PTSD on family members, Critical Incident Stress Management (CISM) focuses on a broader systemic approach to mitigating potential harm. The value of CISM is being realized by increasing numbers of police departments

across the nation. In order to facilitate this support for family members, additional specialists—including chaplains, family counselors and school psychologists—may serve in a supporting role to the team supervisor when expertise with children/families is necessary. CISM in a family context would help avoid some of the pitfalls of the traditional linear model just discussed and would certainly go a long way toward the development of a multidisciplinary/multiprocess model for the inoculation against, and early intervention in, PTSD.

For these reasons, it is important that we be open to getting help at the earliest signs of difficulty in the officer's work, social or home life. AFTERBURN and programs like it establish a protocol for early intervention and pre-event education, and encourage the development of departmental policies and training guidelines for use by all victim service providers. The time for a more diversified multidisciplinary approach is here. We must begin now to prepare our police families for what is to come.

### *The Future*

Society has succeeded in promoting the myth of superhuman cops who are invincible in every way. Unfortunately, this myth serves only to expose the officer and his family to more stress, thereby setting him up for failure.

The reality of "doing the job" can have debilitating, long-lasting effects on the officer and the same consequences for his family.

Family members, significant others and co-workers are all burned by their vicarious exposure to crime and their direct exposure to the officer. The total impact of crime on law enforcement families is just beginning to be understood. The ripple does not stop with the officer. It spreads to the family, the agency and, eventually, the community.

Programs such as AFTERBURN are attempts to bring deserving recognition to *all* victims of crime today. We have ignored the police family far too long. Moreover, we have failed to realize the valuable resource we have in the police family.

Recognition of the afterburn is not the final solution, of course; it is only the beginning. Careers, families and communities—not to mention countless dollars—can be saved when we begin using the resources already available. Early intervention and crisis-response programs can mitigate and sometimes prevent the unnecessary loss of our most valuable resource in law enforcement. ❖

[1] This story was recently related by Sherie Carny, director of Victim Services, South Carolina Attorney General's Office.

[2] "Afterburn: The Victimization of Police Families," a national teleconference, was funded by a grant from the State Victim Assistance Program and produced by the South Carolina Department of Public Safety, Criminal Justice Academy Division, with the SC Educational Television Network. It aired on May 21, 1997, and is available by contacting the author at 803-896-7727.

[3] G.S. Everly and J.M. Lating, *Psychotraumatology: Key Papers and Core Concepts In Post-Traumatic Stress* (New York, NY: Plenum Press, 1995).

[4] G.S. Aumiller and D.A. Goldfarb, *The Heavy Badge*, unpublished manuscript, 1997.

[5] E. Kirschman, *I Love a Cop—What Police Families Need to Know* (New York, NY: Guilford Publications, Inc., 1997).

[6] N.K. Bohl and R.M. Solomon, "Impact of a Husband's Critical Incident on the Family," paper presented at the FBI "Law Enforcement Family: Issues and Answers" Conference, Quantico, VA, July 1993; E.M. Carroll, D.W. Foy, B.J. Cannon and G. Zwier, "Assessment Issues Involving the Families of Trauma Victims," *Journal of Traumatic Stress*, 1991, 4: 25-40; K. Coughlan and C. Parkin, "Women Partners of Vietnam Vets," *Journal of Psychosocial Nursing*, 1987, 25: 25-27; L.J. Maloney, "Post-Traumatic Stresses on Women Partners of Vietnam Veterans," *Smith College Studies in Social Work*, 1988, 58: 122-143.

[7] A.H. Ryan, Jr., "Post-Traumatic Stress Disorder and Related Symptomology in Traumatized Police Officers and Their Spouses/Mates," presented at the FBI "Law Enforcement Family: Issues and Answers" Conference, Quantico, VA, 1994.

[8] J.O. Brende and R. Goldsmith, "Post-Traumatic Stress Disorder in Families," *Journal of Contemporary Psychotherapy*, 1991, 21: 115-124.

[9] G.R. Brooks, "Therapy Pitfalls with Vietnam Veteran Families: Linearity, Contextual Naivete and Gender Role Blindness," *Journal of Family Psychology*, 1991, 4: 446-461.

trauma management consultants

## CHILDREN'S RESPONSE TO TRAUMA

Nancy Rich, MA

Children's responses to trauma vary according to the age of the child. Generally, children respond by reverting to behavior typical of an earlier developmental stage. These responses are considered **NORMAL** if they are of brief (under three weeks) duration. If any of these symptoms continue, there are professionals available to help you with your questions.

| AGES 1 – 6 | AGES 7 – 11 | AGES 12 – 18 |
|---|---|---|
| Bedwetting | Bedwetting | Withdrawal and isolation |
| Crying | Nightmares | Headaches |
| Immobility | Change in sleep patterns | Stomach pains |
| Excessive clinging | – unwillingness to fall asleep | Running away |
| Thumbsucking | – need for night light | Depression and sadness |
| Wetting pants | – fear of sleeping alone | Suicidal thoughts * |
| Loss of bowel control | – fear of darkness | Stealing |
| Fear of darkness | Irrational fears | Change in sleep patterns |
| Inattentiveness | Irritability | Sleeplessness |
| Fear of animals | Disobedience | School problems |
| Fear of being left alone | Excessive clinging | Nightmares |
| Fear of crowds | Headaches | Increased sleep |
| Overactivity | Stomach aches | Confusion |
| Underactivity | Visual or hearing problems | Violent fantasies |
| Nightmares | Refusal to go to school | Avoiding talking of event |
| Inability to sleep without a light or or someone else | Poor performance | Delinquent behavior |
| Awakening during night | Fighting | Use of drugs |
| Sensitivity to noises | Loss of interest | Use of alcohol |
| Irritability | Loss of concentration | Sexual acting out |
| Confusion | Distractibility | Accident prone * |
| Speech difficulties | Withdrawal | Relationship difficulties |
| Eating problems | Refusal to talk about event | Change in appetite |
| Stomach aches | Violent fantasies or play | Aggressiveness |
| Accident prone * | Re-enacting the event | Risk taking behavior * |
| Violent fantasies/play | Accident prone * | Overactivity |
| Re-enacting event | Appetite disturbances | Underactivity |
| Wanting to die * | Over/Underactivity | Irritability |
| Wishing to go to heaven * | Inattentiveness | Confusion |
| | Wanting to die * | Inattentiveness |

*** Any suicidal talk or actions should be taken seriously and professional help should be sought immediately. Younger children do not understand the permanence of death, so do not understand the consequences of "suicidal" behavior. Even very young children can become suicidal.**

(OVER)

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From:

**LIFENET**

# WHAT DO WE SAY TO THE KIDS

I is a disaster clinician and a member of a CISD team. I have frequently been asked "What do we say to the kids?" This is a concern expressed by emergency responders, teachers and parents. I thought it might be useful to share some of the suggestions I've found helpful when working with kids in crisis.

There are two basic assumptions that most adults make about kids that gets them into trouble. The first is that we can (and should) protect children from trauma and the second is that children have a capacity to abstract concepts about crisis.

The first assumption leads us to try to hide our own responses from children. Children's very survival depends on perceiving the emotional state of adults upon whom they depend. They know when their parent is upset. When we don't acknowledge that to the child, he must then make his own assumptions about what is upsetting us. The child has a very self centered view of the universe, and consequently decides that whatever has upset the parent is his fault. This, of course, leads to heightened anxiety in the child and actually makes the situation worse. Not telling a child what is going on, therefore, does not shield him. It actually creates distress.

The second assumption most often gets us into trouble when we try to explain death to children. Too often, we want to reassure the child that the dead person (or pet) is okay, so we tell the child that the person or pet is "happy now", "out of pain", "asleep"or "in heaven". None of these sound like a bad deal to. the child. but because they do not understand the facts about death, they all too frequently decide they would like to be with their loved ones in heaven and may become suicidal. Having seen a large number of children as young as five years old who have become suicidal after a loss has made me aware of what a dangerous proposition reassurances like this are.

It is important to tell the child explicitly about what happens to the body after death and to talk about the permanence of death. This is difficult. but it is much safer for the child. Children most often become suicidal after a loss because of their grief. Children do not usually get suicidal in the fact of trauma. but only in reaction to the deaths of people and animals they care about.

Some other tips which I have frequently used when working with children are:

* Treat all the child's fear as genuine. He is truly fearful.
* Do not make promises you cannot keep.
* Listen to the child - his or her feelings, fears, and beliefs
* Tell them the facts of what happened.
* Include the child in the clean up efforts and other activities designed to return life to normal. He or she will feel more in control if able to help out a little.
* Maintain the routines of normal life as much as possible.
* Young children need to be held.
* Let school personnel know when your child is in crisis - they can frequently help.
* Children work out their feelings through play and art more than through talking. They should be encouraged to draw the event or re-enact it in their play. Help them verbalize what they are doing, how they feel about it, and what their beliefs are about the event.
* Share your feelings with the child.
* Show confidence that both you and the child will be able to cope.
* Do not expect the child to take care of you or your fears. Find help to cope with your own fears.
* Provide realistic reassurance.

There are several sources of information which are useful when working with children. One is Mitchell and Resnik's *Emergency Response to Crisis* and another is a FEMA publication entitled, *Coping with Children's Reactions to Earthquakes and Other Disasters*.

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FROM: EMERGENCY RESPONSE TO CRISIS

Jeffery T. Mitchell
H.L.P. Resnik

# CHAPTER 6

# *Childhood Crisis*

Ann Scanlon-Schilpp, R.N., M.S.

## INTRODUCTION

Children in crisis present a complex challenge for crisis workers. Children in various age groups have specific needs and respond differently to the same crisis events. In addition, children undergoing severe stress frequently regress or return to behavior below their level of development. Another serious problem encountered by crisis workers is that they have a tendency to become emotionally involved with the children they are attempting to help. Emotional involvement frequently interferes with the proper crisis management.

Among the many events that produce a crisis state in a child or adolescent's life, injury, illness, and death are considered the most disruptive. The emphasis in this chapter will be on the care of children who are faced with these and other serious crises.

This chapter will review the main points of the intellectual, emotional, and social development of children in different age groups. By recognizing these developmental levels in children, crisis workers will be in a better position to develop an intervention plan that will be the most effective in the crisis situation.

Although the basic principles of crisis intervention discussed in Chapter One apply to the child as well as to his family, the special needs of children frequently call for special intervention techniques. The information and techniques suggested in this chapter will be most helpful in assisting emergency service personnel in the proper crisis management of children.

## BACKGROUND

During the first year of life, the major causes of infant death are primarily infections, specifically those of the respiratory and

gastro-intestinal tracts. The mortality rate decreases drastically after one year, and the major cause of death in the years leading up to and through adolescence is accidents.[1] The toddler (ages one through three), who now is beginning to explore his environment, is particularly vulnerable to such injuries as burns, falls, vehicular accidents, and ingestion of foreign materials like drugs, cleansing agents, insecticides, and more. The high incidence of death and disability due to accidents in the one to five age group occurs because:

1. The child has little ability to understand cause and effect relationships.
2. The child has little past experience upon which to draw, and use of judgment is not yet a part of his intellectual capabilities.
3. The child imitates adult behavior.
4. The concepts of motion and time are not developed.
5. Muscular coordination is not developed.
6. The child explores his world by bringing it to, and into, his mouth.[2]

The school age child and the adolescent frequently incur injury outside of the home. They are involved in automobile accidents, falls, drownings, or in athletic accidents. Between the ages of five and fifteen, accidents still rank as a leading cause of death. The incidence, however, drops markedly during this period, only to rise again dramatically during late adolescence.[2]

In order to assess the child, it is important to understand the process of growth and development. Since children are in a state of continual change, the job of assessment is a complicated one. Growth essentially refers to an increase in size (weight or height), while development refers to an improvement in skill and functional capacity.[3] This process, though varying to some degree from child to child, is an orderly one. Intellectual growth is markedly influenced by the child's social environment as well as by his emotional experiences. The focus of assessment here will be concerned with the child's psychosocial abilities, specifically his intellectual, emotional, and social development.





*A CHILD'S PSYCHOSOCIAL DEVELOPMENT*

| *INTELLECTUAL* | *EMOTIONAL* | *SOCIAL* |
|---|---|---|
| | Birth to Two Years | |
| Reflexive behavior: cries when wet, hungry, frustrated, or in pain.<br>Gradual development of behavior with a purpose.<br>Interest in new things.<br>Unable to form concepts.<br>Uses symbols and symbolic play.<br>Imagination.<br>Distinguishes "me" from "not me."<br>Memory development.<br>Can minimally infer causes from observing effects. Can predict effects from observing causes.<br>Self-centered. Has difficulty in appreciating other's point of view. | Learning to trust people and environment: most important person is mother or caretaking figure.<br>Needs: response to physical needs by mother through touching.<br>Security, safety.<br>Poor defenses against anxiety: crying, biting, throwing objects, hitting, head banging, rocking, sucking thumb, carrying "security blanket." | Primary source of socialization is family and this occurs within the home environment. |

| *INTELLECTUAL* | *EMOTIONAL* | *SOCIAL* |
|---|---|---|
| | Age 2-4 years | |
| Language development.<br>Imagination, "pretends."<br>Imaginative behavior: verbal and physical (dresses up like Dad or Mom: repeats things parents have said in his presence).<br>Learning through play.<br>Intellectual growth occurs by child gathering information through his senses from environment.<br>Major sense organs utilized for information processing are: the eyes and mouth.<br>Magical thinking: believes because he wishes something, it happens. | Learning to be autonomous.<br>Moving away from tight attachment to mother: learning independence, dressing self, washing, feeding.<br>Situations need to be structured as to kinds of choices.<br>Needs outside control and limits set on behavior, but given freedom to try and freedom to explore. | Primary sources of socialization are family and peers: learns through play with others, can cooperate with another child in play.<br>Learning to share. |

| *INTELLECTUAL* | *EMOTIONAL* | *SOCIAL* |
|---|---|---|
| | Ages 4-7 | |
| Fills gaps in his knowledge through questioning and experimenting "How come," "Why," "What's this." | Learning initiative. | Primary source is family and to a small degree peer group. |
| Uses all of his senses now in gathering information. | Seeks immediate gratification of wishes. | Can cooperate with other children in trying to achieve goal in play. |
| Ability to make judgments through primitive problem solving. | | Sharing. |
| Concept formation as child; now has more past experiences to which he can relate present situation. | | |

| *INTELLECTUAL* | *EMOTIONAL* | *SOCIAL* |
|---|---|---|
| | Age 7-12 | |
| Communicates about shared topics of interest. | Tolerates limited separation. | Family and peer group. |
| Sees others' viewpoint and not just his own. | Developing sense of independence. | Spends most of time with groups of children. |
| Concept of time, space, and motion developing. | Cooperates and understands treatment efforts with simple explanations. | One special friend. |
| Still concerned with the present and needs objects to manipulate to make logical relationships. | Has developed some defenses to cope with anxiety (denial, and magical rituals such as crossing fingers). | |
| Difficulty in projecting into future. | | |
| Operates on trial and error. | | |





| *INTELLECTUAL* | *EMOTIONAL* | *SOCIAL* |
|---|---|---|
| | Age 12-18 | |
| Considers possibilities even without experiencing them: not bound to what he can see and touch. | Strives for independence from family: parents target for this conflict. | Peer groups exerts strong pressure. |
| Considers hypothesis. | Seeking to find identity to "Who am I," "Where am I going." | Prone to taking irresponsible risks. |
| Uses logic in deductive and inductive reasoning without having to use observation. | Body image is an important issue. | |
| Understands cause and effect relationships. | Need for limit setting. | |
| Learning taking place through abstraction. | | |

The above material is used with the permission of Blake, Wright, Waechter: *Nursing Care of Children*. New York, J. P. Lippincott Co., 1970

## ASSESSMENT AND INTERVENTION

In assessment of the child, it is important to consider the following: age, past experiences with injury, what the child was doing when the injury occurred and what the child's developmental level is. Past experience plays a significant role in how the child deals with new situations. If he has been well cared for by his parents; if he has had his physical, social, and emotional needs met, then his response to you will be one of trust and respect for your authority. He obviously will be frightened and, possibly, panicky but approachable.

For the child under six, separation from his mother provokes the greatest anxiety.[4] He also fears pain, as well as disapproval. In the immediate treatment of the child in this age group, it is extremely important that the mother or caretaker be present to provide some security. The mother needs to be told what to do and needs help with maintaining her composure. Simple direct statements to the mother need to be given by the crisis worker. "It's okay to touch your child on the head," "hold his hand," "talk to him." Children between six and twelve are usually hurt doing things that their parents have warned them not to do. Often, the child fears retaliation or punishment from the parent. Guidance

for the mother needs to include a statement that lets her know that while it is okay to be angry with the child, her support and comfort are what he needs now.[5] Other intervention techniques are as follows:

- Since children are quite aware and sensitive to what is happening around them, as well as what is being said, it is important to monitor the conversation that the child will hear.
- It is also important to prevent him from seeing things that will be upsetting, particularly if a brother, sister, or parent is involved in the accident.
- This applies to children who are bystanders as well.
- These children should be escorted away from the scene of an accident by an adult. They should be given brief, simple information about what is happening.
- When approaching the child who has been hurt, the emergency service worker needs to do so calmly and gently.
- Tell the child your name and who you are.
- If the child is alert enough and can communicate, ask him his name, where he hurts, and what happened to him.
- The child's response to your question will tell you the degree of crisis he is in: if he can tell you where he hurts and some information about what happened, it means that his thinking is clear and an avenue for supporting him is now open to you.
- Just as adults can problem solve and cooperate more effectively when given information, so also can the child and adolescent. Simple, brief explanations of what you are going to be doing should be given prior to touching the child: "I'm going to look at your left arm now, Eddie," or "I'm going to take off your shoe, Eddie," or other explanation.
- Always call the child by his name.
- If something painful has to be done, such as an IV insertion, prepare the child for it. "This will hurt some, Eddie, when I put the needle in your arm. It's okay to cry real loudly."
- When you are finished doing the painful procedure or treatment, tell the child it is over and that he handled it well.



- Trust develops when the child is provided with the truth, as painful as it might be.
- Always tell the child about the painfulness of a treatment *before* it is given.
- If the child is capable of being given a choice, and if the situation allows for that, let him make the choice.
- If the child is physically able to help (for example, hold a bandage for you) let him do that.
- Try to make many procedures for the younger child into games.
- Selection of words when talking to a child is important. Be simple and honest.[2, 5, 6, 7]

A child's behavioral responses to injury can range from screaming and crying, to silence. It is important that the emergency service worker accept the child's behavior and his manner of expressing his fear. For the child who is quiet, ask if he is frightened and what might help him. Give him a suggestion like, "Would you like me to hold your hand?" (A great deal of touching is important when dealing with children.) Tell him it is okay to cry or holler if he wants to.

For the young child (age zero to three), who cannot communicate his needs and fears verbally, simple explanations are still needed. Should the mother be present, she should be allowed to stay with the child enroute to the hospital. Also, the helper needs to ask if the child has a favorite blanket or toy that may be given to the child to hold.

If the crisis worker has developed some rapport with the child, this should continue enroute to the hospital. If not the individual making the initial contact should then introduce the child to another person who will be taking care of him. If time permits, the child should be told that he is going to the hospital and he should be told what he can expect to happen there.[7]

In situations where both parent and child are hurt, the parent needs information about what is happening to the child, and reassurance that someone is with the child, caring for him. The child also needs the same information about his parent.

## SOME PRECAUTIONS FOR CRISIS WORKERS

1. Do not leave the child alone.

2. Do not threaten the child with punishment if he is uncooperative.
3. Do not tell him things like, "Big boys don't cry," or "You're acting like a baby."
4. Do not lie to child, "This is just a little stick," when in fact it hurts.
5. Do not frighten the child in order to gain cooperation. ("You'll die if this IV is not inserted.")
6. Do not talk about the child's family or living conditions in front of child.
7. Do not criticize the parents in front of the child.

It is generally believed that parents love and protect their children from the horrors of the world, and yet tragedies occur both to children who have supervision as well as to those who do not. The emergency service worker must be aware of:

1. His own responses to the circumstances surrounding the injury and,
2. The needs of the family during this crisis. No matter what the circumstances of the accident may be, it is important to meet the emotional needs of the family first, *and to do so objectively.* It is imperative *not* to make comments like, "If you had been there, this wouldn't have happened to your child," or any statement that reflects the fact that they were not caring appropriately for their child. Deal with the "here and now" and how they can be supportive to their injured child.[2]

One's own feelings need to be discussed with peers after traumatic situations rather than be kept inside of oneself. The crisis worker may have a child of his own and is reminded of this fact by the child with whom he is working. This identification can elicit many different feelings in the individual. These feelings may include anger, fear, or helplessness. If this identification does occur, the crisis worker may become emotionally distressed at the scene and may act disorganized. Removal from the situation by peers is necessary, and follow-up emotional care should be provided for this individual. (See Chapter 15 on stress and burn out.)

## PREVENTION

Emergency service personnel have the potential to act in many





roles within the community they serve. Besides their primary work in law enforcement and emergency intervention, crisis workers may also function in a prevention role. The crisis situation which they have been called upon to manage may often have other problems attached to it. Recognition of these problems may prevent future difficulties because they have made an accurate initial assessment of the entire situation. A child who has been injured in the home may be the calling card for the crisis worker's entrance into the situation. Once there, he may recognize another child's need for health care, or a family's need for home-safety education. Referrals concerning these areas can either be offered to the family, or made to the appropriate agency (law enforcement, medical, or social services) at that time.

Rapid intervention by other agencies can prevent many cases of neglect, abuse, or ignorance which might produce maiming and/or death.

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# After The Gun Goes ⊙ff

By Keith J. Bettinger

Have you ever jumped up in bed in the middle of the night in a cold sweat? I have.

Have you ever sat alone in a room and begun to cry over something insignificant? I have.

Have you ever found yourself becoming cold and withdrawn, and failing to participate in social or family activities? I have.

Have you ever had nightmares so terrible you woke up seeing yourself or loved ones on the brink of death? I have.

Why have I had these problems? Because I am a police officer, and on June 9, 1975, another officer and I were forced to shoot and kill an armed felon who was trying to kill the other officer and me. At that point I became not a hero as the department proclaimed, but a victim; a victim of Post Shooting Trauma.

Many people think there is nothing wrong with killing someone who is trying to kill you. In fact, some are even envious. They desire the hero status that is heaped upon you, while they go about performing their mundane everyday tasks.

Legally they are correct. There is nothing wrong with killing someone who is attempting to murder you. That is why, when the facts are investigated and presented to the Grand Jury, you are not indicted for homicide. The Grand Jury, a body of your supposed peers, listens and decides the taking of such a life was necessary and justified, and therefore everything is alright.

This type of mentality is very common on the party of the general public, as well as the police hierarchy. Everything is black and white, right and wrong. If the shooting is justified, there are no problems. However, this is not where the problems end but where they begin.

Killing someone preys on your subconscious. Killing someone conflicts with every moral belief you have been indoctrinated with by significant others.

Thou shalt not kill. All civilized societies consider life as being sacred and precious. If life is so precious, how do we justify to ourselves morally, the taking of a life? This is the moral conflict that must be resolved, or Post Shooting Trauma will remain a never-ending problem.

Social Psychology is the study of the individual in the [redacted]p. Let's explore Post Shooting Trauma and


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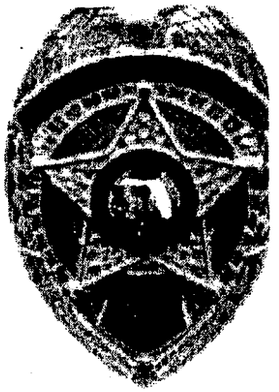

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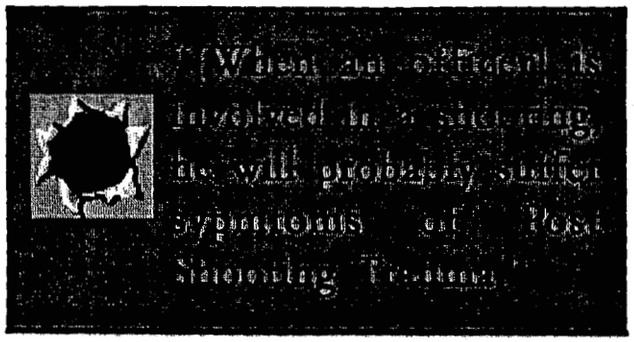
its victims using the same methodology. Consider a Police Department as the group, the society, and the officer involved in a shooting, suffering from Post Shooting Trauma, as the individual within the group.



Police Officers abide by not only the rules of the society they are sworn to protect, but, also have their own written and unwritten rules and codes. These are similar to folkways and mores. When an officer, a member of this large group is involved in a shooting, he will probably suffer symptoms of Post Shooting Trauma, and become a special individual in this group. This individual, his special problems, and the methods that can be used to assist him recover from his traumatic experience are what I'm going to discuss in this article.

Police combat is a unique experience. It is totally different than military combat. It is a close personal encounter. In most instances, a shooting involving a police officer takes place within seven yards. Think of it, a mere twenty-one feet separating you and your opponent in a struggle for survival that can have only one winner. What could possibly be more stressful than this winner takes all confrontation?

Post Shooting Trauma is the internalization of stress following a shooting. [1] It is a combination of stress, fear, confusion and anxiety. It usually sets in after your moral beliefs and reality come in conflict. There are many symptoms of Post Shooting Trauma, and a person suffering from it can suffer any one,any combination, or all of the following symptoms.

The first is sleep pattern disturbances, either insomnia or nightmares. Insomnia is simply the inability to relax and sleep following the shooting. The nightmares are another story. They are very frightening, mostly because the officer doesn't understand why he is having such terrifying visions.

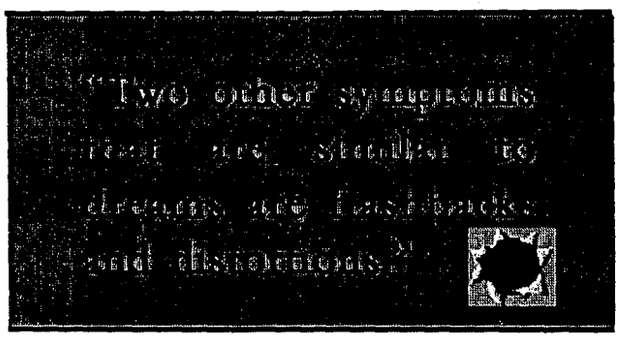
The dreams can be a reliving of the incident, night after night. Or, it can be a dream of being involved in another shooting, and being either wounded or killed. Some officers have dreamed that the person they killed was standing at the foot of their bed.[2] Some admit to being so frightened by this experience they have jumped up in a sweat, screaming in fear. I have experienced nightmares following my incident. The night after my shooting, I dreamed many of my friends were dying around me.

After that, I started to dream of being involved in other gun battles, all with the same results. In the imagined gun battle, I am forced to shoot someone again. Each time, the bullets either come out the barrel of the gun and fall on the ground, o

[1] The Police Chief, June 1981 p.58

[2] Correspondence Det. Dave Petrie, Hialeah, FL. P.D.

if they strike their intended target, they have no impact and the criminal just stands there looking at me. 80% of officers involved in shootings have nightmares related to their incident. 10% have a variation dream in which they dream of being in different shooting incidents. Those that dream of being killed are probably experiencing some form of guilt, whether imagined or real. [3]



However, there is a benefit to having these nightmares. According to Dr. Pasquale Carone of South Oaks Hospital in Amityville, New York, dreams are a way of working out a solution to a problem. Once the solution is reached, the nightmares will usually stop. [4]

A rape victim is also prone to nightmares. She is also a victim of an extremely traumatic experience. She dreams continuously, and as the dreams continue night after night, they usually start to change. The dreams start to go from being a helpless victim to where she is in control of the situation. The nightmares usually end when in her dreams she has overpowered her assailant, and in some instances killed him.[5]

Another form of a nightmare is a hallucination. It is experienced while the officer is conscious. He sees something while he is awake that cannot possibly be. An example of this is an officer who works steady midnights, sees the person he shot and killed sitting next to him in the patrol car, while he is patrolling his area.[6]

There is no way to tell when the dreams will end. Some officers are very fortunate. They don't have any. Others have a few in a relatively short time, make an adjustment and no longer experience them. For others, it seems they never stop. It took about eight years after my shooting for the nightmares to stop. Although they came less frequently, it still took that long for them stop. Occasionally when under a lot of stress I may have a nightmare related to shootings, but happily I can't remember when the last one was. If I do have one, at least I understand why and can deal with it.

Two other symptoms that are similar to dreams are flashbacks and distortions. A flashback is like an instant replay of the incident in your mind. As the officer replays this incident over and over in his mind, he starts to add distortions, which confuse his concept of reality. In most instances, as he is having a flashback he usually sees it taking place in slow motion.

This is a time distortion, and is very common. However, this leads to more confusion and anxiety because the officer starts to believe he had more time to do things

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[3] Correspondence P.O.John White, Dallas, TX. P.D.

[4] Interview [redacted]asquale Carone May 3, 1983

[5] The Aftermath of Rape, Thomas W. McCahill, et.al. pg.27

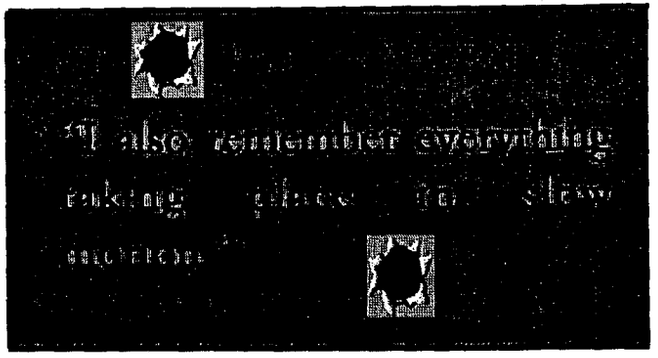
[6] Correspondence P.O. John White, Dallas, TX. P.D.

differently. He starts to think he should have taken the time to come up with an alternative to killing. He should have waited for help, he should have taken the time to ask him to surrender. The truth is, he never had time to do anything but think of his own survival. The incident was over almost as soon as it began.

Another distortion some officers experience is that of sound. Though it does not seem as serious as time distortion, it is real and confusing, and only adds to the officer's trauma.

Sound distortions can be caused by both the stress and surrounding noise. The heart pumping, the adrenaline flowing, the sirens wailing, people screaming. The sheer terror of what is before the officer. Some officers say they never heard the shots they fired.

Another distortion is that of sight. Some officers report seeing the bullets in the cylinder of the gun the criminal was pointing at them. Others say they could see the bullet going toward its intended target. That is inconceivable, considering a bullet travels at over one thousand feet per second. One officer spoke of seeing an imaginary line. If the armed man turned past that point, he had decided he would shoot. The man did turn past that point and the officer did shoot. After he fired the shot, he no longer could see the man.



He started to worry. Where had he gone? Was he going to be shot by this now unseen assailant? He couldn't see the man who was lying dead on the ground right where he shot him. He had put so much attention into his focal point that he developed a form of tunnel vision, and could not see beyond it. The autopsy and the statement he gave showed that the one shot he fired went directly along that imaginary line he saw in his subconscious that he used as a point of commitment. [7]

An officer was working late one night and checking the rear of a store. He surprised a burglar who fired shots at him. He immediately sought cover and took a position behind a large oak tree. The next day, he went back to the area to see things in the daylight. He found the large oak tree to be nothing more than a sapling.

I can recall many of the distortions I encountered. I had a flashback on my way home from work the day of the shooting. I recall seeing the man sitting in an upright position, alive and being instantly transformed into a lifeless human form. I saw this while I was sitting in my car at a traffic light. When I think of it, it's almost as though I can still feel the cold chill that passed through me that day.

I also remember everything taking place in slow motion. I thought I saw the bullet come out the end of the gun barrel and watched it travel until it hit him.

[7] Smith and Wesson Post Shooting Trauma Seminar, Smith and Wesson Academy, March 14-16, 1983

I thought I looked at my gun in amazement and dwelled on the thought of how accurate it was. I remember running about thirty feet to the side of the vehicle he was in. I thought it was taking an eternity. I thought I would never get to the side of the truck. When I did, I still can't believe how terrifying a sight it was watching him come across the seat of the truck as if he was going to overrun me. I fired three more shots. The first hit him, the second missed. How do you miss from two or three feet away? The final shot struck him. I kept firing. I was unable to count to six, the number of bullets in the gun. I never heard the six shots going off. What I did hear was the sound of the empty gun going Click! Click! Click!

Those empty clicks were the loudest sounds I have ever heard in my life and that sound will be with me forever.

After a shooting, some officers retreat into a period of isolation. This can affect their job performance and family relationships. Some no longer participate in family functions. Others no longer have any interest in their usual outside activities such as hunting. A lack of communication between the officer and his family members is very common. This withdrawal can also affect the officer's sex life. A percentage of officers involved in shootings suffer from some form of sexual dysfunction or impotence. This is especially true if they were wounded and lost the gun battle. [8]

Sometimes there are periods of depression and helplessness. Some officers will sit and cry over insignificant things. Others are moved to tears by the sound of patriotic music. The officer cannot explain why this happens to him, but he knows it does. [9]

Some begin to engage in self - destructive behavior. Some take on a "John Wayne Syndrome", taking unnecessary chances. They don't wait for assistance on dangerous calls. They start to feel indestructible. If they survived the first time, what can happen the next time?

For others the realization can become unbearable. Thoughts of suicide are common among officers who have killed. In fact, police officers have a very high suicide rate under normal conditions. Compound it with Post Shooting Trauma and the results can be phenomenal.[10] This depression can become worse during holiday seasons.

An officer who has killed sometimes starts to feel sorry for the family of the person he killed. He starts to dwell on the fact that there is someone missing, someone's son, someone's father, or someone's husband. Though he is happy to be able to spend the holiday with his family, someone's family is feeling the loss he believes

8 Telephone Interview, Massad Ayoob, May 2, 1983

9 Anonymous Police Officer, Post Shooting Trauma Tape, Dallas, TX. P.D.

[10] Smith and Wesson Academy, March 14-16, 1983

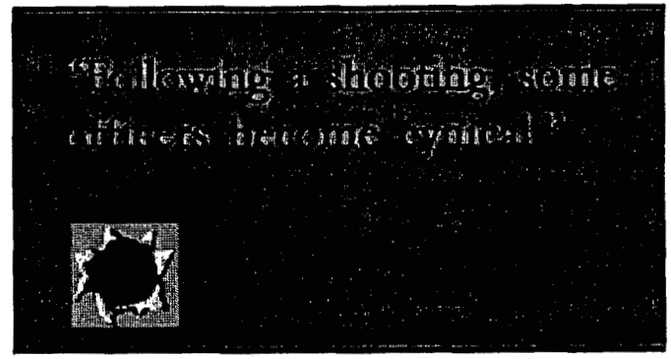
[11] Suffolk County Police Combat Group Meeting

he caused.[11] I know. I was depressed the first Thanksgiving and Christmas following my incident. The man I killed would have killed me if he could have, but his family never did a thing to me. I grieved for them.

Other officers become confused by a reverse feeling, a feeling of euphoria. They start to notice little things. They notice the sweet smell of spring flowers, birds singing, children laughing, the nice warm feeling of the sun on a spring day. They feel as though they are happy they killed someone. This adds to their trauma and confusion. They're not happy they killed, but just happy they survived, and are able to enjoy these little pleasures.

Self-doubt is another problem when an officer returns to work following a shooting. He begins to second-guess himself. He wonders if a similar situation arose again would he be able to do it again.

Another common fear is "What happens if I act too quickly? Will I take a life needlesslly?" Or the reverse, "What if I hesitate and don't act quickly enough, will I be killed?" These are real fears and the officer must come to grips with them if he is ever to be an effective officer again. I remember one night shortly after my shooting. My wife and I were driving home when suddenly we were being chased by another vehicle. We had no idea what was going on, but we were both afraid. I remember taking out my off-duty gun and placing it under my leg. When I was finally able to stop and confront the other driver, I stood behind my car door with my gun in my hand out of sight. He jumpled out of his car and stood with something in his hand accusing me of cutting him off in a hamlet I had not been in. It was a case of mistaken identity. It was also an incident that could have had a tragic ending, had he advanced towards me with whatever was in his hand. I was afraid he might be an associate of the man I killed.




As the situation stood, there was not sufficient reason to shoot him, but certainly enough grounds to arrest him for harassment. But, the fear of my shooting stuck in my mind. I really didn't want to be deeply involved in a traffic dispute, and if the situation had gotten to the point where I was in fear for my life and had the grounds to shoot, I don't know if I would have been able to at the time. At that point, I was more afraid of what would be said about me being involved in two shootings in such a short period of time. Self-doubt and public opinion were more important at that time than my own safety.

Following a shooting, some officers become cynical. They no longer trust the department. They have problems with their supervisors. They no longer respond to either requests or direct orders. Others totally disregard departmental rules and policies. Along with this distrust, they no longer wish to become involved in any police

action. They become unproductive members of the department that can no longer be trusted or counted on.

Part of this problem, though, is brought on by the department. Some departments expect you to be back to work the next day as if nothing ever happened. Others suspend you until the investigation is completed. They make you feel as though you did something wrong. Awards are given out for heroics, but the degree of the award might not meet with the officer's expectations, and again he feels as though he is being cheated. As these feelings increase, the mistrust and cynicism starts to mount. The taking on of compulsions or going to extremes is very common following a shooting.

Alcoholism is rampant in police departments. Alcohol abuse rates of 20-40% in a department are not uncommon.

When you compound the ordinary stress of the job with Post Shooting Trauma, the officer can begin to medicate his stress with alcohol. Drinking in this way is not a social experience, and if it continues the officer can easily cross the line into alcoholism. [12]

Overeating is another compulsion a Post Shooting Trauma victim might go to. I know I am a compulsive overeater. Although I have always tended to eat too much, I truly believe Post Shooting Trauma pushed me beyond the levels I would normally consume.

By combining food and alcohol to relieve stress, soothe nerves, celebrate life, honor heroism, or toast another excuse for overindulging, I was able to bring my weight up beyond a respectable level in less than a year's time. I was totally out of control of my food consumption. I have no doubts that if I had turned to alcohol as opposed to food, I would have become an alcoholic due to my stress. Other officers become compulsive gamblers or spenders. They start to fear their mortality, and live life to the fullest without any thought as to how they are going to meet tomorrow's bills.

Promiscuity can also be a problem of Post Shooting Trauma. After killing someone, the officer starts to feel unclean. He feels as though he has lowered himself into life's gutter. He feels as though he is so dirty and unchaste he can no longer have a healthy relationship with his wife, who he holds in high esteem. He then strays from his main support during such stress, his wife, and seeks the company of a partner who occupies a station in life as low as what he perceives himself to be. [13]

There are also abuses of sick time. Simply put, the officer finds it easier to stay home than to go back to work. If he sits home and watches television, the officer can't get involved and be placed in a situation that threatens him. As this abuse of sick time goes on, the officer makes more problems for himself than he could have ever anticipated. One problem is that his bosses start to look at him as a malingerer. He is undependable and cannot be trusted.

Hero worship soon wears off once the officer starts to be a

[12] Interview Sgt. James O'Brien, Suffolk County Police Department

[13] Smith and Wesson Academy, March 14-16, 1983

problem. As this continues, he might have been in line for a transfer to a desired position. If he cannot be trusted, he can forget about the opportunity ever presenting itself. Or, he might suffer the reverse. If the bosses think he is a problem and wish to create a remedy for themselves, they will transfer him to an unwanted job as punishment.

Why does an officer suffer like this from Post Shooting Trauma? Because he is the victim of a violent crime. An officer involved in a shooting is no less a victim than the store owner that is robbed, the senior citizen who is mugged or the woman who is raped. Each and everyone is the victim of a violent and personal crime. Even though the officer is victorious in battle, he is no less a victim of a traumatic conflict. A conflict that is a close personal encounter.[14] How does an officer overcome Post Shooting Trauma? With the assistance of the special society of which he is a part. What makes up this society surrounding this individual officer? Basically this society consists of three special groups; his family, the other officers he works with, and the department that employs him.

The family has many responsibilities in the officer's recovery. First of all, a wife has to be very understanding. If the marriage is not solid prior to the shooting, it probably will not last. A wife has to know when to talk, when to listen, and especially when to touch. Sometimes that nonverbal communication means more than anything that could be said. Those unspoken feelings demonstrated by my wife have helped me through some difficult times. The wife will also have to screen questions from outsiders. She will have to try and run interference and shield him from the neighborhood ghouls looking for before. She will also have to continually support the children, and maybe even have a conference with the children's teachers in order to protect them from the vicious school yard grapevine. What could be more horrifying for a child than to be told by others that his father is a murderer? This is done not only by children, but by unin-

She will also have to spend more time with the children. She will have to explain to them why their father is not acting as he did



[14] Interview with Massad Ayoob, May 2, 1983

formed people in the community, or newspapers editorializing rather than reporting.

A wife must, under all circumstances, refrain from making stress contributing remarks. It was told at a seminar that one officer's wife said while they were in bed, "Wow, I'm sleeping with a killer." This only creates more stress for the husband.[15]

Finally, a wife must be able to recognize the symptoms of Post Shooting Trauma. When she sees her husband suffering these symptoms, they must sit down and discuss what is taking place and together they should seek a remedy to the problems of Post Shooting Trauma.

The police officers whom the shooter works with also bear a responsibility in his recovery. First of all, they should remember what he is going through. They have to be kind and understanding. They shouldn't go up and pound him on the back and call him killer and tell him how great it is that he killed someone. They also should not go up and tell him they wish they had been the one that killed the criminal; he probably wishes they had too. The pain of surviving is a lot heavier to bear than the feelings of heroism.

What one of these officers should do is go and ask him how he is doing. Ask him how his family is and if there is anything he can do for them. The officer's family is very important to him at this point.

Don't ask him for all the gory details, he has been through it enough with the investigators. However, if

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[15] Op. Cit.

he does decide to talk about the incident, or some aspect of it, do him a favor, be a good listener. At this point, more than anything he needs a sympathetic ear. He might have things to share with another officer, which he cannot or will not discuss at home.

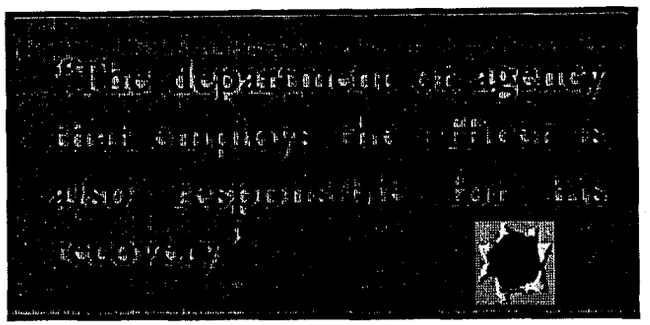
The department or agency that employs the officer also is responsible for his recovery. First of all, the department must understand what Post Shooting Trauma is, and that it is a real problem.

It also must provide him with the services necessary for his recovery. At present, only one out of five major police departments have any type of stress reduction program. Very few have any type of program dealing with Post Shooting Trauma.

Finally the officer himself must admit he has a problem and seek the services that are available to him. Others cannot force someone to be helped. The individual must want to be helped if recovery is going to be possible.

There are many forms of stress reduction that can be used to reduce Post Shooting Trauma. One is behavior modification; the use of deep relaxation is effective. Hypnosis is a very valuable tool also. I found it to be very helpful in reducing my stress during the year following my shooting.

I have done some research on Albert Ellis' Rational Emotive Therapy and how it can be applied to alleviate



Post Shooting Trauma. I think, it too, is a very effective method, especially since it can be done in either a group setting or with an individual, and the severity of its application can be geared to each person as needed.

However, my personal choice for dealing with Post Shooting Trauma is the use of peer counseling. I developed such a program for the Suffolk County Police Department. It is based on the working principles of Alcoholics Anonymous. The SOLVE Team, as it is called, meets once a month and is comprised of people with a common bond; Post Shooting Trauma. What is said stays within the group. Officers are free to openly discuss whatever is bothering them, and other group members explain how they handled similar problems.

Members can tell a new member what to expect during the course of the investigation, at court proceedings, and at home. They can also tell the recent shooter what not to be alarmed by, such as questions by Grand Jury members, or that waiving your right to immunity when testifying before the Grand Jury is standard procedure. They can tell him why the department took his gun for tests, and when he can expect it back.

The group can also teach the department how to handle an officer involved in a shooting. It can recommend changes that can be implemented to assist the officer through this most stressful time. We try to help the officer understand that he did the best job possible with the information that was available to him at the time.

The goal of our group is the return of a healthy officer to not only his department and his community, but to his family as well, and to allow him to function normally. If we can provide him with this service, we have done a great deal to help him, because it has been shown that if an officer is not afforded some form of counseling following a shooting, when presented with a second incident, 70% are either wounded or killed. This is what we are trying to prevent.✪

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Dallas, T.X., Police Department Post Shooting Trauma Tape, Annonymous Officer



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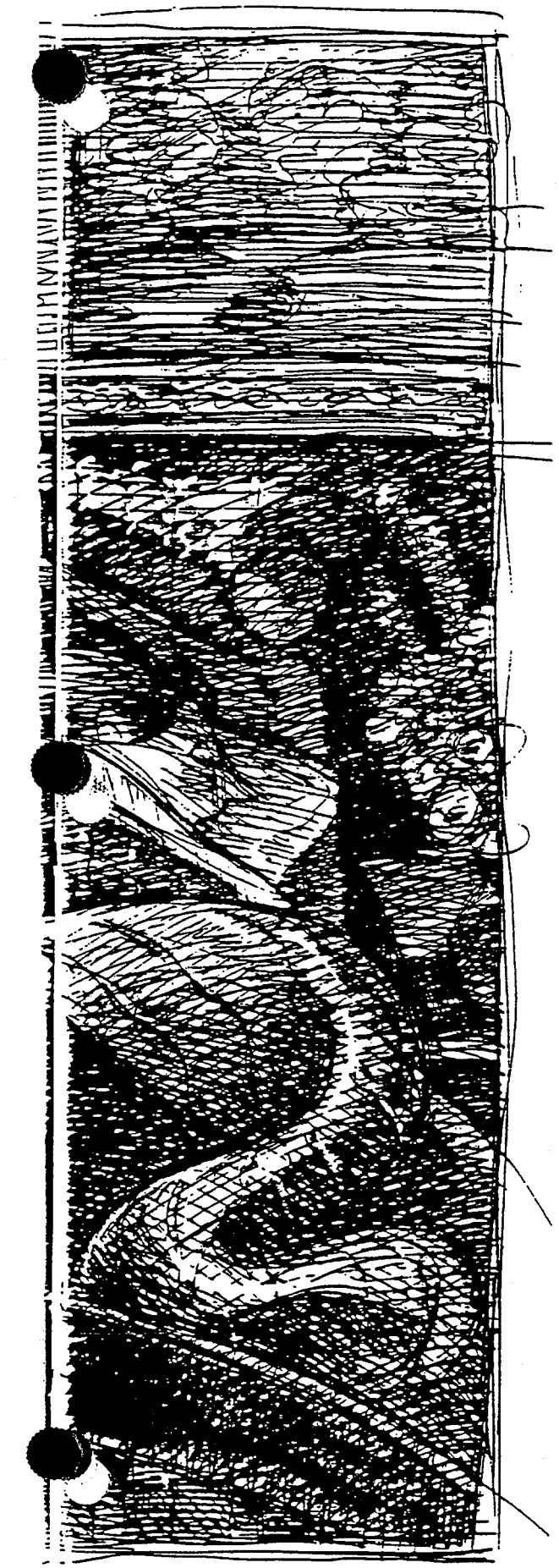

# STRESS

## The History, Status and Future of Critical Incident Stress Debriefings

by Jeffrey T. Mitchell, PhD

In January 1983, *JEMS* published the first article on "Critical Incident Stress Debriefing."[1] It stirred a nationwide and worldwide trend among emergency service organizations to develop programs to assist emergency personnel before and after they encounter distressing events on the job. The two main goals of the Critical Incident Stress Debriefing (CISD) are to:

- Lessen the impact of distressing critical incidents on the personnel exposed to them; and.
- Accelerate recovery from those events before harmful stress reactions have a chance to damage the performance, careers, health and families of emergency services personnel.

A process like the CISD program does not just simply fall out of an article without some roots in history. Before it was written down in that landmark article, there was a long history of development of the CISD process which started in 1974 when this author was a regional EMS coordinator in the State of Maryland.[2,3] Nine years of development went into the CISD process before the concept was presented publicly in the 1983 article.

Human ideas rarely ever formulate by themselves. There are many human experiences and subtle influences which interact with one another until a new idea evolves. The new idea actually has a foundation in many other ideas which were shared between people over decades and perhaps over centuries of time.

The CISD process is one of those concepts which evolved out of the experience and influences of many individuals and organizations. Four major influences can be pinpointed as the foundations of the Critical Incident Stress Debriefing process:

- Military experiences
- Police psychology
- Emergency medical services
- Disasters

### Military Experience

Combat stress reactions have been recognized since 603 B.C.[4] Historians report that the American Civil War produced thousands of combat stress victims.[5] By World War I, new methods of assisting combat stress victims were being employed. It was found that quick treatment of soldiers suffering from severe stress in field hospitals near the front lines was far more effective than delayed treatment

ILLUSTRATION BY BRYAN PETERSON

in distant hospitals. Approximately 65 percent of those who received immediate psychological treatment for stress were able to return to combat duties, but less than 40 percent of those who were given delayed treatment in distant areas were able to return to combat.[6-8]

Rudimentary debriefings, provided by Dr. W. Glenn Srodes on Utah Beach during the D-Day invasion in World War II, were found to be quite helpful to stressed combat troops. Many were able to return to their duties after the brief discussions with psychological support personnel? World War II units without psychological "first aid" sustained significant personnel losses, as distressed personnel had to be evacuated to distant treatment centers. Delays in treatment resulted in very few men returning to effective military duty![10]

The Israeli Defense Forces can be credited with the first effective research on psychological first aid and group psychological debriefings. It was noted in the Israeli studies that rapid intervention near the front lines, which involved group as well as individual support, reduced the incident of serious psychological disturbances, especially Post Traumatic Stress Disorder, by as much as 60 percent![11-13]

### Police Psychology

Police psychology units form the second major influence in the development of CISD teams. Police psychologists came into the emergency services in the mid-60s. Although the majority of police psychologists worked with individual officers and not groups, they contributed a great deal to the understanding of stress effects on the police services and their families.[14] Police psychologists have added tremendously to knowledge about the personality profile of emergency workers, specifically police, and have recommended the best types of psychological support services.

Police psychologists have utilized a number of support strategies which have influenced the development of the CISD process. They include family support services, educational programs, post-shooting trauma teams, peer support officers and group debriefings![15]

### Emergency Medical Services

Emergency medical services organizations began developing psychological support services for staff members in 1972. The first programs were based in large hospitals and trauma centers. Services for staff members arose as an offshoot of services for traumatized victims and their families.[16,17] Those early efforts on the part of hospital-based social workers and psychologists for overburdened and overstressed staffs pointed to the need for the development of support services for field personnel as well as hospital-based personnel.

Nancy Graham, M.S. of Los Angeles, was among the first hospital-based mental-health professionals to see the need to reach out beyond the hospital to those who worked in the field. Her lectures and well-written articles formed another important support for the development of the CISD concepts![3,19]

### Disasters

The last major influence on the current CISD process are disasters. During the last 10 years, the National Institute of Mental Health has sponsored numerous studies on American disasters and has supported the development of several important documents that clearly point out the need for psychological support services, especially debriefings for police, fire and emergency medical personnel![20,21] But even before these documents were published, disasters were showing themselves to be so extraordinarily powerful that few emergency workers escaped without significant stress reactions![22-24] Since large groups of emergency personnel experienced the same type of stress, it was felt that group debriefings would do much to eliminate the common but inaccurate feelings that disaster workers were either unique or abnormal if they experienced distress after working at a disaster![25]

One person who felt strongly that group debriefings were important to alleviate stress in emergency personnel was Captain Chip Theodore of the Arlington County (Va.) Fire Department. In 1982, he worked at the scene of the Air Florida Airlines crash in Washington, D.C. He and his personnel were extremely stressed by that incident and Capt. Theodore pushed for the development of the first Critical Incident Stress Debriefing team in the United States![26] The Arlington/Alexandria CISD team came into existence one year later. The team continues to function today.

### CISD Teams

Since 1983, 75 teams have been established in 25 states across the nation. (Nine states have full statewide teams.) In addition, teams now exist in five nations—U.S., Canada, Australia, Norway and Germany. In all, the teams have provided over 4,500 debriefings to thousands of emergency personnel in events ranging from single victim auto accidents and shootings to full-scale disasters such as the recent Ramstein, Germany air show catastrophe.

### Three phases of CISD development

The CISD concept has passed through two development phases during the last 14 years. In 1974 the first phase was conceptualized and tried out in various forms and ended with the publication of the 1983 CISD article in *JEMS*! The second phase was refinement of CISD strategies and tactics, and further development of

teaching strategies and course content. This phase will continue. The bulk of phase two, however, is drawing to a close with the publication of this article. A consistent training course has been developed and is being employed in team training. The basic protocols for CISD teams across the nation are very similar if not identical.

The third phase of CISD development is evaluation of the process. Further refinement of the intervention strategies is yet to come. This does not mean that evaluations of debriefings have not been achieved. It simply means that CISD evaluation is new and much more must be done. The first evaluation studies have been undertaken by a very credible researcher, Dr. Robyn Robinson of Melbourne, Australia (who in 1986 conducted the largest stress-related study of emergency services ever).[27] Her preliminary data in the current study indicates that the majority of emergency personnel (fire, police and ambulance) who attended debriefings in Melbourne, Australia during the last year felt that the sessions were helpful. In fact, the more serious the incident, the more helpful were the debriefings perceived. In addition, Dr. Robinson found that most attendees at debriefings felt that their group (unit or squad) benefited from the debriefing process even if they, as individuals, only experienced a minimal amount of personal help. Seventy-five percent of those who participated in her recent preliminary study cited three main values of a CISD. They are:

- The opportunity to express oneself and be assured that one's reactions are normal;
- The chance to learn from others and mobilize one's own coping behaviors; and
- The ability to gain a greater understanding of Critical Incident Stress.

Many emergency personnel also reported that they experienced a lessening of stress-related symptoms after a debriefing. The few negative comments provided by people in the study who were debriefed after critical incidents did not indicate that debriefings were not helpful. Instead, they made suggestions for improving the process of the debriefing and the communications between the CISD team and those being debriefed.[28]

Dr. Robinson's research is exciting and promises to shed greater light on the CISD process. Her final report is likely to be filled with carefully gathered data and appropriate conclusions which will guide CISD teams into the next decade. CISD teams everywhere will be looking forward to the publication of Dr. Robinson's recent and future studies.

### Further Support for CISD

Recent studies at Harvard University have lent further support to the provision of immediate intervention after traumatic events. Dr. George Everly suggests defusings and debriefings (see Part 2 of this article in the December 1988 *JEMS*) within 24 to 72 hours after a critical incident. Rapid initiation of defusings and debriefings help block a serious cognitive misinterpretation of the event. Misinterpretation of the *personal* meaning of a critical incident may produce the very serious psychological disorder called Post Traumatic Stress Disorder. Dr. Everly points out that in cases where help for extremely traumatic events was provided within three weeks, the costs for treatment of a severely traumatized person were about $5,000. If help was delayed beyond three or four weeks, a severely traumatized person or his organization might be faced with bills of approximately $200,000 to achieve recovery.[29]

It is obvious that the third phase of CISD development has just begun. Much more research will be needed in the future to assure a stable place for CISD teams as supports for emergency services personnel. The challenge for CISD teams lies in

the development of carefully designed research projects that do not violate the important services of CISD teams or the confidentiality of debriefing participants.

### The Future

Research is not the only challenge to CISD teams in the upcoming years. Other issues must be given careful consideration or the CISD process will be doomed to failure.

The first and most important issue is a continued emphasis on pre-incident stress education. This has always been a mainstay of the CISD process.[22,30] The more information people have on stress and its effects, the better they can recognize stress and seek help when they become overwhelmed. Administrators and instructors have to recognize the essential nature of stress training and commit themselves to continued support of pre-incident training. Otherwise, they will spend more time and resources on rehabilitation people who might have avoided or lessened their stress with appropriate training before such events hit.

The next important issue to be emphasized is administrative support for emergency personnel. Even the best CISD teams, that have provided the very best pre-incident stress training and the best post-incident debriefings, will be frustrated and ineffective if they are forced to work in an environment where administrators do not acknowledge a need to support their most valued resource — *their personnel.*

Another challenge for CISD teams is to maintain the middle position, or even better, a neutral outside position to all of the political factions which exist within emergency services organizations. CISD teams must avoid becoming the political footballs of unions, management, government and special interest groups. CISD teams have been developed to assist stressed emergency personnel and to restore them to service as soon as possible. Any diversion limits their ability to achieve their main objective.

As they become more widely known, CISD teams will be tempted to take on more and more services for their communities. They must be cautious in their efforts to help every group that approaches them with a need. Attempting to help too broad a spectrum of people will dilute the ability of the teams to provide effective services, leaving them fragmented and exhausted with little energy left for the people they were designed to help — *the emergency services personnel.*

Another challenge for CISD teams is to stick closely to the CISD model which has been carefully designed to assist emergency personnel and has been tried on many incidents with notable success (see Part 2 for a description of the CISD model). Significant changes in the tried-and-true methods may cause more damage to emergency personnel. For instance, if a CISD team tries to make a debriefing into a psychotherapy session, which it was never designed to be, emergency personnel may be left more distressed than if help was not provided at all.

On the other hand, CISD teams must make considerable effort to keep up with new developments in the field of stress. They need to be adaptable to new information while simultaneously holding tightly to proven CISD strategies.

### Conclusion

When they were first mentioned in 1983, Critical Incident Stress Debriefings were a new, relatively unresearched, psychological and educational process designed to mitigate the effects of stress and accelerate the normal recovery process of emergency personnel. Many scoffed at the idea of emergency personnel discussing in a group how a critical incident had affected them. Few thought the concept would last long.

Today, CISD teams are being woven in-

to the fabric of emergency service organizations in several countries. Not everyone has become a believer; some actively resist any effort to support them. There will probably always be doubters and resisters. Not everyone in every instance will benefit from a CISD. Many times they'll need more help than a debriefing alone can provide.

But, the evidence is beginning to mount as CISD teams have been successful in assisting many emergency personnel. The teams have grown from a clumsy, unsophisticated developmental stage into a more organized, structured and efficient stage. Hopefully, they will also become integral and permanent parts of emergency service units as they repeatedly prove their value by assisting emergency personnel who are just too valuable to lose.□

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# CISD INTRODUCTORY REMARKS

The following remarks may be used by a team leader to introduce a Critical Incident Stress Debriefing. It is not necessary to state each item in each debriefing. These general remarks do however cover the main introductory points for a CISD. It is best that the concepts presented on this outline be given to a CISD group in the words of the team leader and senior peer. They should not be read to the group from these pages. At times, it may be necessary to add additional comments not shown here. This can be done at the discretion of the team leader. The order of the presentation of the items is not of major importance. What is important is that the basic CISD guidelines are presented by the CISD team during the introductory phase of the debriefing.

* Team leader identifies self.

* We are here because of (describe or name the critical incident).

* Some of you do not want to be here. You feel you don't need a debriefing. Please remember even if you don't need help, others present here do. Please stay. You may be able to help some of the people in this room simply by your presence. Please try to be helpful to one another.

* Some of you feel you can handle this on your own. That is probably true. However, experience demonstrates that people who try to handle everything alone take longer to do it.

* A critical incident is any event which is extraordinary and produces significant reactions in emergency personnel. The critical incident is so unusual that it overwhelms the usual, normal abilities which emergency personnel have to cope with a situation.

* The CISD process is designed to lessen the overall impact of an event and to accelerate recovery in normal people who are having normal reactions to abnormal event.

* We have found that people who talk about a bad incident eat better, sleep better, remain healthier, stay on the job longer and do not have as much disruption in their home life.

* The CISD process is a discussion of an unusual event but it is not a critique or part of an investigation.

* No notes are allowed. Neither do we allow recordings of what is said and the representatives of the media are never allowed.

* Everything that is said in this room is confidential. Heavily emphasize confidentiality. Nothing leaves this room.

* You will only be directly asked to speak two times. The first time we ask each of you to tell us who you are, what your job was at the scene and what happened out there. The second question we will put to you is to ask if you could cite your first thought once you stopped functioning on automatic.

* You do not have to speak at any time if you wish not to speak. However, we do not recommend that because it can do more harm than good. We recommend instead that you open up and talk about the incident.

* Our main job is to get you back in service and keep you as healthy and satisfied as possible. We are not here to take you out of service. We are here to listen to you and to help as best as we can.

* You may ask any questions you wish and we'll try to help you out with some practical and useful information. Please ask any question anytime you wish.

* Please speak only for yourself. You cannot possibly speak adequately for how someone else is reacting.

* Remember, confidentiality is the key. We need to have a pact of trust between all of us. Everyone has already been hurt enough. Don't use anything you learn or hear in this room.

* We do not want anyone to make judgment on anyone else. Every person has their own perspective. Let each state it without judgment.

* We will not take any breaks. If you have to take care of your personal needs do so quietly and then return to this room. Leaving and not returning to this session is considered harmful to you. Much of what we discuss at the end of the session is extremely valuable information which may be helpful. We don't want you to miss it so please hang in there with us.

* Please look around the room and point out anyone who does not belong in this room. The CISD team members will briefly raise their hands so that you might more easily identify them. Anyone else who you don't recognize please point out and we will challenge that person's presence. If an officer were at the scene he belongs here. In the case of line of duty death, the entire department belongs in one of these sessions.

* No one has any rank during this session. We are all just people trying to struggle through some pain and make some meaning out of a chaotic situation so forget your rank and be a person first.

* We will be around at the end of the session. If you want to talk to us, feel free. We are here for you. Anything you can't tell us in the group you are welcome to tell us alone.

* We will begin in just a moment by asking you to tell us about the incident.

* But one final reminder about <u>confidentiality</u> before we get into the facts of the situation. Let's keep whatever is heard here in this room.

* We'll have a handout or two at the end of the session.

GUIDELINES FOR ON SCENE SUPPORT SERVICES AND INTERVENTIONS

I. One-on-One Interventions

A. One-on one interventions will be provided only to those workers displaying OBVIOUS signs of distress and who are receptive to assistance. Signs of OBVIOUS DISTRESS include:

1. Crying
2. Shock-like state
3. Unusual Behavior (may include a change in cognitive skills)
4. Acting Out Behaviors (punching, screaming, kicking, etc.)

B. The interventions will take place when the personnel are not actively engaged in service.

C. The interventions will last 5 to 15 minutes in length.

D. The interventions shall take place in a neutral atmosphere or in a position out of view, sight, or sound of operations when possible.

E. Interventions will focus on the immediate (here and now) and will include the following (as an intervention guide):

1. ASK - What is happening with the individual at that moment

2. LISTEN and REASSURE - that the feelings are normal (not abnormal) and dispel the "myth of uniqueness".

3. STATE -Inform the emergency service worker that the main objective is to return him/her to service as soon as possible, BUT that decision will be made as soon as the worker is ready to make it.

4. ASK - What is the worst part for them right now?

5. ASK - What will help you right now? (Provide the need if possible)

6. GOOD LISTENING - display good attending skills, offer supportive comments.

F. NO "GROUP" INTERVENTIONS IN THE FIELD!!!

NOTE: Interventions are successful if the actions are genuine, sincere, and the team member offers assistance in a confident manner. When in doubt as to what to say or how to say it, Dr. Mitchell offers the following suggestions:

Ask yourself the following:

1. If I were in that persons position right now what could be said to me that would be most helpful?
2. If this were someone I loved and cared about, what would I want done for them right now?

G. Distressed individuals should show signs of improvement within 15 min. of the intervention process.

H. It will be our procedure and our recommendation to the incident commander that all persons receiving one-on-one interventions be given an additional 15 to 30 min. rest period after the intervention is completed. During the rest period, the team member will allow the provider to "rest" and will not remain actively involved with the provider. While the team member will want to feel sure that the provider will not return to duty before he has had to opportunity to check his progress, the team member will give the provider "breathing space". When placing a provider in a "rest state", the team member will tell the provider that he will be back to "check on him" in 15 - 20 min. and request that the provider remain in position until his return. Upon rechecking the provider, the team member should be able to determine and recommend with some assurance and confidence whether the provider should be returned to duty or an alternative.

I. Restoring a provider to service will depend upon how well he/she is functioning and/or feeling after the intervention and rest period. Some considerations include:

1. If a provider is very distressed and 15 minutes. of one-on-one seem ineffectual, consideration for immediate removal should be given.

2. If a provider is displaying psychotic behavior, immediate removal is indicated.

3. If a distressed provider has calmed, but is still very distressed or again becomes distressed during the rest period, removal is most likely indicated.

4. If a distressed provider is in any way injured, removal to a hospital or medical area is indicated.

5. If a distressed provider receives intervention, begins to improve is given 15 - 30 min. rest period, and upon rechecking is determined able to return to service, the recommendation to command will be that the provider should assume lighter duty away from the most stressful assignments, and that he should not return to his/her previous function.

6. Removal sites may include the most appropriate of: home, hospital, medical area, or new/lighter duty.

NOTE: It is generally a wise idea to have medical personnel assess the vitals of distressed individuals and assess them for injuries.

## II. Advice and Counsel To Command

Team Members may offer advise and counsel to a command officer when appropriate, but have NO command authority. All decisions are the responsibility of the commanding officers. The Team will neither take or assume any position of command or authority for incident management. As previously stated, the Team Leader shall act as the liaison between the overall incident commander and the Team Members whenever possible.

Some considerations for minimizing stress effects and maximizing performance may include:

A. Rotation of Staff

1. Two hours of duty then a 15 to 30 minute rest period will:
   a. Decrease possibility of injury
   b. Decrease fatigue
   c. Decrease intense emotional drain

NOTE: If the crew is almost finished with a task, let them complete the task before changing their duty assignment.

2. When rotating crews, it is suggested that part of the old crew be replaced with part of the new crew. This will permit the new crew to learn the task. Once this is accomplished, the remaining members of the old crew will be replaced by the rest of the new crew.

3. If it is not possible to give crews a rest period, rotate them to lighter duty. Crews should go from intense duty to medium duty to light duty. Those at light duty should work their way up to intense duty.

4. Four hours of duty without a break will cause extreme emotional and physical fatigue.

5. Maximum exposure should be no longer than 12 hours at the scene regardless of rest/rotation sequences. This is especially true if the possibility exists that the same personnel may have to resume duty at the scene the next day.

6. Command may need to alter normal procedures during lengthy operations. An example may be: during a lengthy operation of many hours or days, it may be necessary to allow workers to sleep at or near the scene during rest periods.

7. Caffeine products should not be offered to crews until after 4 hours of operation. Water and juices should be served throughout. No salt tablets should be offered since they may irritate the stomach.
If Gatorade is used, dilute with 1/4 to 1/2 with water to cut excessive sugar intake.

B. Field Observations

1. The team members may at times have a better vantage point for observing the intricacies of the operations and the tasks. If a team member notices anything out of the ordinary, or anything that might present a situation of concern later, he should bring it to the attention of the Team Leader. Some examples would include:

a. Inappropriately dressed providers
b. Clothes not conducive to weather
c. Providers who arrived without protective gear and on duty
d. Need for water or rest breaks
e. Need for food
f. Need for toilet facilities
g. Need to establish a demobilization
h. Need to establish a victim/survivor staging area
i. Need to call victim support organizations
j. Need to send someone with a provider being removed from scene
k. Need to remove provider from operations
l. Need to restore provider to lighter or alternative duty
m. Any substantial reason for providing insight to command when it can be determined that command is unaware of a potentially harmful situation.

III. Assisting Victims, Survivors, Families

While assisting victims, survivors, and families is not the primary function of the Team, it may be necessary to provide interim support services to these individuals so that the emergency service crews may perform their duties without being hampered. The Team will maintain a listing of victim resources during on scene operations and will call these services if warranted and approved by command. The Team may initially need to provide a staging area for families to meet away from the operation site and out of the way of the emergency service workers. Once on the scene, management of these persons should be turned over to the appropriate victim support agency.

Local resources to be contacted are:

Delaware County Chapter of the American Red Cross: 874-1484 or 566-4580 or 352-6320
Crisis Intervention Crozer 447-6081 Fitz 237-4210
Delaware County Civil Defense/Emergency Management 565-8700

## DEMOBILIZATION SERVICES

Demobilization services will be reserved for large scale, highly intense or unusual events that last a minimum of 8 hours. The objectives of a Demobilization are to:

I. Provide a place for disengaged (not returning to service ) units to rest, get something to eat and drink away from the site in a comfortable atmosphere before returning to quarters or home.

II. Provide information and support on possible stress related affects.

III. Provide a place to command officers to give closing remarks or incident updates.

IV. Provide a resource for initial ventilation of feelings if necessary.

GUIDELINES FOR DEMOBILIZATION SERVICES

MAKE SURE THE UNIT WILL NOT BE RETURNING TO SERVICE BEFORE INITIATING DEMOBILIZATION SERVICES FOR THAT UNIT!

The Demobilization Center can be located in any large room where it is possible to carry out the above activities.

Demobilization Services will be handled by several Mental Health Team Members and Peer Support Members not needed or engaged in incident activities. The process will be as follows:

1. Command will determine if a demobilization site shall be established.
2. ALL disengaged units and personnel will be processed through the Demobilization Center.
3. As the units leave the scene, they will stop at the center.
4. Upon arrival at the center, a Team Member will meet each arriving unit and usher them to a corner of the room. Units will be kept together and the combining of differing types of units will be discouraged.
5. The Demobilization Lecture will take no longer than 15 mins. and will consist of the following information:
   a. Recognition of the workers efforts and their fatigue
   b. State as your objectives a desire to give the workers a chance to rest, eat, and "unwind" before going home or back to quarters.
   c. If it is probable or possible that a formal debriefing will take place tell them how they will be informed as to its location, time, etc.
   d. Inform the workers:
      - some of them may have no reaction to this event and that's good and not an abnormal reaction...
      - some of them may have a delayed reaction and that's ok too..
      - some of them may already be experiencing some uncomfortable feelings as a result of the event, and this too is normal..
      - some of the most commonly reported reactions to events such as this are.... (offer a brief list of signs and symptoms)

- give them the prepared "Demobilization Sheet" and refer to its content
- If they want to stick around and ask any questions or talk about anything, we'll be here, or you can call us later at the numbers on the sheet.
- Dismiss them to get something to eat and tell them their officers will be in soon to meet with them.

6. One MH Team Member will remain in reserve to meet with the next incoming group.
7. All Team Members should be giving the same information to all groups, therefore, it will be necessary for the Demobilization Team to meet and develop an outline/script to insure continuity.

When unit officers arrive or before the units leave, the officers will/should do the following:

- Tell the unit that it did a good job
- Tell the unit what it is expected to do next (wash off the equipment and then go home, etc.)
- ONLY officers should report on the illness, injury or death of any co-worker and the progress and the location of the party. TEAM MEMBERS DO NOT OFFER THIS INFORMATION, BUT WILL PROVIDE SUPPORT IF NECESSARY. Remember you are not a member of their unit/family and it is not your place to inform them of any such news. You will be viewed in a "bad light" and will not be able to offer support when it is needed.

## DEFUSINGS

Defusings are performed after the incident and after the unit has returned to the station. The purpose is to offer information, support, allow initial ventilation of feelings, to set up or establish a need for a formal debriefing, and to stabilize crew members so they can go home or back in service. It is similar to a "mini debriefing" but, is not as detailed or as long. Guidelines for Defusing Services are as follows:

1. Defusings should be done immediately after the event. The ideal time frame is from 3 - 4 hours post incident to the end of the same day. If it is not possible to hold the defusing within these guidelines, a Formal Debriefing will have to be performed. The key is <u>immediate</u> intervention.

2. Defusings are a "group" process (as opposed to one-on-one) and all persons of the unit involved in the incident should attend the Defusing.

3. Defusings should last approximately 45 minutes.

4. Defusings can be performed by Peer Support Persons but the PSP should be well aware of his/her personal limitations and should call for support from a Mental Health Member or Senior Peer if the situation warrants. Peers directly involved with the operations should not perform defusings for this group.

5. Defusings should be held in a comfortable atmosphere, free from distractions and interference. All parties should remain in the Defusing until its conclusion.

6. The format for the Defusing shall be as follows:

    a. Introduction - ask the group to tell you what happened.

    b. Ask the group -"What was the worst part?"

    c. Allow freedom of discussion to take place on the "worst part". After the discussion subsides, offer information on possible signs and symptoms of stress they may or may not experience and information on what they can do about it. Give the Informational Handout to each one and make sure they know how to get in touch with the Program Coordinator, yourself, the Clinical Director, of other Team Members.

    d. Allow initial ventilation of feelings. Acknowledge the feelings, validate the feelings, and move on. DO NOT probe or dwell, it is much too early after the critical incident for this tactic.

    e. Keep the session informal, but to the point. Do not allow the crew to lapse into a Critique of Operations. The Team Members primary function is to facilitate and direct the session.

## FORMAL DEBRIEFING PROCESS

Debriefings are specially structured group meetings between the persons directly involved with the Critical Incident and CISM Team Members. It is a confidential, non-evaluative discussion of the involvement, thoughts, reactions and feelings resulting from the incident. It has psychological and educational components. It serves to mitigate the stress impacts resulting from exposure to a Critical Incident through ventilation of feelings, along with educational and informational components. It is not psychotherapy nor is it a form of therapy or treatment. It will produce a therapeutic effect in that it will assist participants in understanding their stress affect and it will "accelerate normal recovery process in normal persons suffering normal affects after an encounter with an abnormal situation." Its goals are to:

- Provide stress education
- Provide a mechanism for ventilation of feelings before they can do harm.
- Provide reassurance that what they did was appropriate, what they are experiencing is normal, and that they will most probably recover.
- Forewarn those who have not yet been impacted that they MAY be impacted later and inform them on ways to deal with it.
- Reduce the fallacy of "uniqueness".
- Reduce the fallacy of "abnormalacy".
- Provide positive interaction with mental health services and providers.
- Add or restore group cohesiveness.
- Assist inter-agency cooperation.
- Help set up a prevention program.
- Screen those that may not yet be ready to return to service.
- Refer those requesting or requiring additional services.

The Formal Debriefing Process will adhere to the guidelines developed by Dr. Jeffrey T. Mitchell. No alternate forms of group process, group dynamics, therapy, or counseling will be employed during these sessions.

The Program Coordinator and/or the Clinical Director will evaluate the need for a debriefing when one has been requested. Some of the considerations will include:

1. The number of individuals affected. If less than 3, Individual or Small Group Consults will be arranged and lead by a Mental Health Team Member.

2. The symptoms that are being reported by the participants in the event. Continuation of symptoms of acute or delayed stress are an indication that a debriefing is probably necessary.

3. Any noted or reported change in behavior of the participants in the event.

4 Any regression of behavior in the participants in the event.

5. Of the symptomatic persons, do they need a Formal Debriefing, or just opportunity to "talk it out" with peers or administration?

6. Do the circumstances warrant a debriefing, are the symptoms pronounced, or is the group seeking information on stress management?

7. Other factors and considerations pertinent to the event, the persons involved, and the signs and symptoms expressed.

8. Debriefings will be recommended for the following events:
   - Death of an Emergency Service Provider in the line of duty.
   - Serious injury to an Emergency Service Provider in the line of duty.
   - Mass/multi casualty incidents with serious injury/death.
   - Suicide of an Emergency Service Worker.
   - Civilian killed as a result of emergency service or police operations.

The Formal Debriefing Process will consist of the following components:

I. Pre-Debriefing Activities/Meeting
II. Introductory Phase
III. Fact Phase
IV. Thought Phase
V. Reaction Phase
VI. Symptom Phase
VII. Teaching Phase
VIII. Re-entry Phase
IX. Post Debriefing Activities/Meeting

Who Will Be Debriefed?

Any persons directly involved in the operation of the event, or any person for whom the event has elicited an unusually strong reaction should be debriefed. It may be necessary to perform several debriefings for one incident dependent upon the nature of the event, the numbers to be debriefed, the types of units, or the nature and extent of their involvement in the event. Persons not directly involved in the event will (in most cases) not be debriefed. The exception to this will be the serious injury or death of a unit member. Children, members of the family (participants or survivors), victims, or members of the press should NOT attend the debriefing. If services are needed for these persons, referrals or alternative services may be provided.

Where Will the Debriefing Take Place?

The Debriefing may take place in any area that is large enough to accommodate the number, that is free from distraction and interruption, that is fairly comfortable, where it is possible to place all participants in a circular seating arrangement without visual interference, and that offers a sense of neutrality.

When Will the Debriefing Take Place?

Debriefings should take place 24 - 72 hours after the event, or as soon after this time as it is possible to get the parties together.

It will be necessary to match the schedules of those participating in the debriefing with those of the team members involved in the debriefing. We do not want to place any undue hardship on any party, but priority for time will have to be given to the participants. Since our aim is to return them to a pre-crisis state, it would not be advisable to expect them to make major adjustments in schedule to accommodate a time that may be more convenient for team members. Every attempt will be made to accommodate the schedules of all parties involved.

How Long Will the Debriefing Last?

Many things have to be taken into consideration in responding to this question. Travel time, Pre-Debriefing Activities/Meeting, Site Evaluation, Debriefing Process, Post Debriefing Activities/Meeting, etc. The Pre-Debriefing Activities/Meeting should last approximately 45 mins. to 1 hour. The Debriefing Process averages approximately 3 hours. Post Debriefing Activities/Meeting length will be dependent upon the Team Members and the debriefing participants. It is impossible to accurately gauge the length of the debriefing process. It is advisable that no member commit themselves to attend a debriefing when they are limited in time, or must report to work within 8 hours of a scheduled debriefing start time.

What About Refreshments?

If the unit desires to serve refreshments, this is permissible. However, it is suggested that the most appropriate time to offer them is after the Formal Debriefing has taken place.

Who Will Lead the Debriefing?

Debriefings are lead (facilitated) by Mental Health Team Members. Co-Leaders may be Mental Health Members or experienced Peers. Peer Support Personnel (PSP) are valuable members of the Debriefing process as they are the ones the participants can and will identify with as the ones who most understand their plights, feelings, and concerns.

How many Participants will there be in a Debriefing?

A Formal Debriefing will not be held for less than 3 persons. When there are less than 3, one-on-one consults or a mini group session will be used. Ideal debriefing group size is between 3 and 40 participants. Maximum group size should be approximately 60 participants. In groups of over 40 participants, the procedures for the debriefing process must be adapted. (see "Additional Debriefing Considerations")

## I. Pre-Debriefing Activities/Meeting

A. Team Members responding to a Debriefing should, when possible, travel to the debriefing site together.

B. The goals and objectives of the Pre-Debriefing Activities/Meeting are:

1. To permit the Team Members the opportunity to go over all facts, rumors, and data concerning the incident.

2. To visit the incident site if necessary.

3. To review any videos, news paper articles, reports, etc. about the incident.

4. To talk to the participants to become aware of any other facts about the incident not previously known (TO CUT THE CHANCE FOR "SURPRISE" DURING THE DEBRIEFING PROCESS)

5. To develop a strategy for the Debriefing:
   - Determine who the is leader
   - Develop any signs or signals that may be needed during the debriefing
   - Establish Team Member roles

6. To set up the seating.

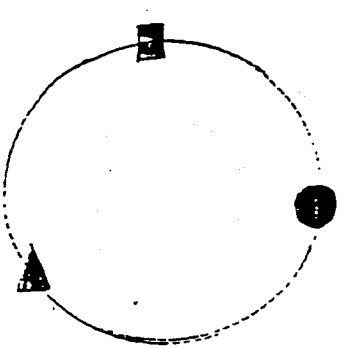
7. To make sure the unit is Out of Service and/or that the participants
   will not be called to service during the Debriefing Process.

C. Seating Arrangements

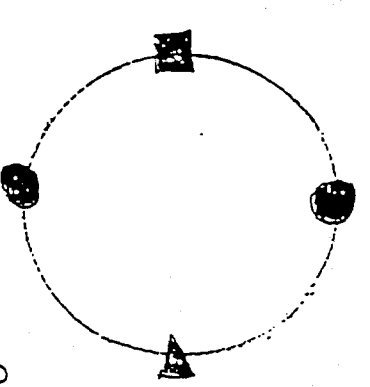
1. Chairs should be placed in a circle. They should be close enough to accommodate all participants but not be uncomfortable. Extra chairs should be placed in the circle for Team Members and extra chairs should be placed in the circle or in close closed proximity to accommodate late arrivals.

2. Some suggested seating arrangements:

3 Team Members



4 Team Members



■ LEADER ▲ Co-LEADER ● PSP

3. Doors to the Debriefing area should be closed but not locked.

4. The Senior Peer shall act as the "Bouncer". According to Dr. Mitchell, it will be this persons responsibility to "bounce the appropriate people into the Debriefing, and bounce the inappropriate out." The ideal placement of the "bouncer" will be the Peer position nearest the door of primary entrance and egress. It will also be the responsibility of the "bouncer" to check on persons who have left the Debriefing and not returned. He/she will attempt to "negotiate a return" of these persons to the Debriefing. He/she will not force or attempt to force the return of any individual not wishing to return. In this circumstance, the Senior Peer may find they are in a position to offer some one-on-one counseling and should offer names and phone numbers for referral services to this person. After the encounter, the Senior Peer should return to the Debriefing.

## II. Introductory Phase

During the Introductory Phase, the Mental Health Leader will set the rules for the debriefing, introduce him or herself and give a brief description of what will take place during the debriefing process. He will state the purpose of the debriefing and the Team's involvement ie: "to try to help you deal with some thoughts and reactions you may be experiencing and to give you information on how you can help yourself deal with these issues. You may be able to work through this alone, but we have found that people who go through the debriefing process sleep, eat, perform their job and home responsibilities better, and that's what we want for you."

NOTE: Before beginning the debriefing rules, information specific to the incident may need to be discussed or pictures, videos, etc. may need to be reviewed to refresh memories if the incident happened a while ago.

### A. Rules for the Debriefing

1. You do not have to talk during the debriefing, but if you do, what you may say may help reassure and support your colleagues.

2. This meeting is strictly confidential. No notes will be taken and no recordings will be made. It is important that we make a pact of trust among everyone here that no one will disclose any information about anyone or anything said during the debriefing.

3. No breaks are taken during the debriefing process. If you need to use the facilities, please attend to your personal needs but then return to the group.

4. No one talks for another. You may only comment about your own thoughts, feelings or reactions.

5. You do not need to say anything that may legally incriminate you, or offer information that may be necessary for any investigation or litigation.

6. No pagers are to be on and the company (or at least those participating) is to be out of service.

7. No one has rank during the debriefing process. Everyone is equal.

8. This is NOT a critique of operations. We are not here to place blame.

9. The CISM Team is NOT part of any investigating agency. We are only interested in your welfare.

10. Look around the room. If someone is here that should not be here, please let me know before we begin. These include press, and any others not directly involved in the incident. (will need to be tailored to each debriefing)

11. Feel free to ask questions.

III. Fact Phase

During this phase the leader will ask the members of the group to go around the circle and state their name, what their role was, and what happened. This will serve to recreate the event and present the pertinent facts surrounding the incident.

If this proves to be especially difficult for a participant, acknowledge and validate their feelings and move on to the next person.

When the circle gets to the PSP and Co-Leaders, they will introduce themselves and identify their level of emergency service involvement, and offer a sense if identity and reassurance to the participants.

IV. Thought Phase

This phase requires the participants to conceptualize what they have heard and seen. The leader will ask the participants to share their first"thought" and when they first realized they were thinking about the event. During this phase the participants will be taking the information supplied during the Fact Phase from the general state and applying it to a more personal state of thinking.

The leader will acknowledge, offer reassurance, and move on to the next participant. No probing will take place.

V. Reaction Phase

After the process of taking the incident from the outer environment and into the cognitive, the leader will ask the participants to share their reactions to the incident. He/she may ask them to describe what each sees as the worst part of this incident. The leader will not probe except to get clarification on a specific issue. During this phase the PSP members will not talk, offer any reassurance, suggestions, experiences, etc. The leader will facilitate this phase solely unless he signals or requests assistance.

VI. Symptom Phase

After the participants have been able to bring the impact of the event to a personal level and have been able to identify some personal reactions to it, the leader will then ask the group to share information on any physical, emotional, cognitive, or behavioral signs or symptoms they may be experiencing. ie: "How did you know this event was different? I know when something really gets to me I don't sleep well and my stomach gets upset."

The leader will want the participants to share items that happened during or shortly after the event, a few days later, and in the present.

VII. Teaching Phase

After the signs and symptoms have been expressed, the leader (with support form other team members) will offer reassurance that these are normal reactions and may teach additional signs and symptoms that may not have been expressed. It is during this phase that information will be offered on positive coping methods, on issues specifically raised and general information on stress management. The leader will also invite the participants to ask any specific questions about the management of stress that they may have.

VIII. Re-entry Phase

This is the time to "wrap up any loose ends", offer additional reassurances, answer any outstanding questions, offer the opportunity for participants to say anything they did not get a chance to say, and give the participants the opportunity to restate anything they may have said before. It is also during this phase that the leader may wish to bring out an emotion that he/she feels is present but, as yet, has not been expressed.

During this phase, the participants may wish to develop a "plan of action". They may wish to develop a preventative program, determine what they would like to do to make things better, or investigate information and educational resources. The Team Members will provide support for their decision and offer guidance and information.

## IX. Post Debriefing Activities/Meeting

After the Debriefing has ended, the Team will remain to talk to the participants and assist them in resolving any outstanding issues. They may also want to mentally note anyone they feel may need to be referred for additional services and will bring these people to the attention of the Mental Health Team Members if they feel such a suggestion would not be well received or appropriate coming from them. The Post-Debriefing time is a critical time in establishing a feeling of normalcy, of establishing a sense of continued trust and support from the team, and for making sure that those who may need additional help and support are given the appropriate resources to receive it.

After the Formal Debriefing and Post Debriefing Activities, the Team Members shall meet and discuss the debriefing strategy used, any concerns, topics and issues. Recommendations for Follow-Up Services will be noted and the Debriefing Report will be completed by the Team Leader.

## Additional Debriefing Considerations

1. If the event is the death of a emergency service provider, 2 Formal Debriefings are probably indicated. The first should be performed 8 to 12 hours after the death and the second should be performed 3 to 5 days after the funeral.

2. If the event involves a prolonged event with or without the death of a child, a defusing should be preformed and possibly a debriefing.

3. If the group size is larger than 40; the procedure for the Fact Phase will change. Each participant will not be asked to state who he is, what his role was, and tell what happened. The request for this information will be opened to the group and the participants will respond in a random, group forum fashion. The remaining procedures will remain intact.

4. It is permissible for the Team Leader to have a 3x5 card during the debriefing with information key to each phase listed. If he/she elects to bring this card to the debriefing, the reason for the card's presence shall be explained to the participants so they are not alarmed and so they are further reassured that no notes are being taken.

5. Team size will be 2 to 6 members per debriefing. The size of the team will be dependent upon the size of the group. The rule of thumb of 1 to 10 will be generally employed for each event. In the event that the Team arrives and finds that there are few participants and several Team Members, the Team Leader will request extra Team Members to leave the Debriefing and return at the end. It should be understood by all members that such may occur at the last moment.

6. Debriefings may need to be postponed for the following reasons:
   - A child is present at the debriefing
   - Press will not leave
   - Spouses/family of ES providers are present
   - Survivors, victims, family are present

- More than 60 participants attend when not expected and there are not enough Team Members present to handle the additional participants

7. In situations where the participants are very resistant, more education and teaching will need to be employed.

8. If a participant is obstructive to the point that the debriefing process is jeopardized, sabotaged or otherwise irrevocably interrupted and disrupted, it will be the responsibility of the Leader to attempt to successfully "join" this individual or negotiate a discontinuance of this behavior. If this is not possible, and the debriefing process is still salvageable, the senior peer or co-leader may attempt to enjoin this person in one-on-one counseling while permitting the leader to continue the debriefing. Decision for a postponement or any alternative will, be rest with the Team Leader.

## FOLLOW UP SERVICES

The philosophy behind Follow Up Services is twofold: first, we want to make sure that any participant we feel may need, or who requests additional support is given the resources to investigate his/her options. Thus, we will provide a referral source of names and services to those individuals. Secondly, we want all participants to realize that their welfare is important to us, that we care about them, and that they can count on us for support.

Follow Up Services may take many forms. They may be initiated by the participant in the form of a telephone call or personal appearance. A commander may call and request we "check in" on members of his crew, or Team Members may initiate the contact through dispatch procedures, or they may be made by the Program Coordinator or Clinical Director as a process of quality assurance.

Team initiated Follow Up will be at the direction of the Clinical Director or Program Coordinator. Follow up recommendations will be made on the intervention reports, and the appropriate team members will be dispatched. If a PSP member feels he would like to "check in with" someone or organization he has provided intervention service for, he/she should first discuss the matter with the Program Coordinator or the Clinical Director. This will enable us to provide continuity to the program, insure that privacy is not invaded, and most importantly, make sure the most appropriately trained members provides the required service.

## INDIVIDUAL CONSULTS

Individual consults will take two forms. Individual consults may be take the form of a small group debriefing session in those instances where only 1 - 3 members of a unit have experienced or are impacted by a critical incident. As with all activities and services, these will be dispatched through protocols.

The second type of individual consults will be in the form of referrals to mental health clinicians for those requiring this type of service.

PSP involvement in these services will be to:

- Assist as a peer support person in a small group debriefing session
- Provide names and numbers to participants requesting additional services

## SPECIALITY DEBRIEFINGS

It will not be the policy of the Delaware County CISM Program to provide intervention or debriefing service outside the framework of our program. If a request for service is initiated by an outside organization, every attempt will be made to seek alternative sources for these groups. In the event that no resource exists or is currently available, the Program Coordinator and the Clinical Director will evaluate the request on a case by case basis.

## INITIAL DISCUSSIONS

If a PSP is present during the initial discussion stage following an event, he/she will attempt to permit a free and open exchange from all participants. He/she will also attempt to redirect the discussion or stop it if it leads to "scapegoating" or victimization of a co-worker or unit, or if the humor expressed goes beyond the point of appropriate.

The PSP will remain aware of his/her limitations and will seek assistance and guidance as appropriate.

Table 1

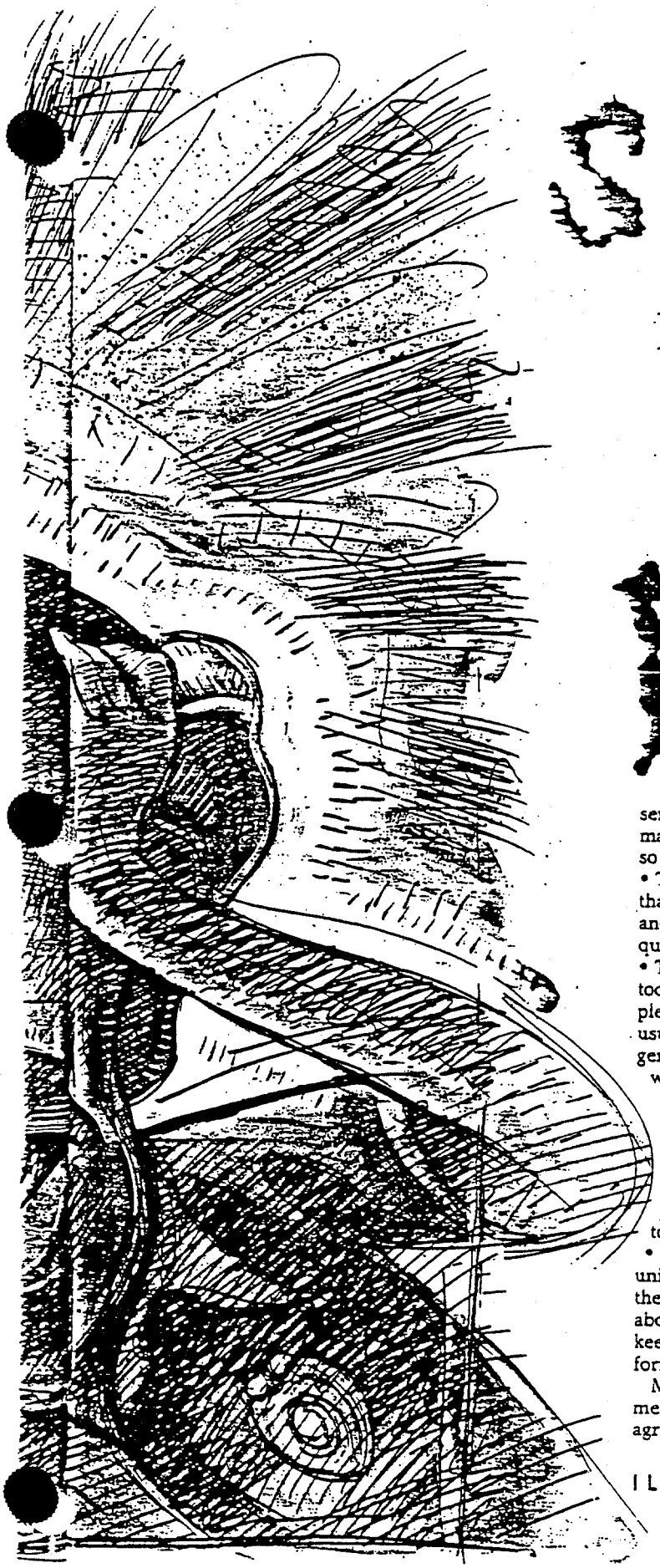
Stages of CISD

| | | Objectives |
|---|---|---|
| Stage 1 | Introduction | To introduce intervention team members, explain process, set expectations. |
| Stage 2 | Fact Phase | To describe traumatic event from each participant's perspective on a cognitive level. |
| Stage 3 | Thought Phase | To allow participant's to describe cognitive reactions and to transition to emotional reactions. |
| Stage 4 | Reaction Phase | To identify the most traumatic aspect of the event for the participants. |
| Stage 5 | Symptom Phase | To identify personal symptoms of distress and transition back to cognitive level. |
| Stage 6 | Teaching Phase | To educate as to normal reactions and adaptive coping mechanisms, ie, stress management. Provide cognitive anchor. |
| Stage 7 | Re-Entry Phase | To clarify ambiguities and prepare for termination. |

(see Mitchell and Everly, 1992 for step-by-step guidelines)

# Do You Feel Like You're Falling Apart?

## Let the Experts Help You Through Critical Incident Stress



# STRESS

## Development and Functions of a Critical Incident Stress Debriefing Team

by Jeffrey T. Mitchell, PhD

During the past two decades, mental-health professionals have gradually become aware of the stresses that negatively affect emergency personnel. As a result of this increased awareness, several general classifications of mental-health professionals have developed interests in emergency workers. For example:

- The "entrepreneurs" who see emergency personnel as just another business deal. They generally have little understanding of the population they serve and make no special provisions for the emergency worker. A main concern is to cultivate a positive impression with administrators so they have the best potential to develop a lucrative contract.
- The "glory seekers" who are nowhere to be found unless an event that attracts the media occurs. They suddenly appear as "experts" and lap up as much exposure as possible during the incident, then quickly fade away when the excitement dies down.
- The "number crunchers" who do not see genuine research as a tool to help emergency service workers, but instead as a way to complete a degree, get published or draw attention to themselves. They usually appear suddenly, demand a lot of survey data from emergency workers, and disappear without a trace of feedback to those who have spent their time working on the surveys.
- The "well-meaning but unknowing" who have not taken time to learn that emergency personnel are normal people reacting to abnormal events. They use nondirective or "psychiatric" interventions on emergency people which will not work. They are generally clumsy in their approach to emergency reponse personnel and unable to establish a connection because they failed to learn about their special personalities and needs.
- The "dedicated and trained" professional who understands the unique personalities of emergency personnel and the special jobs they perform. They take the time to go through special training, read about emergency personnel and ride along with them on calls. They keep a low profile, are not primarily motivated by money and perform careful research that aims at bettering emergency workers.

Most emergency personnel have encountered these types of mental-health professionals in the course of their career. They will agree that the dedicated and trained type is the very best for service

ILLUSTRATION BY BRYAN PETERSON

on a critical incident stress debriefing (CISD) team and that the wrong type of mental-health professional is usually worse than no help at all.[1]

### CISD Teams

CISD teams are made up of dedicated and trained mental-health professionals who combine their expert knowledge and talents with specially trained peer support personnel drawn from the emergency service's ranks. The CISD team is essentially a partnership between the two groups with a common goal—the reduction of critical incident stress in emergency personnel.

CISD teams serve any emergency personnel regardless of the organization. They provide services to hospital-based emergency and critical-care personnel as well as firefighters, police officers and prehospital EMS providers. Individuals are not charged for these debriefing services.

**The main objectives of CISD are to mitigate the impact of a critical incident and accelerate the return of personnel to routine functions after the incident.**

The makeup of a team is roughly one-third mental-health professionals and two-thirds peer-support personnel. Most teams have 20 to 30 specially trained people chosen for service after they have applied and been interviewed by the team leadership.

The average team serves a community of about 100,000 people and is activated for major stressful events six to eight times a year. There may also be a number of smaller events that require the services of one or two peers and, occasionally, a mental-health professional. Caution should be exerted, therefore, not to establish too large or too small a team since team members won't want to be over or under utilized.

Another point to keep in mind when establishing a team is the size of the area served. Since mental-health resources are limited, it is recommended that a team serve a region encompassing several jurisdictions. The majority of current CISD teams encompass several jurisdictions and all emergency agencies within them.

Serving a large area is important for several reasons. First, it is not a good idea to formally debrief your friends and fellow workers because it is too emotionally draining. Second, supervisory staff members may join the team and are always more helpful to people outside their own organizations because of management issues that may arise. Third, the debriefing attendees feel more comfortable when receiving services from people they do not see or work with on a regular basis.[2]

### General Functions of a CISD Team

CISD teams function in three areas: pre-incident, incident and post-incident.

*Pre-incident CISD Functions:*

The pre-incident functions have always been an essential part of CISD team activity and include:

- Educating line personnel about stress, stress recognition and stress reduction. Education should include material on critical incident stress, how it differs from non-emergency stress, a description of the CISD team and how to utilize it if the need arises.[3,4]
- Educating the command staff about stress and its effects on themselves and their personnel. This segment should include specific information on field strategies for stress control during a crisis. Commanders should also know the capabilities and limitations of the CISD team and how to initiate services during and after a critical incident.[5]
- Developing stress management protocols for field use. It is well-established that if guidelines are written down and practiced, they are more likely to be followed. The protocols should list guidelines for commanders on items such as the optimal length of work time, frequency of rest periods, maximal time at the scene, food, shelter, replacement of gloves and use of the CISD team members during major events.[6]
- Providing significant other or spouse and family education programs to enhance the quality of life for emergency personnel and the people important to them.[7]
- Organizing individual counseling programs, employee assistance programs, chaplain services and disaster intervention plans as well as any other programs helpful to emergency responders.[8]

*CISD Functions During an Incident:*

- On-scene support services

During the incident, a debriefing team is involved with providing on-scene support services that assist obviously distressed personnel. It advises and counsels command staff and gives direct and indirect support to the victims until other appropriate agencies can be mobilized to provide services.

- Defusings

These are shorter, unstructured debriefings that encourage a brief discussion of the events and significantly reduce acute stress. Defusings are done anywhere from one to three hours following the incident, often at the station, and generally last from 30 minutes to an hour. Only those crews most affected are involved; not all workers from the scene attend, as would be the case in debriefings.

If the defusings are not accomplished within 12 hours, a full formal debriefing is the next alternative approximately three days after the incident. A well-run defusing often eliminates the need for a full formal debriefing. Even if both are still necessary, a debriefing held three days to a week after a defusing usually is more beneficial. People are more willing to talk during a debriefing when first presented with a supportive defusing shortly after the incident.[9]

- Demobilizations

These are reserved for large-scale incidents only and take the place of a defusing. Immediately after emergency units cease and disengage from operations at a major incident, units are sent to a large meeting facility where they are met by mental-health professionals. Unlike the defusing or debriefing, personnel are not requested to discuss the incident. Instead, the mental-health professional assigned to their unit provides a 10-minute presentation on the typical effects of critical incident stress and the signs and symptoms that may appear. The personnel are given as many practical suggestions for stress management as possible along with an opportunity to ask questions or make comments. The mental-health person assigned to their group remains available to privately discuss the situation or their reactions. Talking to the other mental-health professionals at the debriefing center is also an option. Chaplains may be present at the debriefing center and are available if an emergency person would prefer to discuss something with them. No one is required to talk unless they choose to.

All of the personnel being demobilized are given an opportunity to get something to eat and relax before returning to duty or home. They are encouraged to rest during the transition from a major event back to routine duties. The entire demobilization process should be completed within 30 minutes, and two-thirds of that time should be allotted to rest and eating.[9]

*Post-incident CISD Team Functions:*

Once an incident is over and defusings or demobilizations complete, emergency

personnel enter a phase lasting about 24 hours where they generally prefer not to discuss the situation with outsiders. Many private thoughts emerge as crew members attempt to sift through all the details of the incident. Many times they are concerned with whether protocols and procedures were followed exactly. It may be required that they write reports or go through the preliminary investigations. They are usually *not* ready to deal with whatever feelings may have been generated during the incident.

Emergency responders usually do not benefit from CISDs during that 24-hour period because their reactions are too intense to absorb the important messages presented in a debriefing. What is usually more important is to provide individual support to those people showing the greatest need and to provide advice to command staff trying to plan for the support services required.

Following a crisis, emergency workers are likely to close ranks, preferring to talk with individuals in the unit or participate in small group conversations related to the event. This conversation is called the "initial discussion" and CISD teams usually have little involvement in it. However, peer support personnel, including those involved in the incident, are trained to watch for telltale signs of distress in their fellow workers: irritability, excessive humor, increased derogatory remarks against one another, significant changes in behavior and withdrawal from others. When these signs of distress become apparent in their coworkers, peer support personnel contact the CISD team coordinator who may initiate the setup of a formal CISD.[10]

### Formal Critical Incident Stress Debriefing

The formal CISD is a psychological and educational support group discussion that utilizes a specially trained team of mental-health professionals combined with peer support personnel. The main objectives of CISD are to mitigate the impact of a critical incident and accelerate the return of personnel to routine functions after the incident.

Events that require a CISD include the following:

- Any event that has significant emotional power to overwhelm usual coping mechanisms.
- line-of-duty deaths
- serious line-of-duty injuries
- emergency-worker suicide
- disasters
- unusually tragic deaths to children
- significant events where the victims are relatives or friends of emergency personnel
- events that attract excessive media attention
- events that seriously threaten the lives of the responders.

Because overuse of CISDs dilutes their effectiveness, they are reserved for only those events that overwhelm the usual coping methods of emergency personnel.

Before a debriefing is held, all of the coordination associated with the debriefing is done, including the announcement to those involved and the setup of the room. Also, the CISD team reviews the incident by reading the reports and newspaper clippings and by viewing photographs or video tapes of the incident. Many CISD teams visit the scene before conducting a debriefing.

Once the debriefing begins, it follows a carefully designed structure that progresses through seven phases and provides important stress-reduction information. While participants are not required to speak, they are encouraged to discuss various aspects of the incident that distressed them. The whole process usually takes two to three hours to complete.

During the debriefing, personnel should not be required to respond to calls; others in the system need to fill in for them. Also, only those involved in the incident should attend, including command officers. If the critical incident affected various types of emergency personnel at the scene, a joint multi-agency debriefing is often held. It is important then to pick peer-support personnel from each of the services for the CISD team. If an incident involves only EMS personnel, it is important to choose EMS peers since EMS people are more likely to trust fellow workers. The same concept holds true for police and fire personnel.

The CISD begins with an *introduction* from the CISD team members at which point they state that the material to be discussed is *strictly confidential*. It should also be emphasized that the CISD is *not* an operations critique. Attendees are then told what to expect during the debriefing and assured that the major concern of the CISD team is to restore people to their routine lives as soon as possible with minimal personal damage to the emergency service's worker. The basic rules of the debriefing are explained before the team members move into the next phase.

The second phase of the CISD is the *fact phase* in which people are asked to describe what happened at the scene. This is a relatively easy phase for emergency personnel used to talking about the operational aspects of an incident.

Once the incident is described, the debriefing team leader will lead the discussion into the *thought phase* of the process. The usual question asked in this phase is, "Can you recall your first thoughts once you stopped functioning in an automatic mode at the scene?" This helps people to "personalize" their experiences. The events are no longer a

collection of facts but an individual, meaningful recollection of how they personally experienced the incident.

The fourth phase of a debriefing is the *reaction phase*, the point at which people can describe the worst part of the event for them and why it bothered them. If a critical incident has any significant emotional content attached to it, it will usually be discussed during this phase. It can occasionally become a heavy emotional phase of the debriefing but is not necessarily intense.

It is not the objective of a CISD team to promote emotional behavior but, instead, to foster discussion so that recovery is as rapid as possible. This phase allows people to discuss the worst parts of an incident in a controlled environment that enhances venting thoughts and feelings

**Following a crisis, emergency workers are likely to close ranks, preferring to talk with individuals in the unit.**

associated with the event and prepares them for useful stress reduction information.

The fifth phase of the CISD process is the *symptom phase*. The group is asked to describe stress symptoms felt at three different times: The first being those symptoms experienced during the incident; the second are those that appeared three to five days after the incident; and the last being symptoms that might still remain at the time of the debriefing. Changes, increases and decreases of symptoms are good indicators for the mental-health person of the need for additional help for some attendees.

The next phase of the CISD process is the *teaching phase*. The CISD team members furnish a great deal of useful stress-reduction information to the group. They also incorporate other information, such as the grief process, promoting communication with spouses and suggesting how to help one another through the stress.

The seventh phase of the debriefing process is called the *re-entry phase*, when personnel may ask whatever questions they have. A summary is given by the team and the CISD is concluded.

After debriefing, the team remains at the debriefing center to talk with those needing additional individual assistance. Referrals are made for counseling if necessary.

Finally, the CISD team holds a post-debriefing meeting to quickly review the debriefing and discuss ways to improve their functions for future debriefings. However, the main reason for meeting is to make sure that everyone on the team is OK before going home—hearing the pain that others experience may bring about some pain for the debriefers.[11]

### Follow-up Service

All defusing, demobilizations and debriefings must receive follow-up services. Follow-ups usually begin 24 hours after the debriefing. The many ways that follow-up can be achieved include:

- telephone calls to individuals
- discussions with commanders
- visits to the stations
- sending peers to see that personnel are doing all right
- educational programs
- individual counseling sessions
- spousal support services
- other activities as the needs arise.[12]

### Other CISD Team Considerations

Simply reading this article in no way gives anyone the ability to perform a CISD. *Minimum* training time for a CISD team is two days with continuing education on a timely and regular basis. A CISD is ineffective without trained peer-support personnel.

Likewise, a CISD team without mental-health professionals is not only ineffective, but dangerous because mental-health professionals are necessary to provide leadership and supervision. They also possess diagnostic skills to recognize those issues more serious than stress alone. Missed symptoms may cause an emergency worker to commit suicide.

It takes a special task force at least six months to one year to properly organize a CISD team in most communities. CISD teams should have the same training and operating protocols, and these should be developed in writing, so that they are interchangeable.

People should be accepted onto CISD teams because of their competency, *not* because of politics.

CISD teams survive and are successful if they meet regularly, cross-train by having mental-health personnel ride on emergency units for field exposure and provide continuing stress education to field personnel.

Much has already been written on CISD teams and their development. Review the protocols and the accomplishments of other teams before developing a team in your region.

### Conclusion

Critical incident stress debriefing teams have experienced a phenomenal growth in five years, overcoming many problems and achieving many successes. They have assumed an important place within emergency services organizations and are likely to continue their support services into the future.

Teams need to be carefully developed, protocols need to be expanded and improved and team members must be given the very best training. There are many challenges associated with the development and operation of a CISD team. It will take many dedicated people to ensure the stability and success of the teams as they provide the valuable service of healing the helpers.

Additional information on CISD teams can be obtained from:

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## PERCEPTUAL DISTORTION

Listed below are perceptual distortions that some police officers will experience as a result of the high arousal states that occur during high threat situations.

A survey listing these distortions as described below was administered to officers who had been involved in deadly force encounters. The percentage column indicates the percentage of officers who experienced each distortion during their deadly force encounter.

***Number of officers responding to survey:*** **53**

| ***Percentage*** | ***Distortion*** |
|---|---|
| 87 | DIMINISHED SOUND: You did not hear some sounds at all, or the sounds had an unusual distant, muffled quality. (This applies to sounds you ordinarily would obviously hear such as gunfire, shouting, nearby sirens, etc.) |
| 83 | TUNNEL VISION: Your vision became intensely focused on the perceived threat and you lost your peripheral vision so that you had reduced ability to see other things around you. |
| 80 | AUTOMATIC PILOT: You responded automatically to the perceived threat giving little or no conscious thought to your actions. |
| 74 | HEIGHTENED VISUAL CLARITY : You could see some details or actions with unusually vivid clarity and detail. |
| 70 | SLOW MOTION TIME: Events seemed to be taking place in slow motion and seemed to take longer to happen than they really did. |
| 64 | MEMORY LOSS FOR PARTS OF THE EVENT: After the event you came to realize that there were parts of it that you could not remember. |
| 62 | MEMORY LOSS FOR SOME OF YOUR ACTIONS: After the event you came to realize that you could not remember some of your own actions. |
| 51 | DISSOCIATION: There were moments when you had a strange sense of detachment, as if the event was a dream and not real, or like you were looking at yourself from the outside. |
| 40 | INTRUSIVE DISTRACTING THOUGHTS: You had some thoughts not directly relevant to the immediate tactical situation pop into your head such as thinking about loved ones, later plans, etc. |
| 21 | MEMORY DISTORTION: I saw, heard, or experienced something during the event that I later found out had not really happened. |
| 15 | FAST MOTION TIME: Events seemed to be happening much faster than normal. |
| 15 | INTENSIFIED SOUNDS: Some sounds seemed much louder than normal. |
| 13 | TEMPORARY PARALYSIS: There was a brief time when you felt paralyzed and unable to move. |

Survey by Dr. Alexis Artwohl, Ph.D.

| Perceptual distortions commonly experienced by people during moments of peak stress | | | | | |
|---|---|---|---|---|---|
| Time Distortion | 83% | Auditory Distortion | 69% | Visual distortion | 83% |
| Slow motion | 67% | Diminished sound | 51% | Tunnel vision | 67% |
| Fast motion | 16% | Intensified sound | 18% | Heightened Detail | 16% |

## NORMAL REACTIONS TO ABNORMAL SITUATIONS

(percentages refer to officers involved in shooting situations)

1. *HEIGHTENED SENSE OF DANGER*.....58%
2. *ANGER/BLAMING*.....49
3. *NIGHTMARES*.....34
4. *ISOLATION/WITHDRAWAL*.....45
5. *FEAR/ANXIETY*.....40
6. *SLEEP DIFFICULTIES*.....46
7. *FLASHBACKS/INTRUSIVE THOUGHTS*.....44
8. *EMOTIONAL NUMBING*.....43
9. *DEPRESSION*.....42
10. *ALIENATION*.....40
11. *GUILT/SORROW/REMORSE*.....37
12. *MARK OF CAIN*.....28
13. *PROBLEMS WITH "SYSTEM"*.....28
14. *FAMILY PROBLEMS*.....27
15. *FEELINGS OF INSANITY/LOSS OF CONTROL*.....23
16. *SEXUAL DIFFICULTIES*.....18
17. *ALCOHOL/DRUG ABUSE*.....14
18. *STRESS REACTIONS*.....no percentage available

*INTENSITY OF REACTIONS TEND TO WAX AND WANE OVER TIME, PEAKING DURING FIRST FEW WEEKS, THEN GRADUALLY SUBSIDING.*

# Death Notifications

1. **OBTAIN ALL THE NECESSARY INFORMATION CONCERNING THE EVENT**
   Before you make contact with the next-of-kin, get all of the pertinent information ("Who, What When, Where, and How"). Have a working knowledge of the events leading up to and surrounding the death, such as time, did medical personnel respond, was the victim transported to a hospital, is anyone else injured, cause of death, and what condition are they in. Try to get as much information as you can before you knock on the door. Once you make contact and start the notification process, the emotional intensity makes is very difficult to stop and check for the basic information.

2. **COORDINATE A PLAN OF ACTION WITH YOUR PARTNER**
   When possible, do death notifications in pairs. Working in pairs offers emotional support and, due to the intensity of the situation, officer safety factors need to be considered. The use of uniformed personnel, if in nothing other than a support role, is preferred. Take a few moments to clarify roles with your partner. Decide who will say what and even say the exact words you plan to use several times to yourself or to your partner before doing the notification. The person who is going to do the actual notification should tell the their partner what they plan to say.

3. **IDENTIFY AND CONFIRM WHO IS THE LEGAL NEXT OF KIN**
   When possible, identify and confirm who the next of kin is before approaching the location where the notification will be made. When the realities of the situation do not allow this to happen, this must occur at the beginning of the notification, i.e. " Are you Mrs. John Smith?" "Is John Q. Smith your husband?"

4. **ARRIVE AT THE LOCATION AND "GET IT OFF THE DOORSTEP"**
   Once at the location where the notification will be made, and the while introductions are being made, ask if you "may come inside." Privacy, safety, determining who else is in the household, and preventing the door from being closed in your face are the obvious reasons for wanting to "get it off the doorstep." Be prepared for emotional outbursts.

5. **"SAY THE WORDS"**
   Even when prepared for the emotional shock that may follow, many times officers struggle for the "right words" to use when making a death notification. Remember, there are no "right words" that will make the hurt go away. Don't create a misunderstanding of the message with the words you select. Avoid terms such as "he passed away," "you lost him this evening," etc. While these phrases are designed to soften the task emotionally for the person making the notification, they lead to possible misunderstanding or misinterpretation. A direct approach leaves little room for misinterpretation, i.e. "There has been an auto accident and your wife has been killed." "I am sorry, but your son was killed this evening in a drive by shooting." The intense impact of death notifications cannot be "softened" by verbal or semantic manipulations. The best an officer can hope for is that the news was given empathetically and directly without any misunderstanding.

6. **SILENCE, REPEAT THE WORDS, ANSWER QUESTIONS**

Even when all of the previous steps are done well, the emotional impact of the message and a sense of denial may cause the real content of the notification to not be heard the first time the words are spoken. This can take the form of "dead silence," or spontaneous utterances, such as "what," "that can't be," "there must be some mistake," "how could this have happened," etc. Be prepared for an emotional outpouring from the recipients of the death notification and a need to have their specific questions answered. Occasionally, the questions are quite painful and the officer's first inclination is to attempt to shelter the recipients of the notification from any additional pain. Questions such as "Did she suffer?", "Was death instant?" are frequently asked and often quite hard for the officer to answer. Don't try to hide or give false information no matter how benevolent your reasons. Be prepared and remember, asking to see the body frequently comes up.

7. **GIVE THE NECESSARY INFORMATION IN WRITING**

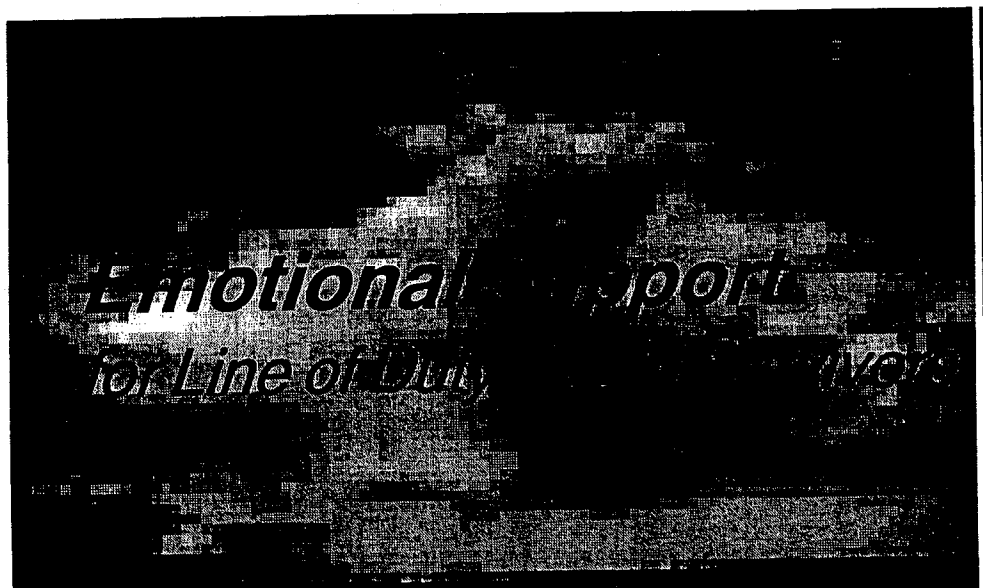
At moments of intense psychological distress our capacity to process information is severely impaired. Even when information is given clearly and concisely the recipient is often unable to process it. Providing the information in writing allows the family to refer back over the next hours and days to information that is necessary to make the appropriate decisions and arrangements. Information such as where is the medical examiners office, what's the phone number there, who do I speak about concerning the autopsy, how do we have the body released, etc. should be given in writing. Giving something in writing not only helps the family receiving the death notification, it leaves the officers with a sense of providing something concrete that will be of some help after having delivered such devastating news.

8. **DEBRIEF WITH PARTNER**

After the notification is completed it is important to review the process with your partner. Don't forget to find out if the call hit close to home for any of the officers involved. This is particularly important if the facts concerning the specific call have some special significance such as an officer with children at a child's death, an officer with aging parents at the death of an older person, or any other situation that touches the individual circumstances of an officer. Many times officers will attempt to block the emotional impact to dealing with death by using denial of emotion as a defense mechanism. While this can be quite effective in the short-run, in the long run it can cause the officer to lose touch with his or her personal emotional sense.

9. **FOLLOW-UP WITH RECIPIENT OF DEATH NOTIFICATION**

Some jurisdictions provide this service with crisis counselors or victim-witness type services. Those jurisdictions that do not can be helpful for both the family receiving the death notification as well as for the agency that will be dealing with the family possibly through an investigative period. This follow-up can assist the family by helping to determine if any unfinished business exists. Obviously there are cases where this will not be possible or feasible.




*by Peggy Sweeney Rainone*

he headlines report the grim news of yet another "fallen hero". The death of a law enforcement officer or firefighter who has died "in the line of duty". A dedicated professional who sacrificed his or her life that others may live or that homes and property would be saved from the unmerciful demon—fire. Most civilians half-heartedly acknowledge the event while searching for more significant information relating to their personal lives; a baseball score, stock market figures, want ads, or horoscopes. This newsworthy happening is, for them, just words on a page. Their lives will not be changed by this tragedy. But for the family and co-workers of this fallen hero, life, as they knew it, will never be the same.

Emotions run rampant and their seemingly normal lives spiral into a frightening and dark abyss where pain, loneliness and grief are constant companions. Surviving this personal tragedy is, at times, almost unbearable. How does one survive? What lessons can be learned from these experiences?

Before we can learn to cope with pain and grief, we must first understand why we feel and respond to traumatic events as we do. In any loss—divorce, loss of a friendship or job, death of a loved one, or even geographical relocation—there is grief and mourning. Grief is an individual's feelings and thoughts following a loss. Grief is the emotional, physical, mental, and even spiritual responses human beings experience when their dreams and plans for life take an unexpected turn. Mourning is our outward expression, like crying, to these feelings. For example, even a small loss experience, such as, a rained-out ballgame or a broken promise, can cause grief. We are saddened, angry, or disappointed at the outcome. We, unwillingly at times, must surrender control of a situation to unforeseen circumstances or to another person. Grief and mourning are normal, healthy responses. Every one of us journeys through grief in our own way and on our own time schedule. To expect anything different is an impossibility.

When someone dies, our response to this loss is equal to our relationship with this person. The stronger the emotional bond, the more intense the grief reactions. To illustrate, the death of a mere acquaintance pales in comparison to the death of a much-loved family mem-



GRIEVING BEHIND THE BADGE

H•U•G•S

# How to Understand Grief Seminars

This one-day seminar will provide a general understanding of loss and grief and the paticular impact it has on Law Enforcement officers, Fire/ Rescue, Dispatchers, and Emergency Medical Services professionals. Participants will discuss job-rleated stress issues and coping skills will be provided to assist them in resolving many of these issues in both their personal and professional lives.

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ber, friend, or co-worker. In addition, the manner of death (sudden or anticipated) and personal life stresses will also influence our grieving.

When someone dies suddenly—auto accident, heart attack, or line of duty death—we experience immediate grief. There is no chance for us to say good-bye, make amends for past indiscretions, or tell the deceased the depth of our love. In contrast, when a loved one dies from a long-term illness or injury (anticipated death) we may have had the opportunity to prepare for the loss. This is not to say that we will not grieve following an anticipated death, but rather that our length of grieving and the extent of our pain may be lessened somewhat because we have expressed our thoughts and vocalized our love, and have helped the one who is dying accept their death and put closure to their life.

Furthermore, our grief process may be complicated by various everyday problems like job-related stress, personal health issues, financial worries, caring for an invalid parent, or coping with a troubling youth. These distractions can influence our ability to focus on our grieving causing us to delay or even suppress the grieving process.

Healing grief is not an easy task. Your grief journey is like a roller coaster ride. Just when you think you are doing better, something—a song, a memory, a special holiday—will plunge you into despair. Rejoice in the good moments and days you have; they will help you survive the more painful and lonely ones. Surviving a loss takes a very long time; many months or even years. Get plenty of rest, eat healthy, and exercise. Keeping a journal of your thoughts and experiences will aid you in realizing your progress in healing and your reinvestments in life and living. It's ok to cry; this is not a sign of weakness. You are not going crazy, you are very normal. Reading is another good source of learning and healing. Several good books on grief include:

- *Don't Take My Grief Away* by Doug Manning
- *Widowed* by Dr. Joyce Brothers
- *The Bereaved Parent* by Harriett Schiff
- *When Parents Die* by Edward P. Myers

*"Many people believe that children are resilient and because they appear to continue their normal behaviors..... Do not be deceived."*

Do children grieve? Many people believe that children are resilient and because they appear to continue their normal behaviors—playing, wanting to be with their peers, or even misbehaving—this person's death has not made an impact on their lives. Do not be deceived. Children, even as young as toddlers, are affected and do grieve. It is important to continue their normal routine as much as possible. They will need even more tender, loving care. Although it may seem that they are adjusting to life after the funeral, it is imperative to keep the lines of communication open. Do not be afraid to share your feelings and frustrations with them. Don't shy away from talking about the deceased person or asking the child how they are

feeling. Be aware of adolescents and teens who may experiment with drugs or alcohol as a means of coping with their grief and emotional pain. A family that has suffered the devastation of loss must not be afraid to reach out and help one another.

Last, but certainly not forgotten, is the grief and pain felt by the officer's or firefighter's other "family"; the men and women who worked side-by-side with those who died. They experience a grief that few civilians truly understand. A line of duty death impacts the agency or department to its very core. The traumatic event may cause nightmares, anxiety, anger or guilt. It is important that these survivors are provided an outlet to express their feelings, preferably a debriefing or regular support group meetings. Suppressing grief may cause them to doubt their self-worth as a community servant or, worse yet, question whether anyone appreciates the risks they take and the need they have to be the professional they are.

There are many lessons to be learned on the journey through grief. Our lives are like a tapestry woven over time with events and memories of people who have touched our lives. Some tapestries are simple, while others are intricate and sewn with many colors; each a unique masterpiece. The tapestry you continue to weave will reflect your individual pain and sadness, loneliness and longing, love and memories.

*"It is important that these survivors are provided an outlet to express their feelings..."*

This special hero has touched many lives and in their living and dying they have shared their gifts and talents and have taught us to value life. Focus on the positive aspects of their life. Take these memories and become a more warm, loving, and caring person. Reach out to those less fortunate or who may be hurting emotionally and share with them all you have learned from your grief experience. By reinvesting in life and sharing love with others, you will honor this hero who made the ultimate sacrifice. In so doing, they will never be forgotten. ✪

*Peggy is founder and president of HUGS (How to Understand Grief Seminars), a licensed mortician, and bereavement educator. She facilitates educational workshops and training seminars on loss and trauma for professionals and families. Grieving Behind the Badge is a workshop she has designed specifically for law enforcement, corrections, and emergency response professionals. Peggy is also the founder of Halo of Love, a support group for bereaved parents, and CHAT (Children Healing After Trauma), an educational program for children and educators. You may contact her through her website at: http://www.angelfire.com/tn/GrievingBehindBadge*

U.S. Department of Justice
National Institute of Justice

National Institute of Justice / Research in Brief

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# Line-of-Duty Deaths:
## Survivor and Departmental Responses

Frances A. Stillman, Ed.D., Research Director, Concerns of Police Survivors

### Introduction

*Officer Brummett* was performing a routine traffic stop when a passing car struck and killed him. For the first 6 months after the incident, his widow refused to accept the fact that her husband had died. After 6 months, she accepted his death but felt emotionally numb and unable to grieve. She said she needed to be "strong" so she would not upset others.*

*More than 2 years after the accident, Mrs. Brummett remained distressed by her loss. Plagued by nightmares of he husband, she had trouble controllin her thoughts about his death and h consequent problems. She could no concentrate at work and began to dri heavily. She felt alienated from most her friends and family.*

*Not his real name.

From the Director

The National Institute of Justice is proud of its efforts in "protecting the protectors"—reducing the risks police officers face on the job. The most dramatic example is the Institute's role in developing lightweight police body armor, which has been credited with saving the lives of more than 700 police officers nationwide.

But despite these and other efforts, far too many police officers still are killed in carrying out their sworn duty to protect citizens from criminal attack. Line-of-duty deaths, whether felonious or accidental, are a sad and frequent reminder of the danger inherent in police work. While the loss to the department and the community is serious, each police death leaves family, friends, and coworkers with the emotional trauma of a devastating loss.

There is a bond joining those in the "police family" that is formed by the shared experiences they have faced. A police death hits hard within that family, as others are reminded of their own vulnerability.

Many mistakenly believe that the spouses, children, and parents who survive police deaths are somehow more prepared for their losses than are other people. But knowing that the job can be dangerous does not prepare an individual for the actual experience of losing a loved one. Police survivors often endure prolonged psychological stress because they do not seek help. They are hurt by the misconception that, because they are part of the police community, they should somehow be stronger emotionally and better prepared for such a tragedy.

To learn more about the problems faced by survivors of police deaths, and how police departments can help, the National Institute of Justice sponsored this study by Concerns of Police Survivors. The findings presented in this *Research in Brief* clearly show the magnitude of distress survivors face.

Too often, when police survivors do seek help, it isn't available. As this *Research in Brief* indicates, police departments can do much more to help survivors cope with their loss. Many departments have no formal procedures for completing required paperwork and assisting family members with funeral plans and requests for benefits. Most departments do not consider the emotional and psychological needs of survivors to be a part of their responsibility.

When police departments establish systematic policies for dealing with a departmental death, they are better able to respond to the needs of survivors. Effective procedures allow a police department to respond in a prompt, organized manner and remain sensitive to the profound human emotions they must confront. The immediate and continuing response of police departments when an officer is killed has a definite impact on the well being of survivors.

Departments with no formalized policies can learn from those that have developed clear and caring procedures for dealing with line-of-duty deaths. The information from this study can help departments begin to meet this great unfulfilled need.

James K. Stewart
Director
National Institute of Justice

# Critical Incident Procedures: Crisis Management of Traumatic Incidents

By Sheriff CHARLES B. WELLS, Manatee County Sheriff's Office, Manatee County, Florida; Captain RONALD GETMAN, Florida Highway Patrol; and Inspector T. H. BLAU, Manatee County Sheriff's Office, Manatee County, Florida

Critical incidents are traumatic events that may be experienced by law enforcement personnel or their families. The traumatic element of such events is a threat to an individual's survival or continued functioning of such intensity that it is likely to produce significant symptoms or reactions in the average law enforcement officer. Such traumatic events have certain common characteristics:

1. The event is likely to be sudden and unexpected.
2. The event is a threat to the officer's existence or well-being.
3. The event may include an element of loss (partner, physical ability, position).
4. The event may result in an abrupt change in the officer's values, confidence or ideals.

The critical incidents most frequently faced by law enforcement officers include the death of a fellow officer, the wounding or injury of an officer in the line of duty, involvement in a hostage situation, the use of deadly force, and the suicide of a fellow officer.

## Effects

The immediate and longer-range reactions of a traumatic incident are dependent, in part, on the personality and previous experience of the officer. An intervention program designed to assist traumatized officers can minimize the adverse effects.

Most officers go through three phases of reaction following a traumatic event: the impact phase, the recoil phase and the post-traumatic phase.

*The Impact Phase*—The impact phase immediately follows the traumatic event and is characterized by the following:

1. It usually begins with the traumatic event and continues until the stressor no longer has direct effect.
2. It may last a few minutes or several days.
3. The officer's focus of attention is on the present and on the traumatic event. This phase lasts longest in instances of an officer's death or in cases of an officer's use of deadly force. The traumatized officer, or surviving partners in the case of an officer's death, may experience repetitions of the event in the form of flashbacks during investigations and other discussions. Investigations by senior officers, the media and lawyers may require officers to continue focusing on the traumatic event for days or even weeks.
4. Reactions by the traumatized officer may include feeling or acting stunned or bewildered, narrowing of attention, isolation of emotions, and/or automatic behavior with bland emotions. The more the events following the traumatic event continue to stress the officer, the longer and more intense this phase is likely to be.

*The Recoil Phase*—The recoil phase begins with the end of the impact phase and lasts until the officer is able to return to his usual routine of everyday duty and living. This phase can last from several days to several weeks. The recoil phase is characterized by the need to retell the story, which is a way of attempting to master the traumatic event. This phase may be characterized by a tendency to be over-reactive to ordinary events; a need to share and receive support from other officers; and acute emotional reactions such as depression, impotent rage, withdrawal, anxiety, bad dreams, sleep disturbances, and somatization.

*The Post-Traumatic Period*—The post-traumatic phase usually begins when the officer returns to a regular routine. The officer appears to be stable but the long-range effects of a traumatic critical incident may appear. The officer may experience periodic episodes of depression or hopelessness, insomnia or disturbing dreams, and a continuation or re-experiencing of reactions.

## Intervenors

Those who can be of greatest help to the victims and survivors of critical incidents include (1) those who are close to and accepted by the victims/survivors, and (2) those who have the skill and experience to be of service. The most effective intervenors may have either or both of these characteristics. The most commonly involved intervenors are:

1. *Fellow officers*—Generally highest in acceptance by victims and survivors, fellow officers vary considerably in counseling skills and/or experience. The potential to help is high, while the potential to worsen the situation is relatively low, except in the case of those with insensitive or destructive personalities.
2. *Immediate supervisors*—Supervisors offer the same potential to be of help as fellow officers and can also arrange smooth transitions and attend to the necessary administrative details with the least stress on the traumatized officer.
3. *Unit commanders*—As an authority figure of considerable significance in the lives of all concerned, the commander of the unit in which the traumatic incident occurred is in a position to counsel, give general support and set a standard and model for helpful behavior. The unit commander can also ensure that the immediate supervisor takes care of all administrative matters and can give the supervisor support and guidance during all phases of the traumatic incident process.
4. *Peer counselor*—A police officer who has been trained as a peer counselor provides continuing support, monitoring, or follow-up intervention where effects of trauma are long-term or chronic. Contacts between the peer counselor and victims are confidential.
5. *Chaplain*—In most law enforcement departments the chaplain is seen as the most neutral and accessible source of understanding and support. Spiritual counsel is especially helpful when the trauma involves a death.
6. *Mental health professionals*—Psychol-

ogists, psychiatrists, and other professionally trained mental health workers may be helpful if they have experience counseling law enforcement personnel and their families.

7. *Other officers' family members*—Spouses and other family members of fellow officers can be particularly helpful in lending support to the families of slain officers or of officers who are victims of other traumatic incidents. Most law enforcement agencies have an informal network of officers' wives who are ready and able to help out in emergencies.

8. *The media*—Newspapers and television reporters, editors and producers can have a very powerful influence—postive and negative—following a critical incident. Traumatic events involving law enforcement personnel usually are considered to be of major interest to readers and viewers. Whether the reporting of such incidents is sympathetic and supportive or, as in some instances, distressing or even destructive to victims and survivors, depends on a variety of motives, bureaucratic requirements and personalities of media representatives. In most instances, reporting the story—not its impact on the traumatized officer or survivors—will be the priority of the media.

9. *The citizenry*—Following a critical incident, the communications received from concerned, interested or opinionated citizens can have a significant effect on the reaction of the officer and his family to the event.

## Intervention Points

Help should be available and rendered at all appropriate times following a traumatic critical incident. The range of possible intervention times is from immediately following the event to as long as a year later. In general, the earlier the appropriate intervention, the more effective it is likely to be.

1. *At the scene*—Conflict control, stabilization and support immediately following the critical incident can make the difference between a short-term, acute reaction or chronic post-traumatic stress. The most effective intervenors at the scene are likely to be fellow officers, immediate supervisors, unit commanders, the media and civilian bystanders.

2. *The investigation*—Regardless of the individual(s) or specific emotional trauma involved, the mandated regulations and procedures must be carried out. The traumatized individual, partners, other officers or even family members may be required to testify. The immediate supervisor and unit commander are the most significant intervenors in this phase.

3. *The first 24 hours*—During the impact phase, and as the officer enters the recoil phase, the peer counselor, the immediate supervisor and the mental health professional are most likely to provide positive intervention.

4. *Week 1*—As the officer-stress victim moves from the recoil phase to the post-traumatic period, the immediate supervisor, the peer counselor and the mental health professional continue to be the first-line intervenors. The unit commander may also be of assistance.

5. *Weeks 2-4*—As the officer returns to duty and familiar routines, his partners, fellow officers and immediate supervisor are in the best position to monitor and intervene if stress reactions continue or develop. Where necessary and appropriate, the peer counselor or mental health professional may continue with crisis consultation or support.

6. *Months 1-6*—Where stress reactions (job-related or family-related problems) continue or appear in this time period, professional help is indicated. Although the peer counselor and supervisors may be supportive, it is likely that stress reactions extending for this period of time have deeper roots that should be explored in a professional mental health setting.

## Intervention Techniques

Some intervention techniques can be used effectively by almost any intervenor while others require special training or qualifications. The inappropriate use of some intervention techniquess can be in some cases dangerous (clinical exploration, interpretation). The effectiveness of any intervention technique to help relieve post-traumatic stress is governed by the timeliness, tone, style and intent of the intervention. Some of the more commonly favored techniques for the relief of post-traumatic stress include:

1. *Attentive listening*—This technique can be used by any intervenor and is usually helpful in any stress-relief effort. Good eye contact, an occasional nod and genuine interest without comment are the essential mechanics of this technique.

2. *Being there with empathy*—Simply "being there" and indicating availability, concern and an awareness of the turbulent emotions being experienced by the stressed individual adds reassurance and hope. The fellow officer or peer counselor who has experienced a similar traumatic incident can be most empathetic. Additional help can be given by letting the traumatized officer know what he is likely to experience in the days to follow.

3. *Reassurance*—This technique is valuable only if the reassurance is reality-oriented and should take the form of reassuring the victim that routine matters will be handled, premises and property will be secured, family will be protected and the victim's responsibilities will be handled by others. It is vital that the traumatized officer be reassured that he is not alone. Organizational support from command personnel can

### An Example of Initial Assignments for Crisis Management and Intervention in a Line-of-Duty Death

Line-of-Duty Death. The death of an officer in the line of duty affects all members of the department, as well as the fallen officer's family and friends. The entire community is likely to feel the loss. When the partner or the supervisor of a fallen officer becomes aware of or is notified of a line of duty death, the following procedures are to be followed:

1. The chief of the department is to be notified forthwith.

2. The designated crisis team manager is to be notified and dispatched immediately to the scene.

3. The crisis manager is to report his or her presence to the supervisor at the scene.

4. The crisis manager will designate a crisis team member as staff leader at headquarters to establish communications with the crisis manager at the scene and to assemble the crisis team members designated by the crisis manager. The staff leader will be directed by the crisis manager to contact the fallen officer's partner, best friend, the chaplain and where appropriate, the fallen officer's former training officer, all of whom should be apprised of the details of the situation and placed on alert.

5. When the crisis manager has established the relevant details of the incident, he or she should formulate an action plan to accomplish the following:
   a. Notification and support of family survivors.
   b. Continuing communication with senior staff
   c. Press liaison
   d. A 24-hour plan for utilization of the crisis team.

6. This preliminary plan should be cleared immediately with the senior officer at the scene and with the chief.

7. Once cleared, the plan should be implemented. The crisis manager should assign a crisis team member to the scene and immediately return to headquarters to supervise the crisis plan implementation.

be an important reassurance for the officer-victim. Such support may include a clear picture of what the department will do, how the incident reviewed by superior officers, and local assistance where appropriate.

4. *Supportive counseling*—This technique requires formal training. Using counseling procedures such as effective listening, restatement of content, clarification of feeling, reassurance, community referral, and networking, the victim can be helped to prepare for a return to less stressful circumstances. Peer counselors are particularly skilled in these techniques.

5. *Group grief sharing*—In death-of-an-officer incidents, holding meetings of family, partners, associated law enforcement personnel and others closely associated with the dead officer can help prevent or relieve excessive stress responses by allowing the participants to vent their emotions fully.

6. *Interpretive counseling*—This intervention technique can be used by peer counselors or mental health professionals to stimulate the victim to search for and discover the underlying emotional stresses that intensify a naturally stressful traumatic event. This procedure should be used only when it is clear that the victim's emotional reaction is significantly greater than the circumstances of the critical incident warrant. Interpretive counseling may reveal emotional difficulties that require more extensive professional help than that which can be provided in the context of crisis consultation.

7. *Clinical exploration*—The victim of a traumatic critical incident may develop a series of stress reactions that do not abate with the crisis procedures described above. When this happens, the victim may suffer a chronic post-traumatic stress disorder. Extended post-traumatic stress is debilitating and requires referral for clinical exploration of the condition by psychologists, social workers, psychiatrists and/or other mental health professionals who have experience and training in working with law enforcement personnel.

## Conditions of Intervention

Intervention techniques and skills must be applied in appropriate ways following a traumatic critical incident. Some of the most important conditions are described below.

1. *Immediacy.* Intervention during the hours immediately following a critical incident is crucial. All techniques other than interpretive counseling and clinical exploration tend to be most effective in the 12 to 24 hours following the trauma.

2. *Brevity.* All techniques described above are likely to work best with a minimum of verbiage and repetition. Language should be concise and communication brief.

3. *Privacy.* Except for group grief sharing, intervention techniques are best provided to the victim in as private a setting as possible.

4. *Respect.* The traumatized victim of a critical incident may respond in unusual or unexpected ways. The intervenor who expects to render effective help must be prepared to tolerate unusual behavior and continue to respond with acceptance and respect. It is destructive for an intervenor to become distressed by a victim's behavior and criticize or attempt to control the victim's responses by being authoritarian or by demanding that the victim "shape up."

5. *Support.* The intervenor in a traumatic critical incident situation must be supportive. Whether in earlier or later stages, intervention is more likely to be successful if the victim sees the intervenor as fully supportive, on the victim's "side," and willing to do anything within reason to ease the victim's burden.

## Making Critical Incident Procedures Operational

Each law enforcement department must develop its own standardized procedures for responding to traumatic events. Written regulations and procedures tend to be rigid, but in the case of procedures developed and specified for dealing with traumatic events, the application of the required actions should be subject to the judgment and availability of the intervenors. Larger departments should have available trained peer counselors and mental health staff or consultants. Smaller law enforcement units should develop close ties with larger departments so that trained and experienced intervenors can be "borrowed" when an emergency situation arises. In general, critical incident response procedures can be codified in departmental regulations or orders under headings similar to the following:

1. *Activation.* Regulations dealing with official response to traumatic incidents should begin with clear-cut descriptions of the events that would require a critical incident response from the department.

2. *Crisis team manager.* Department procedure manuals should designate the individual(s) who are to be contacted as soon as a critical incident occurs. These individuals should be senior staff who are trained and experienced in responding and managing rapidly and efficiently.

3. *Crisis team members.* Specific members of the department should be designated on an ongoing duty ros as a crisis team cadre. The crisis manager should select those members for the response and management team who have experienced traumatic incidents, as well as newer team members who would profit from the experience of serving with more seasoned crisis intervenors.

4. *Press liaison.* Some departments have a permanent public information officer. Others have no formal press contact personnel. Media professionals can be significant intervenors—helpful or unhelpful—in a critical incident situation. One member of the crisis management team should be prepared to meet with the press. This team member should be prepared to provide accredited press representatives with

a. All the facts consistent with the law, department policy and the best interest of the ongoing investigation;
b. A briefing as to the concerns about victims and survivors and how the press may be most helpful as intervenors;
c. Twenty-four-hour availability to answer questions and provide a single-source liaison between the press and the crisis manager.

5. *Initial assignments.* Department procedural manuals or regulations should provide specific information on assignments for the crisis manager and crisis team members for the various kinds of critical incidents likely to occur. An example of such a procedural statement is included at the end of this article.

6. *Meetings and reports.* The department's procedural manual should specify when the crisis management team should meet with respect to the different kinds of crises likely to be encountered. The types of formal and informal reports to department management should be specified in detail.

The details with which each procedure is described will depend to some extent on the size and resources of any specific department. Standards will develop as techniques of intervention are developed, tested and modified. Much of the effectiveness of these procedures will depend on the skill, experience and sensitivity of the department's leadership and the offic selected to act as crisis team mem and managers. ★

From:

LIFENET

# WHAT DO WE SAY TO THE KIDS

As a disaster clinician and a member of a CISD team. I have frequently been asked "What do we say to the kids?" This is a concern expressed by emergency responders, teachers and parents. I thought it might be useful to share some of the suggestions I've found helpful when working with kids in crisis.

There are two basic assumptions that most adults make about kids that gets them into trouble. The first is that we can (and should) protect children from trauma and the second is that children have a capacity to abstract concepts about crisis.

The first assumption leads us to try to hide our own responses from children. Children's very survival depends on perceiving the emotional state of adults upon whom they depend. They know when their parent is upset. When we don't acknowledge that to the child, he must then make his own assumptions about what is upsetting us. The child has a very self centered view of the universe, and consequently decides that whatever has upset the parent is his fault. This, of course, leads to heightened anxiety in the child and actually makes the situation worse. Not telling a child what is going on, therefore, does not shield him. It actually creates distress.

The second assumption most often gets us into trouble when we try to explain death to children. Too often, we want to reassure the child that the dead person (or pet) is okay, so we tell the child that the person or pet is "happy now", "out of pain", "asleep"or "in heaven". None of these sound like a bad deal to the child, but because they do not understand the facts about death, they all too frequently decide they would like to be with their loved ones in heaven and may become suicidal. Having seen a large number of children as young as five years old who have become suicidal after a loss has made me aware of what a dangerous proposition reassurances like this are.

It is important to tell the child explicitly about what happens to the body after death and to talk about the permanence of death. This is difficult, but it is much safer for the child. Children most often become suicidal after a loss because of their grief. Children do not usually get suicidal in the fact of trauma, but only in reaction to the deaths of people and animals they care about.

Some other tips which I have frequently used when working with children are:

* Treat all the child's fear as genuine. He is truly fearful.
* Do not make promises you cannot keep.
* Listen to the child - his or her feelings, fears, and beliefs
* Tell them the facts of what happened.
* Include the child in the clean up efforts and other activities designed to return life to normal. He or she will feel more in control if able to help out a little.
* Maintain the routines of normal life as much as possible.
* Young children need to be held.
* Let school personnel know when your child is in crisis - they can frequently help.
* Children work out their feelings through play and art more than through talking. They should be encouraged to draw the event or re-enact it in their play. Help them verbalize what they are doing, how they feel about it, and what their beliefs are about the event.
* Share your feelings with the child.
* Show confidence that both you and the child will be able to cope.
* Do not expect the child to take care of you or your fears. Find help to cope with your own fears.
* Provide realistic reassurance.

There are several sources of information which are useful when working with children. One is Mitchell and Resnik's *Emergency Response to Crisis* and another is a FEMA publication entitled, *Coping with Children's Reactions to Earthquakes and Other Disasters*.

Nancy Rich, M. S. W.
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CHILDREN'S RESPONSE TO TRAUMA

Nancy Rich, MA

Children's responses to trauma vary according to the age of the child. Generally, children respond by reverting to behavior typical of an earlier developmental stage. These responses are considered NORMAL if they are of brief (under three weeks) duration. If any of these symptoms continue, there are professionals available to help you with your questions.

| AGES 1 – 6 | AGES 7 – 11 | AGES 12 – 18 |
|---|---|---|
| Bedwetting | Bedwetting | Withdrawal and isolation |
| Crying | Nightmares | Headaches |
| Immobility | Change in sleep patterns | Stomach pains |
| Excessive clinging | – unwillingness to fall asleep | Running away |
| Thumbsucking | – need for night light | Depression and sadness |
| Wetting pants | – fear of sleeping alone | Suicidal thoughts * |
| Loss of bowel control | – fear of darkness | Stealing |
| Fear of darkness | Irrational fears | Change in sleep patterns |
| Inattentiveness | Irritability | Sleeplessness |
| Fear of animals | Disobedience | School problems |
| Fear of being left alone | Excessive clinging | Nightmares |
| Fear of crowds | Headaches | Increased sleep |
| Overactivity | Stomach aches | Confusion |
| Underactivity | Visual or hearing problems | Violent fantasies |
| Nightmares | Refusal to go to school | Avoiding talking of event |
| Inability to sleep without a light or or someone else | Poor performance | Delinquent behavior |
| | Fighting | Use of drugs |
| | Loss of interest | Use of alcohol |
| Awakening during night | Loss of concentration | Sexual acting out |
| Sensitivity to noises | Distractibility | Accident prone * |
| Irritability | Withdrawal | Relationship difficulties |
| Confusion | Refusal to talk about event | Change in appetite |
| Speech difficulties | Violent fantasies or play | Aggressiveness |
| Eating problems | Re–enacting the event | Risk taking behavior * |
| Stomach aches | Accident prone * | Overactivity |
| Accident prone * | Appetite disturbances | Underactivity |
| Violent fantasies/play | Over/Underactivity | Irritability |
| Re–enacting event | Inattentiveness | Confusion |
| Wanting to die * | Wanting to die * | Inattentiveness |
| Wishing to go to heaven * | | |

*** Any suicidal talk or actions should be taken seriously and professional help should be sought immediately. Younger children do not understand the permanence of death, so do not understand the consequences of "suicidal" behavior. Even very young children can become suicidal.**

(OVER)

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FROM: EMERGENCY RESPONSE TO CRISIS

Jeffery T. Mitchell
H.L.P. Resnik

# CHAPTER 6

# *Childhood Crisis*

Ann Scanlon-Schilpp, R.N., M.S.

## INTRODUCTION

Children in crisis present a complex challenge for crisis workers. Children in various age groups have specific needs and respond differently to the same crisis events. In addition, children undergoing severe stress frequently regress or return to behavior below their level of development. Another serious problem encountered by crisis workers is that they have a tendency to become emotionally involved with the children they are attempting to help. Emotional involvement frequently interferes with the proper crisis management.

Among the many events that produce a crisis state in a child or adolescent's life, injury, illness, and death are considered the most disruptive. The emphasis in this chapter will be on the care of children who are faced with these and other serious crises.

This chapter will review the main points of the intellectual, emotional, and social development of children in different age groups. By recognizing these developmental levels in children, crisis workers will be in a better position to develop an intervention plan that will be the most effective in the crisis situation.

Although the basic principles of crisis intervention discussed in Chapter One apply to the child as well as to his family, the special needs of children frequently call for special intervention techniques. The information and techniques suggested in this chapter will be most helpful in assisting emergency service personnel in the proper crisis management of children.

## BACKGROUND

During the first year of life, the major causes of infant death are primarily infections, specifically those of the respiratory and

gastro-intestinal tracts. The mortality rate decreases drastically after one year, and the major cause of death in the years leading up to and through adolescence is accidents.[1] The toddler (ages one through three), who now is beginning to explore his environment, is particularly vulnerable to such injuries as burns, falls, vehicular accidents, and ingestion of foreign materials like drugs, cleansing agents, insecticides, and more. The high incidence of death and disability due to accidents in the one to five age group occurs because:

1. The child has little ability to understand cause and effect relationships.
2. The child has little past experience upon which to draw, and use of judgment is not yet a part of his intellectual capabilities.
3. The child imitates adult behavior.
4. The concepts of motion and time are not developed.
5. Muscular coordination is not developed.
6. The child explores his world by bringing it to, and into, his mouth.[2]

The school age child and the adolescent frequently incur injury outside of the home. They are involved in automobile accidents, falls, drownings, or in athletic accidents. Between the ages of five and fifteen, accidents still rank as a leading cause of death. The incidence, however, drops markedly during this period, only to rise again dramatically during late adolescence.[2]

In order to assess the child, it is important to understand the process of growth and development. Since children are in a state of continual change, the job of assessment is a complicated one. Growth essentially refers to an increase in size (weight or height), while development refers to an improvement in skill and functional capacity.[3] This process, though varying to some degree from child to child, is an orderly one. Intellectual growth is markedly influenced by the child's social environment as well as by his emotional experiences. The focus of assessment here will be concerned with the child's psychosocial abilities, specifically his intellectual, emotional, and social development.





## *A CHILD'S PSYCHOSOCIAL DEVELOPMENT*

| *INTELLECTUAL* | *EMOTIONAL* | *SOCIAL* |
|---|---|---|
| | Birth to Two Years | |
| Reflexive behavior: cries when wet, hungry, frustrated, or in pain.<br>Gradual development of behavior with a purpose.<br>Interest in new things.<br>Unable to form concepts.<br>Uses symbols and symbolic play.<br>Imagination.<br>Distinguishes "me" from "not me."<br>Memory development.<br>Can minimally infer causes from observing effects. Can predict effects from observing causes.<br>Self-centered. Has difficulty in appreciating other's point of view. | Learning to trust people and environment: most important person is mother or caretaking figure.<br>Needs: response to physical needs by mother through touching.<br>Security, safety.<br>Poor defenses against anxiety: crying, biting, throwing objects, hitting, head banging, rocking, sucking thumb, carrying "security blanket." | Primary source of socialization is family and this occurs within the home environment. |

| *INTELLECTUAL* | *EMOTIONAL* | *SOCIAL* |
|---|---|---|
| | Age 2-4 years | |
| Language development.<br>Imagination, "pretends."<br>Imaginative behavior: verbal and physical (dresses up like Dad or Mom: repeats things parents have said in his presence).<br>Learning through play.<br>Intellectual growth occurs by child gathering information through his senses from environment.<br>Major sense organs utilized for information processing are: the eyes and mouth.<br>Magical thinking: believes because he wishes something, it happens. | Learning to be autonomous.<br>Moving away from tight attachment to mother: learning independence, dressing self, washing, feeding.<br>Situations need to be structured as to kinds of choices.<br>Needs outside control and limits set on behavior, but given freedom to try and freedom to explore. | Primary sources of socialization are family and peers: learns through play with others, can cooperate with another child in play.<br>Learning to share. |

| *INTELLECTUAL* | *EMOTIONAL* | *SOCIAL* |
|---|---|---|
| | Ages 4-7 | |
| Fills gaps in his knowledge through questioning and experimenting "How come," "Why," "What's this."<br>Uses all of his senses now in gathering information.<br>Ability to make judgments through primitive problem solving.<br>Concept formation as child; now has more past experiences to which he can relate present situation. | Learning initiative.<br>Seeks immediate gratification of wishes. | Primary source is family and to a small degree peer group.<br>Can cooperate with other children in trying to achieve goal in play.<br>Sharing. |

| *INTELLECTUAL* | *EMOTIONAL* | *SOCIAL* |
|---|---|---|
| | Age 7-12 | |
| Communicates about shared topics of interest.<br>Sees others' viewpoint and not just his own.<br>Concept of time, space, and motion developing.<br>Still concerned with the present and needs objects to manipulate to make logical relationships.<br>Difficulty in projecting into future.<br>Operates on trial and error. | Tolerates limited separation.<br>Developing sense of independence.<br>Cooperates and understands treatment efforts with simple explanations.<br>Has developed some defenses to cope with anxiety (denial, and magical rituals such as crossing fingers). | Family and peer group.<br>Spends most of time with groups of children.<br>One special friend. |





| *INTELLECTUAL* | *EMOTIONAL* | *SOCIAL* |
|---|---|---|
| | Age 12-18 | |
| Considers possibilities even without experiencing them: not bound to what he can see and touch.<br>Considers hypothesis.<br>Uses logic in deductive and inductive reasoning without having to use observation.<br>Understands cause and effect relationships.<br>Learning taking place through abstraction. | Strives for independence from family: parents target for this conflict.<br>Seeking to find identity to "Who am I," "Where am I going."<br>Body image is an important issue.<br>Need for limit setting. | Peer groups exerts strong pressure.<br>Prone to taking irresponsible risks. |

The above material is used with the permission of Blake, Wright, Waechter: *Nursing Care of Children*. New York, J. P. Lippincott Co., 1970

## ASSESSMENT AND INTERVENTION

In assessment of the child, it is important to consider the following: age, past experiences with injury, what the child was doing when the injury occurred and what the child's developmental level is. Past experience plays a significant role in how the child deals with new situations. If he has been well cared for by his parents; if he has had his physical, social, and emotional needs met, then his response to you will be one of trust and respect for your authority. He obviously will be frightened and, possibly, panicky but approachable.

For the child under six, separation from his mother provokes the greatest anxiety.[4] He also fears pain, as well as disapproval. In the immediate treatment of the child in this age group, it is extremely important that the mother or caretaker be present to provide some security. The mother needs to be told what to do and needs help with maintaining her composure. Simple direct statements to the mother need to be given by the crisis worker. "It's okay to touch your child on the head," "hold his hand," "talk to him." Children between six and twelve are usually hurt doing things that their parents have warned them not to do. Often, the child fears retaliation or punishment from the parent. Guidance

for the mother needs to include a statement that lets her know that while it is okay to be angry with the child, her support and comfort are what he needs now.[5] Other intervention techniques are as follows:

- Since children are quite aware and sensitive to what is happening around them, as well as what is being said, it is important to monitor the conversation that the child will hear.
- It is also important to prevent him from seeing things that will be upsetting, particularly if a brother, sister, or parent is involved in the accident.
- This applies to children who are bystanders as well.
- These children should be escorted away from the scene of an accident by an adult. They should be given brief, simple information about what is happening.
- When approaching the child who has been hurt, the emergency service worker needs to do so calmly and gently.
- Tell the child your name and who you are.
- If the child is alert enough and can communicate, ask him his name, where he hurts, and what happened to him.
- The child's response to your question will tell you the degree of crisis he is in: if he can tell you where he hurts and some information about what happened, it means that his thinking is clear and an avenue for supporting him is now open to you.
- Just as adults can problem solve and cooperate more effectively when given information, so also can the child and adolescent. Simple, brief explanations of what you are going to be doing should be given prior to touching the child: "I'm going to look at your left arm now, Eddie," or "I'm going to take off your shoe, Eddie," or other explanation.
- Always call the child by his name.
- If something painful has to be done, such as an IV insertion, prepare the child for it. "This will hurt some, Eddie, when I put the needle in your arm. It's okay to cry real loudly."
- When you are finished doing the painful procedure or treatment, tell the child it is over and that he handled it well.



- Trust develops when the child is provided with the truth, as painful as it might be.
- Always tell the child about the painfulness of a treatment *before* it is given.
- If the child is capable of being given a choice, and if the situation allows for that, let him make the choice.
- If the child is physically able to help (for example, hold a bandage for you) let him do that.
- Try to make many procedures for the younger child into games.
- Selection of words when talking to a child is important. Be simple and honest.[2, 5, 6, 7]

A child's behavioral responses to injury can range from screaming and crying, to silence. It is important that the emergency service worker accept the child's behavior and his manner of expressing his fear. For the child who is quiet, ask if he is frightened and what might help him. Give him a suggestion like, "Would you like me to hold your hand?" (A great deal of touching is important when dealing with children.) Tell him it is okay to cry or holler if he wants to.

For the young child (age zero to three), who cannot communicate his needs and fears verbally, simple explanations are still needed. Should the mother be present, she should be allowed to stay with the child enroute to the hospital. Also, the helper needs to ask if the child has a favorite blanket or toy that may be given to the child to hold.

If the crisis worker has developed some rapport with the child, this should continue enroute to the hospital. If not the individual making the initial contact should then introduce the child to another person who will be taking care of him. If time permits, the child should be told that he is going to the hospital and he should be told what he can expect to happen there.[7]

In situations where both parent and child are hurt, the parent needs information about what is happening to the child, and reassurance that someone is with the child, caring for him. The child also needs the same information about his parent.

## SOME PRECAUTIONS FOR CRISIS WORKERS

1. Do not leave the child alone.

2. Do not threaten the child with punishment if he is uncooperative.
3. Do not tell him things like, "Big boys don't cry," or "You're acting like a baby."
4. Do not lie to child, "This is just a little stick," when in fact it hurts.
5. Do not frighten the child in order to gain cooperation. ("You'll die if this IV is not inserted.")
6. Do not talk about the child's family or living conditions in front of child.
7. Do not criticize the parents in front of the child.

It is generally believed that parents love and protect their children from the horrors of the world, and yet tragedies occur both to children who have supervision as well as to those who do not. The emergency service worker must be aware of:

1. His own responses to the circumstances surrounding the injury and,
2. The needs of the family during this crisis. No matter what the circumstances of the accident may be, it is important to meet the emotional needs of the family first, *and to do so objectively*. It is imperative *not* to make comments like, "If you had been there, this wouldn't have happened to your child," or any statement that reflects the fact that they were not caring appropriately for their child. Deal with the "here and now" and how they can be supportive to their injured child.[2]

One's own feelings need to be discussed with peers after traumatic situations rather than be kept inside of oneself. The crisis worker may have a child of his own and is reminded of this fact by the child with whom he is working. This identification can elicit many different feelings in the individual. These feelings may include anger, fear, or helplessness. If this identification does occur, the crisis worker may become emotionally distressed at the scene and may act disorganized. Removal from the situation by peers is necessary, and follow-up emotional care should be provided for this individual. (See Chapter 15 on stress and burn out.)

## PREVENTION

Emergency service personnel have the potential to act in many





roles within the community they serve. Besides their primary work in law enforcement and emergency intervention, crisis workers may also function in a prevention role. The crisis situation which they have been called upon to manage may often have other problems attached to it. Recognition of these problems may prevent future difficulties because they have made an accurate initial assessment of the entire situation. A child who has been injured in the home may be the calling card for the crisis worker's entrance into the situation. Once there, he may recognize another child's need for health care, or a family's need for home-safety education. Referrals concerning these areas can either be offered to the family, or made to the appropriate agency (law enforcement, medical, or social services) at that time.

Rapid intervention by other agencies can prevent many cases of neglect, abuse, or ignorance which might produce maiming and/or death.

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The National Center for Victims of Crime

# *INFOLINK*: CHILDREN AND GRIEF

**Overview**

The death of a family member or friend can be a painful, confusing and often frightening experience at any point in one's life. Yet, to suffer this loss as a child brings with it a unique and perhaps more complex set of issues and intricacies. Lack of emotional maturity and limited coping capabilities may render a child emotionally unable to work through the grief that accompanies the death of a loved one.

The definition of grief encompasses the "psychological, social, and somatic reaction to the perception of loss" (*Grief Resource Foundation, p.1*). In examining the grief of a child, the various developmental stages of growth must be considered individually. While these stages may not be exact, they are representative for most children.

**Birth to One Year**

Opinions seem to vary somewhat on concepts of death and response to grief for infants up to six months of age. Some professionals believe that children do not respond to death, as their memory capacity for relationships is not yet developed and they cannot respond to their loss. Others believe that while children in their first six months of life are not able to conceptualize death or grieve for a specific loss, they will feel some anxiety as the death may interfere with their basic needs (*Grief Resource Foundation, p.3*). Most experts concur that from six months to one year of age, a child is at least vaguely aware of the absence of a parent or guardian and, thus, may experience some limited grief (*Papenbrock and Voss, p.5*).

***Child's Response*:**

During this developmental stage a child may respond by crying, altering her/his sleeping or eating schedules, changing her/his bowel and bladder patterns and perhaps withdrawing emotionally (*Papenbrock and Voss, p.5*).

***Child's Needs*:**

- Additional touching, holding and cuddling; and
- Strict adherence to usual schedule. (*Papenbrock and Voss, p.6*).

**One to Two Years of Age**

Although children still have no means of conceptualizing or attributing meaning to death, the loss of a primary caregiver will usually result in the experience of some displeasure or depression. In addition, during this developmental stage, children usually respond to the probable change in their environment and the emotional state and grief of those around them (*Grief Resource Foundation, p.1).*

***Child's Response*:**

Similar to the previous developmental stage, a child may become more irritable, show a change in eating, sleeping, bowel/bladder patterns, withdraw emotionally, and perhaps show a temporary delay in development.

Protest, despair, and detachment are the three general phases comprised in this stage (*Grief Resource Foundation, p.3).*

***Child's Needs*:**

- Provision of a stable environment;
- Adherence to normal schedule;
- Additional comforting, touching, hugging and holding;
- Play time with present caregiver; and
- Expressions of love. (*Papenbrock and Voss, p.5).*

**Preschool Child: Three to Five Years of Age**

Preschool children have a limited understanding of death: they perceive death as temporary and reversible. They believe the dead person is sleeping and can be awakened, broken and can be fixed, or gone and will return. At this stage, they have no concept of personal death -- they believe death only happens to other people (*Grief Resource Foundation, p.1*).

***Child's Response*:**

- Periods of anger, sadness, anxiety, outbursts and conversely, indifference;
- Eating and sleeping disturbances, bowel and bladder difficulties, stomach aches, and/or headaches;
- Regressive behavior such as thumb sucking, excessive clinging, etc;
- Heightened fears, especially the fear of abandonment;
- Fantasies of guilty that he/she somehow caused death (*Papenbrock and Voss, p.7)*; and
- Excessive questions about the death and an openness to discuss the death, even with strangers (*Papenbrock and Voss, p.2*).

***Child's Needs*:**

- Additional holding, touching, hugging and expressions of love;
- Acceptance of child's reactions;
- Reassurance that they are not to blame for the death and that they will be taken care of;
- Communication -- children need an honest explanation about the death and clarification that death is not temporary;
- Professional support may be sought if disruptive or uncommon behavior persists *(Grief Resource Foundation, p. 3-7*).

**School Age Child: Six to Nine Years of Age**

Children in this age group have a clearer understanding of death. By the time a child is nine-years-old, they usually come to understand the reality of death in terms of its irreversibility, though they may still believe it only happens to other people. They may be interested in the physical and biological aspects of death. They may believe that thoughts can make things happen, even accidents and death. Children in this developmental stage usually alternately confront and deny their grief, as they are often unprepared for the length of the grieving process (*Grief Resource Foundation, p.2).*

***Child's Response*:**

The child may disavow death and utilize denial as a defense mechanism. Subsequently, children may not questions or discuss death and appear unaffected. In actuality, children in this developmental stage encounter strong feelings of loss, yet it is often difficult for them to express these emotions (*Grief Resource Foundation*).

Children may have difficulty eating and sleeping, stomachaches, headaches, excessive fearfulness and/or guilt. Children may be angry, and anger may be directed at certain people who "caused" death or allowed it to happen (i.e., God, doctors, nurses, etc.). Children's grieving process may be further complicated by school environment and the following may occur:

- school performance may decline;
- child may be unable to concentrate;
- child may direct anger towards teacher or classmates;
- physical ailments may occur prior to or during school; and
- classroom behavior may be inappropriate *(Papenbrock and Voss, p.8)*.

***Child's Needs*:**

Honest, open discussions about death are crucial. Children in this developmental state need information. Encourage the child to express his or her anger and share your own feelings. Be supportive and provide physical affection.

Contact the child's teachers and encourage them to maintain contact with you regarding the child's progress. As children in this age group tend to approach and them retreat from the reality of death, parents and caregivers need to be aware of, and sensitive to, this "on-again," "off-again" aspect of grieving (*Grief Resource Foundation, p.8*).

**Pre-Adolescent and Adolescent: 10 to 18 Years of Age**

At this stage, older children and adolescents have a more mature view of death and understanding of its irreversibility and of mortality. They also understand personal death, although adolescents usually view themselves as immortal. Adolescents often have an increased interest in personal purpose in life ("meaning of life"), and in what happens after death. Death may be romanticized. Some experts are concerned that as children continually view death through movies and television, their perceptions of the finality of death and the experience of dealing with such loss are jaded, and they believe it is easier to manage than it is in reality (*Grief Resource Foundation, p.2)*.

***Child's Response*:**

- Guilt, anger, confusion, depression, and shock;
- Crying, stomachaches, headaches, insomnia, and exhaustion, as well as dramatic reactions such as temporarily not eating, sleeping, etc.;
- Decrease in school performance;
- Change in peer group; and
- Possible drug use and/or sexual promiscuity.

The biological and emotional changes brought on by puberty during this developmental stage further complicate reactions to loss and the grieving process. There is a great tendency for this age group to be very egocentric; thus, they are inclined to be preoccupied with how the death affects them personally and give little consideration to its impact on others. As assertion of independence during this developmental stage is of considerable importance - the loss of a parent or guardian may shock a child into realizing how much this person was needed (*Grief Resource Foundation, p.3*). This may especially affect a son who has lost his father or a daughter who has lost her mother, and may be extremely overwhelming (*Papenbrock and Voss, p.9)*.

***Child's Needs*:**

- Assist in helping a child verbalize her/his grief;
- Promote discussion of death and grief and listen to what a child is saying;

- Encourage the child to release grief in healthy ways (i.e., discussion, physical activity, etc.);
- Validate concerns and emotions;
- Establish limits on behavior and consequences of violating limits; and
- Provide peer support group and/or professional help depending on a determination of the individual child's needs *(Papenbrock and Voss, P.10).*

When children encounter death, especially the death of a parent or guardian, their ability to grieve and their grieving process is greatly effected by their stage of developmental growth. While children's grief processes may vary throughout their early life and adolescence, an adult's ability to be honest, to listen, to be supportive and to be there for the children will sustain them during this difficult time and help facilitate a healthy process of grieving.

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# Campus Law Enforcement Journal

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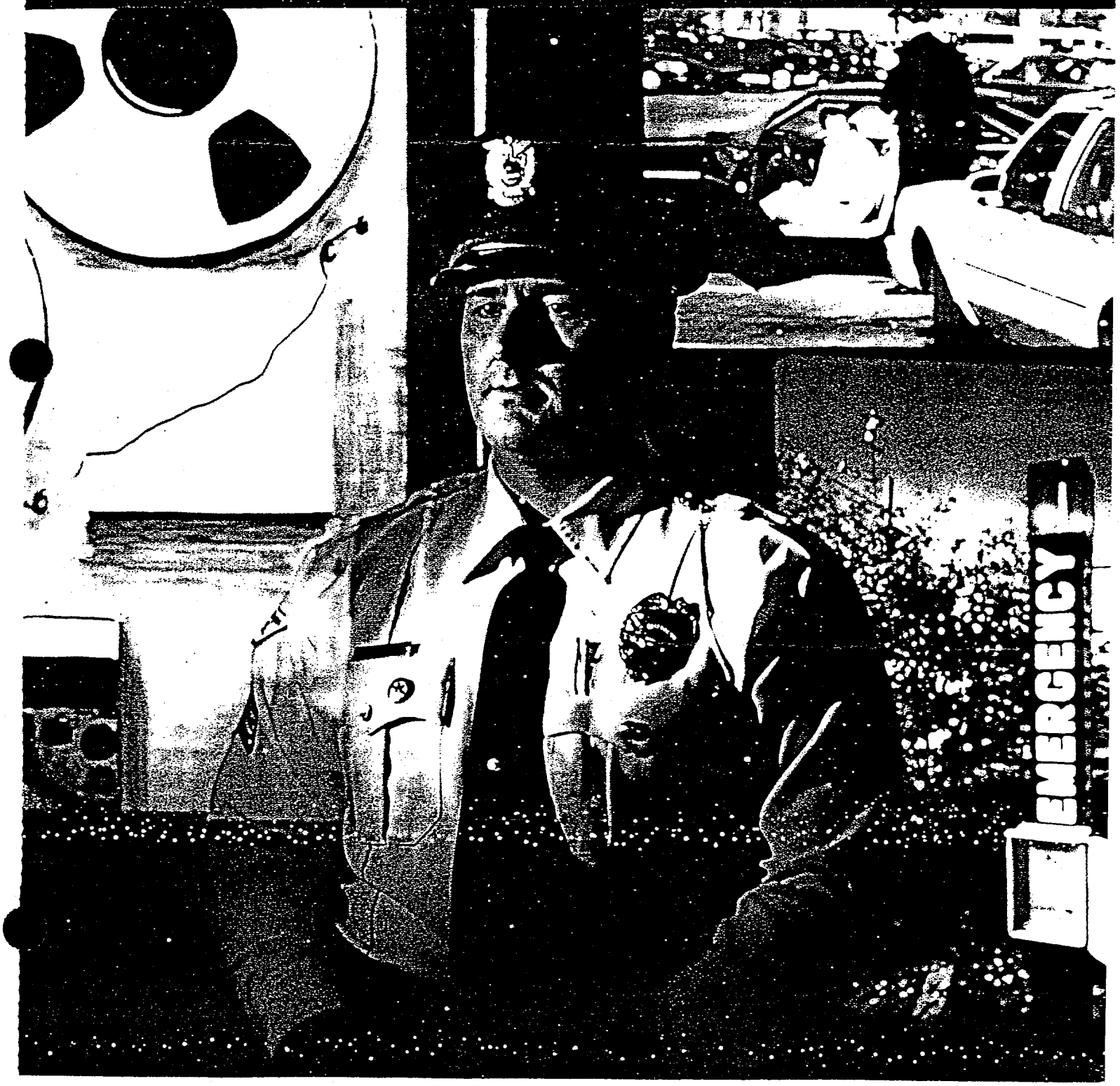


# "Chief, Your Officer Is Dead!"

by Harry R. Hueston II
Assistant Chief of Police
University of Arizona

## Introduction

On August 24, 1990, at approximately 0015 hours, the doctor at the Trauma Center in the University Medical Center told me "Chief, your officer is dead."

Hopefully, none of you will ever experience the trauma associated with handling the death of a police officer killed in the line of duty at your own agency. Unfortunately, all of you have attended funerals of fellow officers killed in the line of duty. In fact, in 1989 there were 66 officers killed in the line of duty.

How do you handle the death of your police officer? Is there a procedure or an outline available in handling the protocol involved with the death of a police officer?

In this article I would like to share with you an outline the University of Arizona Police Department developed as a result of the shooting death of U.A. Police Corporal Kevin Barleycorn. The outline is categorized into seven parts:

1. The incident description
2. Notification
3. Ascertaining what exactly happened — impact of multi-agency investigations
4. Funeral arrangements
5. Media
6. On-going investigations of the incident
7. Counseling
8. Conclusion

I intend this article to be used as a resource outline for you to follow in the event you have to deal with the death of an on-duty police officer in your agency.

1. *Incident Description*
   - A. Define exactly what occurred and secure the crime scene.
   - B. Determine whether your department has the resources necessary to handle an in-depth investigation or should turn it over to a larger agency with the resources and manpower to handle the investigation. Note — in smaller agencies the entire department becomes a victim with the death of a fellow police officer.
   - C. Initiate the crime scene investigation.
   - D. Obtain eyewitness statements from the officer(s) involved or statements of other witnesses to ascertain what occurred.
   - E. Interface with the other responding agency(ies) arriving at the scene.
   - F. Handle the initial emotions of the officers at the scene.
   - G. Handle the media.

2. *Ascertain Exactly What Occurred.*
   - A. Agency control of investigation.
   - B. Debriefing with chief by the on-scene investigator during various stages of the investigation.
   - C. Debriefing with officers at the scene.
   - D. Development of a press statement.

3. *Notifications*
   - A. External
     - spouse
     - family
     - church
     - crisis counselor
     - hospital minister
     - administrators outside the police department: mayor, president of university, administrative personnel
   - B. Internal
     - officers/personnel at the scene
     - officers/personnel not at the scene
     - psychologist call in
     - off-duty personnel call in

4. *Funeral Arrangements*
   - A. Establish a liaison to the family.
   - B. Family wishes: type of service — police involvement.
   - C. One officer plans funeral service:
     - flowers
     - rose ceremony (11 roses)
     - taps or bag pipes
     - coordination with other jurisdictions
     - aerial fly-by (missing man formation)
     - singer or type of music
     - eulogies: who and in what order
     - mourning bands policy
     - family transportation
     - security of home
     - flag for casket
     - honor guard
     - squad or officer involvement: pall bearers — rose ceremony
     - reception for officers, family, V.I.P. following the service
     - coordination with clergy
     - honor guard at mortuary
     - visiting police
   - D. Establishment and coordination of a memorial fund.
   - E. Centralization of one department administrator for the completion of forms: personnel and benefit forms for the officer's next of kin:
     - department/institutional
     - insurance
     - U.S. Justice
   - F. Creation of a legal liaison for the family.

5. *Media Coverage*
   - A. Establish a primary public information officer or, in the event of a multi-agency investigation, develop an understanding of which agency will release or comment.
   - B. Clear delineation of what information each P.I.O. will be responsible for.
   - C. Preparation of the initial press release for the chief and assist with the initial press release for the university/college administration.
   - D. Development of follow-up press releases.

*continued on page 18*

"Chief . . . continued from page 16

E. Central contact point for continuing release of investigation information.
F. Release of photograph of the officer.
G. Identification of officers willing to be interviewed about emotional impact, personal perspective, or other personal areas.
H. If ethnic issues are involved, identify community leaders who can be briefed by the chief on the ethnic issues which may affect your community.

6. *On-Going Investigation*
A. Criminal
1. Identify principal investigator.
2. Assign one quality control investigator.
3. Ensure critical issues are handled expeditiously — forensic reports, eyewitness reports, officers reports, etc.
4. Daily, have investigator update the chief, P.I.O., and administration on the timely release of related critical information to officer's family, departmental members, and media.
5. Contact point with prosecuting attorney and involvement with pending litigation involving the suspect.
6. Follow up results of litigation.
7. Place officer (if involved) on administrative leave with pay or light duty until initial investigation is completed.

B. Internal Affairs
1. Initiate internal affairs investigation with one supervisor.
2. Outside agency — chief may request internal affairs to initiate investigation into the case.
3. Begin review of appropriate departmental training procedures and regulations.
4. Review of state statutes by prosecuting attorney.
5. Officer(s) actions reviewed by prosecuting attorney.
6. Secondary agency review — ie: outside police agency to secondarily review incident — administrative review.
7. Managing results of administrative reviews — internal, external, and prosecuting attorney.
8. Releasing results of internal affairs reviews to department, media, and family.

7. *Counseling*
A. Initial
1. Notification and response of on-call psychologists.
2. Notification and coordinating the response of behavioral science units of corresponding agencies, if requested by chief.
3. Group counseling of all employees involved at the scene or working at the time.
4. Group counseling of all employees responding to department dealing with the death of a fellow officer.
5. If a fellow police officer is involved, initial contact with officer who was involved in shooting and his family.
6. Initial contact with family of slain officer.
7. Initial contact with individual officers if they request or if psychologist on scene dictates this.
8. Psychologist's assessment of department's psychological state with chief.
9. Administrative review with psychologists — chief and other administrative personnel not involved in the group counseling.
10. Scheduling of psychologist for following days at various hours to handle and observe officers if needed.

B. Follow up
1. Scheduling of psychologist attending all funeral services.
2. Scheduling of psychologist whenever substantial case information is released — ie: forensic reports, if there is impact on officers, or officer involved.
3. Scheduling of psychologist for group counseling sessions for spouses and children or individual family members at officer's request.
4. If another officer is involved in the shooting, long-term follow-up counseling with psychologist and officer involved in the shooting and their spouse.
5. Cost analysis: projected cost of psychologist counseling and completion of insurance forms, plus the notification to administration on projected cost analysis and impact on department operating budgets.
6. Provide individual counseling for officers who request additional counseling.
7. Discuss at briefing with officers and psychologist the psychological concerns which may occur in the future with officers.
8. Administrative review of the long-term counseling cost and anticipated counseling sessions with officer and spouse, this done with the chief and psychologists.
9. Monitoring of departmental operations via patrol officers handling various incidents related to shooting incident, anticipated training or monitoring actions taken by sergeants, supervisors, and chief's administration.
10. Psychological written release of officer to regular duty.
11. Anticipated counseling when trial starts — anticipated psychological needs for the officer involved and other officers if needed.
12. Audit of individual officer's request with chief and psychologist — concept of limiting visit — or at what point does the cost of counseling shift over to the individual officer (exclusive of the officer involved in the shooting).
13. Monitoring the abuse of the counseling if there are indications from the psychologist of problems.

*"Chief . . . continued*

8. *Conclusion*

As a result of Cpl. Barleycorn's death, our department realized the need to establish written policies on all issues — notification processes, investigation, follow-up investigations, psychologist's review, media, and funeral arrangements. Other areas needed to be reviewed. These included:

1. A review of all existing rules and procedures associated with the responses of officers and the department to an officer involved in a shooting.
2. The on-going preparation for the pending adjudication process.
3. If another officer is involved in the shooting, the return of the officer involved to regular duty and a follow-up assessment of his performance.
4. The assessment of the department's performance — the return to normalcy following the funeral and related memorial services.
5. Dealing with the post-shooting trauma syndrome — with the family, the officer involved in the shooting, and the family of the officer involved in the shooting.

I hope you will learn from our experience in dealing with the death of one of our own. My intent is to share our parameters with you to prompt you into developing some written directives in handling the death of a police officer in your department.

The overall affect of Cpl. Barleycorn's death was best said in the following poem, created by a fellow officer:

A Night We Won't Forget

We have a job to do
A job that we do well,
August twenty-fourth
The night an officer fell

Responding to a call
A fight that just broke out,
Another bloody nose or two
Is that what it's about?

Arriving on the scene
My back-up now in sight,
A young man with a gun in hand
It's more than just a fight

He's aiming at my partner
I know what I should do,
I'll lunge and take the threat away
So he won't shoot at you

He's pointing at my face now
I have to draw my gun,
No partner! Don't you rush him!
My God what have you done?

I knew I had to shoot him
You pushed him so I'd stand,
Your life you gave it for me
The courage of your hand

And now I will long suffer
The tremors of that night,
Responding to a routine call
Your back-up for a fight

Each day we put our badge on
In order to protect,
The students on our campus
Who give us no respect

We have a job to do
A job that we do well,
August twenty-fourth
A night that seemed like Hell

-Officer Mark Reyes
U.A.P.D. #612

# ARIZONA
# DEPARTMENT OF PUBLIC SAFETY

## DEATH NOTIFICATION
## and
## FUNERAL ARRANGEMENT
## MANUAL

DPS 932-02004 6/84

# ARIZONA DEPARTMENT OF PUBLIC SAFETY

# DEATH NOTIFICATION & FUNERAL ARRANGEMENT MANUAL

**Prepared by the**
**Operational and Management Analysis Section**

DPS 932-02004 6/84

## FOREWORD

This manual outlines the procedures for post-death arrangements of current and retired employees. It covers notification, assistance to family members, and, in the case of current employees, coordination of funeral and burial arrangements.

In all instances, the Department shall honor the wishes of the family. The decision to use all or part of the services offered or modification of some details, will remain with the immediate family.

To provide the most harmonious atmosphere possible, employees designated to perform any specified duties are directed to familiarize themselves with the details contained in this manual and practice their functions prior to the ceremony.

## TABLE OF CONTENTS

## I. NOTIFICATIONS

### A. ON-DUTY DEATH

When a Department employee expires in an on-duty status, the following notification sequence will be followed:

1. Immediate Supervisor

The employee's immediate supervisor will be notified as soon as possible. Details surrounding the death will be obtained by the supervisor.

Upon confirmation of circumstances and events surrounding the death, the employee's immediate supervisor shall cause the second-level supervisor and Duty Officer to be notified.

The employee's supervisor shall make prompt personal notification to the employee's immediate family and shall provide them with information concerning the death. If requested, he shall also assist in contacting the family physician, clergy, and out-of-town or out-of-state relatives and friends.

2. Chain of Command

The second-level supervisor shall notify all Bureau Chiefs and the Director. The Bureau Chiefs shall assume responsibility for further notification within their respective bureaus as they deem appropriate.

3. Duty Officer

The Duty Officer shall be responsible for notifying the Media Relations Officer and for sending out a follow-up informational teletype to all Department of Public Safety Communication Centers. The teletype should be distributed in a timely and accurate manner.

4. Media Relations Officer

If it is determined that an announcement of the employee's death will be made to the news media, coordination of the announcement will be under the direction of the Media Relations Officer.

5. Acting or Unavailable Supervisors

An acting supervisor at any level in the chain of command shall assume the notification responsibilities of the position.

If during the notification sequence a supervisor is not available, the next higher command level shall be notified and assume the responsibilities and the duties of the unavailable supervisor.

B. OFF-DUTY DEATH

When an employee is notified of the off-duty death of another employee or a retiree, the notification procedure previously specified will be followed, with the following two exceptions:

1. Upon the death of an off-duty employee, the immediate supervisor shall contact the family to verify the details of the death and then proceed with routine notification procedures if so requested.

2. In the death of a retiree, the Duty Officer shall notify the Director's Executive Officer. Responsibility for personal contact may be delegated to a supervisor in the immediate area of the retiree's residence.

## II. RESPONSIBILITIES

Upon completion of all notifications, the Department may provide additional assistance to the family of the deceased employee or retiree. Full funeral service coordination will be offered only to the families of current employees. Post-funeral family assistance will also be available. In all instances, the wishes of the family will determine the extent of assistance actually provided.

### A. REPRESENTATIVE EMPLOYEE

1. The deceased employee's immediate and second-level supervisors shall select an employee to act as the Representative Employee. In the death of a retired employee, the Director or his designate shall appoint the Representative Employee. The selected employee should be a friend of the deceased and a person who can provide emotional support to the family.

2. The Representative Employee's responsibilities include providing assistance to the family of the deceased before, during and after the funeral, as well as coordinating funeral activities with the Funeral Detail Officer.

3. The Representative Employee shall devote time and effort to the family of the deceased employee or retiree, and will perform the following duties with the utmost diplomacy, discretion and decorum:

   - discuss the family's immediate financial status and arrange for available assistance through any appropriate employee association;

   - determine from the family the degree of Department of Public Safety involvement desired at the funeral and related activities;

   - assist the family in contacting clergy, friends and relatives and establishing preliminary funeral service planning;

- determine the date, time and location of the pending funeral or memorial service and visitation periods;

- if requested, establish a list of Department of Public Safety pallbearers and, in the case of commissioned officers, Honor Guard members;

- provide transportation assistance for the immediate family, if desired.

4. Inquiries from the news media concerning the death will be coordinated by the Representative Employee with the Department's Media Relations Officer, who shall have access to the deceased employee's personnel file for any press releases.

B. FUNERAL DETAIL OFFICER

The Funeral Detail Officer shall be designated by the Highway Patrol Bureau Chief. The Funeral Detail Officer shall be responsible for coordinating requested funeral activities under the direction of the Representative Employee.

1. Coordination of teletypes and other notices concerning visitation periods and funeral services will be completed by the Funeral Detail Officer.

2. The Funeral Detail Officer will coordinate completion of the following funeral arrangements:

- notify pallbearers;

- select and inspect Honor Guard members;

- coordinate photographs to be taken of the service(s), with family concurrence;

- arrange for the escort of the funeral procession;

- provide for traffic control; or coordinate with the funeral home for traffic control;

- coordinate Department of Public Safety vehicles;

- provide for church or chapel security;

- notify and coordinate with local law enforcement agency;

- coordinate any briefings and practice sessions required prior to the ceremony.

3. Since funeral and burial service locations may vary, the exactness of specific steps or actions cannot be sufficiently addressed. Prior planning and coordination by the Funeral Detail Officer with all involved entities shall be accomplished.

## III. SERVICES

The desires of the family are paramount and will be honored in coordinating the funeral services and procedures. The following guidelines are intended to assist the Funeral Detail Officer in establishing specific responsibilities.

### A. UNIFORM AND PERSONNEL

1. The formal Class "A" uniform, as defined in the Department's Uniform Manual, will be the funeral service uniform. Badge shrouds will be worn from the time of notification of a commissioned employee's death through the day of the funeral.

2. The funeral entourage will consist of six pallbearers and ten to twelve Honor Guard members who shall wear white gloves during the funeral proceedings.

### B. VIEWING/VISITATION PERIODS

1. One or two Honor Guards shall be positioned at each end of the casket in the "Parade Rest" stance. They should be alternated with relief Honor Guards at one-hour intervals.

2. All other uniformed officers attending the Viewing/Visitation period shall remove their hats upon entry and place them under the left arm, with badge forward. Commissioned officers not involved in the services have the option of wearing a uniform or civilian clothes to any of the services. However, Class "A" uniform requirements prevail for all uniformed attendees. No formal salutes will be given during viewing/visitation periods.

### C. CASKET TRANSPORTATION PRIOR TO FUNERAL SERVICES

1. The Honor Guard and pallbearers shall arrive at the funeral home at the time indicated by the Funeral Detail Officer. The pallbearers shall take a position inside the building as directed by the Funeral Detail Officer.

2. The Honor Guard shall form two ranks, facing each other, at the entrance of the building or near the hearse, with sufficient distance between ranks to permit passage of the casket and the pallbearers. They shall stand at "Parade Rest".

3. As the casket moves from the funeral home to the hearse, the Honor Guard, upon command, shall assume the positions of "Attention" and "Present Arms" (Execute the hand salute). They shall remain in this position until the loading door is closed and the command of "Order Arms" is given. (Commands directed to the Honor Guard only, during all ceremonies, will be prefaced with the words, "Honor Guard".)

4. The Honor Guard shall escort the procession to the service in at least two fully marked Patrol vehicles. The pallbearers shall ride in a vehicle designated by the Funeral Detail Officer.

5. The Funeral Detail Officer shall coordinate route and other driving information with drivers of escort vehicles, and also coordinate with the local police agency or funeral escort service providing traffic control for the procession.

D. ARRIVAL AT FUNERAL SERVICE

1. Parking for Department of Public Safety vehicles will be arranged by the Funeral Detail Officer.

2. Department of Public Safety personnel and other uniformed police personnel shall be instructed to enter the church and be seated immediately upon their arrival.

3. All uniformed officers attending the service shall remove their hats upon entry and place them under the left arm, with badge forward.

E. FUNERAL SERVICES

1. When the casket and the family arrive at the church, the pallbearers shall take a position at the rear or side of the hearse, two ranks of three, each facing the other. (The family may elect to be seated in the church prior to movement of the casket into the church.)

2. The Honor Guard shall take a specified position near the hearse or, if considerable distance is involved, at the entrance to the church, or they may escort the casket from the hearse to the church depending on prior arrangements.

3. If not acting as casket escort, the Honor Guard shall form two ranks, each facing the other, with sufficient distance between ranks to permit passage of the casket and the pallbearers. They shall assume the "Parade Rest" position.

4. Upon commands by the Funeral Detail Officer, the Honor Guard shall assume the position of "Attention" and then "Present Arms" (the hand salute), holding the salute until the command of "Order Arms" is given.

5. The Honor Guard may, upon command, file behind the casket and family when entering the church and take their designated seats near the entrance.

6. The pallbearers shall take specific seats near the casket.

F. CONCLUSION OF SERVICES

1. By prior arrangement, the Honor Guard shall form their established position at the exit or near the hearse, or may escort the casket to the hearse.

2. Upon exiting from the service, uniformed DPS personnel, except pallbearers, shall form ranks outside near the hearse or in an adjacent area. (All uniformed officers will be directed to the designated location when leaving the service.) Department of Public Safety uniformed officers and other police agency uniformed officers may form an aisle of at least two ranks with sufficient distance between ranks to permit passage of the casket being borne or guided by pallbearers. The ranks shall stand at "Parade Rest". The Funeral Detail Officer shall make reasonable effort to see that uniformed personnel attending the service are briefed on the procedures to be followed.

3. The Funeral Detail Officer or a designated assistant, in a command voice at first appearance of the casket, shall give the commands "Officers, Attention" and "Present Arms" (applying to both the Honor Guard and the ranks of uniformed officers). The salute will be held until the casket is in the hearse and the door is closed. The command "Order Arms" will then be given. The number of uniformed officers and the distance involved will be considered in determining the volume of commands and the response desired.

G. FUNERAL PROCESSION

The suggested order of vehicles in the funeral procession is as follows:

1. Vehicles #1, #2, and #3 will be Department vehicles designated for members of the Honor Guard and the Funeral Detail Officer. (A motorcycle escort may lead the procession if the use of motorcycles has been coordinated prior to the procession.);

2. Vehicle #4 will be designated for the clergyman and pallbearers;

3. Vehicle #5 will be the hearse. (The clergyman may ride in the hearse);

4. Vehicles #6 and #7 will be designated for the immediate family and relatives of the deceased officer;

5. Additional vehicles may be used for family members;

6. Other Department of Public Safety, police agency and official vehicles will follow behind the last family vehicle;

7. All other persons wishing to attend the graveside service shall be directed and coordinated to proceed behind the last official vehicle.

All Department vehicles at a funeral service shall be washed and clean.

Prior to departure, the driver of vehicle #1 shall be provided with route, speed, cemetery parking, and any other necessary information.

Traffic control from parking area to procession and at intersections along the procession route may be provided by Department of Public Safety personnel or the local police agency, based on prior arrangements.

H. CEMETERY

1. As the funeral procession enters the cemetery, the hearse and the family cars will stop as close as possible to the gravesite.

2. The pallbearers shall take their established position on either side of the loading door of the hearse.

3. The Honor Guard shall take their established position near the hearse or near the gravesite. If sufficient distance is involved, the Honor Guard may escort the casket to the gravesite. (The positions and actions of the pallbearers and Honor Guard will be established by the Funeral Detail Officer prior to the service.)

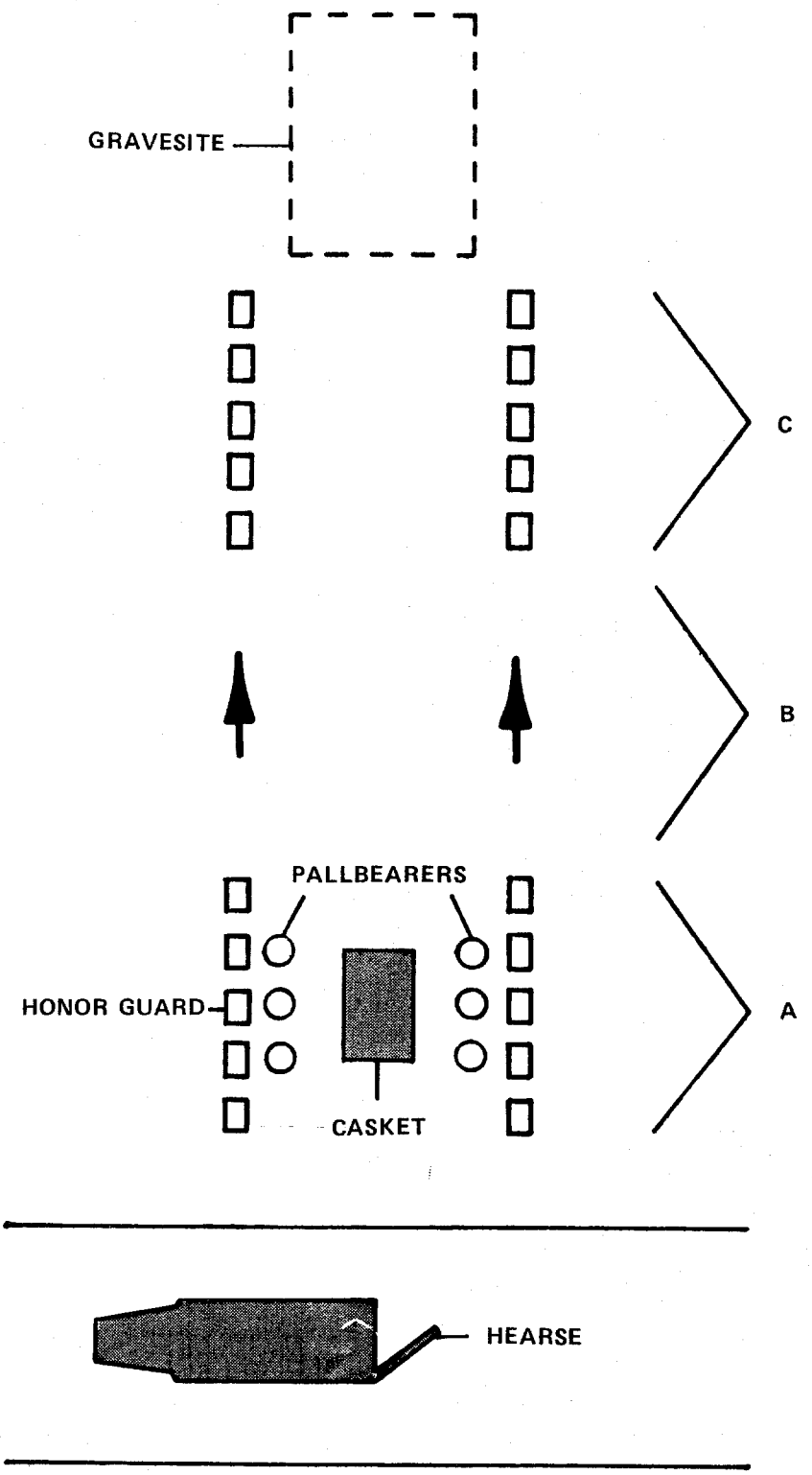
4. If the Honor Guard is to be stationed between the hearse and the gravesite, near the pallbearers, they will form two ranks, facing each other, with sufficient distance between ranks to permit passage of the casket and the pallbearers. They will assume the "Parade Rest" position.

5. When the casket first appears from the hearse, the Funeral Detail Officer, in a command voice, shall give the commands of "Honor Guard, Attention" and "Present Arms". (The pallbearers shall disregard the "Present Arms" command.) When the casket is within the ranks of the Honor Guard, they shall be given the command, in low volume, "Order Arms". They shall turn with a directional command ("South Face" or "North Face") and, at the command "Forward March," shall march at pace with the pallbearers. (Command and march practice are needed for the casket escort.)

6. If the Honor Guard is stationed at the gravesite, they shall be formed as in Paragraph #4, above. As the escort approaches the gravesite, the Honor Guard shall be given the commands of "Honor Guard, Attention" and "Honor Guard, Present Arms". The salute will be held until the pallbearers place the casket in the designated location. The command "Order Arms" will then be given. The Honor Guard shall then, if possible, form their two ranks at the head of the casket. The pallbearers shall form their ranks behind the two ranks of the Honor Guard. The Honor Guard shall remain at "Attention" during the gravesite ceremony. The pallbearers will assume the "Parade Rest" position behind the Honor Guard.

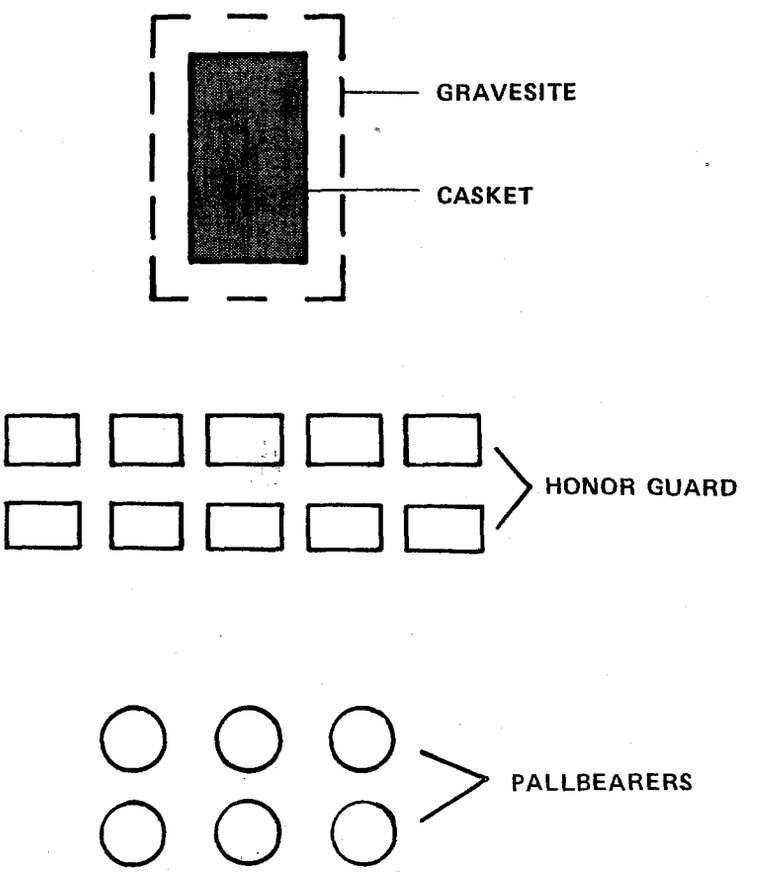
7. Throughout the graveside service, all uniformed officers in the audience will stand at the "Parade Rest" position and remain covered, except during prayers. During prayers, uniformed officers shall remove their hats and place them under the left arm, badge forward, with heads bowed and with hands clasped to the front. The normal "Parade Rest" position with heads covered, will be reassumed at the conclusion of prayers.

## TYPICAL HONOR GUARD/CASKET POSITIONING




Option A: Casket passes between Honor Guard near hearse.
Option B: Honor Guard escorts casket to gravesite.
Option C: Casket passes between Honor Guard near gravesite.

TYPICAL HONOR GUARD/CASKET POSITIONING AT GRAVESITE



## IV. FLAG CEREMONY

1. When the deceased officer is a veteran of the United States Armed Forces, a United States flag may be used to cover the casket during the funeral service. (An Arizona State flag may be used to cover the casket during the funeral service if the deceased officer is not a veteran of the United States Armed Forces.)

2. The United States flag will have been placed on the casket with the blue field and stars at the head and over the deceased officer's left shoulder.

3. If the Arizona State flag is used, the same procedures will be followed as outlined for the United States flag. The upper half of the flag, the thirteen rays, will be placed over the deceased officer's left side. Only members of the Honor Guard shall render the salute when the Arizona State flag is utilized in the service.

4. At the designated time in the ceremony, two previously selected members of the Honor Guard or pallbearers, upon signal, shall step forward to handle the flag-folding ceremony. One officer shall step to the head of the casket, the other to the foot of the casket.

5. The officers shall grasp the corners of the flag, holding it taut in a horizontal position, and sidestep approximately two paces away from the casket and family.

6. The Funeral Detail Officer shall give the command of "Officers, Present Arms" to all uniformed personnel when the flag is raised from the casket. The salute will be held until the flag is folded and presented to the widow or other family member. The officer at the foot of the casket shall fold the flag as described in the Appendix (Section VI).

7. The officer folding the flag shall give the flag to the deceased employee's immediate supervisor for presentation to the designated family member. After completing the presentation, the command of "Order Arms" will be given. The two officers from the Honor Guard shall then return to their ranks.

8. When the flag is presented to the designated family member, it is recommended that the following words be spoken:

> "Mr./Mrs. _____ (or other name), this flag is presented to you on behalf of the United States Government and the State of Arizona in appreciation of (Rank) (Name)'s loyalty and service."

9. After the services, Department of Public Safety employees shall disband when the immediate family members rise to leave. The Honor Guard and pallbearers shall be dismissed after the family members have left the gravesite.

## V. FOLLOW-UP ASSISTANCE

1. After the funeral services have been concluded, the Representative Employee shall follow through with necessary paperwork pertaining to the employee's or retiree's benefits. Paperwork involving payroll, retirement, group insurance, or industrial benefits will be expedited through the Department. Union or association benefits, credit union, private organization, Veterans Administration, Social Security, health or private insurance benefits may also be coordinated by the Representative Employee.

2. The Representative Employee will assist the family with providing necessary proofs and applications for claims and adjustments of any other insurance policies. The deceased employee's personnel file may be used to obtain much of the information necessary in preparing the described documents.

3. The Representative Employee shall make follow-up calls or visits to the family of the deceased employee or retiree and will determine if any additional assistance is needed for the family's well-being. He shall make periodic written reports to his supervisor for processing through the chain of command.

4. The Director's Executive Officer shall coordinate with the Representative Employee on the preparation and presentation of appropriate memorials or plaques.

## VI. APPENDIX

### FLAG-FOLDING PROCEDURES

The flag should not be lowered into the grave or allowed to touch the ground. When taken from the casket, it will be folded as follows:

1. Fold the lower striped section of the flag over the union (blue field and stars);

2. The folded edge is then folded over to meet the open edge;

3. A triangular fold is then performed by bringing the striped corner of the folded edge to the open edge;

   The outer point is then turned inward parallel with the open edge to form a second triangle;

4. Triangular folding is continued until the entire length of the flag is folded in the triangular shape of a cocked hat, with only the blue field and stars visible;

5. The remaining portion of the flag, at the end of the last fold, will be tucked into the last open edge.

   (Officers who have been selected to fold the flag should practice this procedure prior to the actual ceremony.)

CHAPTER 11 OF THE TRAINING MANUAL DOES NOT INCLUDE ANY HANDOUTS AND NO HANDOUTS WERE INCLUDED IN THIS SECTION

Maureen Matkovich
07/16/2001

# CONFLICT

## WHAT IS IT?

* Differences in opinions, values, desires, needs, wants or habits
* An unavoidable part of daily living
* A "dangerous opportunity" that enhances intimacy, prevents stagnation, stimulates interest and creativity
* Best case it is mildly **disruptive**
* Worst case it is totally **destructive**
    * Once it erupts, it is difficult to control
    * Has a tendency to expand
    * Often it becomes detached from its initial causes and may continue long after the initial issues have become irrelevant of have long been forgotten
    * Frequently escalates until it consumes all things and people it touches

## BENEFITS OF CONFLICT *(A Dangerous Opportunity)*

* Helps foster intimacy - we cannot find personal intimacy without conflict
* Aids in the development of children
* Encourages personal and intellectual growth
* Can prevent stagnation, stimulate interest and curiosity, and foster creativity
* Spurs technological development
* Helps create and renew our social, religious, political and business organizations
* A necessary ingredient of organizational renewal, a moderate level helps:
    * increase the motivation and energy available to do required tasks
    * increase innovativeness of individuals
    * develop an increased understanding of one's own position

## TWO TYPES OF CONFLICT

* **REALISTIC**

  * conflict where there are opposed needs, goals, means, values, or interests

  * can be faced and resolved successfully using conflict resolution techniques

* **NONREALISTIC**

  * conflict that stems from ignorance, error, historical tradition and prejudice, dysfunctional organizational structure, win/lose types of competition, hostility, or the need for tension release

  * creates unwarranted tension between people and can cause unnecessary destruction

  * to a large degree can be prevented or controlled

## TWO COMPONENTS OF CONFLICT

* **Emotional** - includes anger, distrust, defensiveness, resentment, fear, and rejection

* **Substantive** - incudes conflicting needs, disagreements, over policies and practices, and differing conceptions over roles and uses of resources.

## CONSIDER THESE POINTS

* Substantive issues can be handled more constructively after the emotions have subsided

* Substantive conflict often generates feelings of anger, distrust, etc

* Emotional conflict may increase the substantive issues

* The components and types of conflict are often intertwined and difficult to separate

* Emotional arousal actually makes us different people than we are in moments of calmness

## PREVENTION AND CONTROL

* Use fewer roadblocks (name calling, ordering, threatening, judging)
* Reflective listening helps the other dissipate negative emotions
* Assertion skills help prevent the buildup of emotions that so often cause conflict
* Awareness of what things are likely to start a needless conflict can help eliminate many confrontations (your triggers - looks, actions, comments, etc)
* Dumping your tension without adding to another's
* Increased emotional support from family and friends can help decrease unnecessary conflict
* Increase you tolerance and acceptance of others
* A careful appraisal of the full consequences and cost of conflict may help you avoid needless disputes.

### *A FEW WORDS OF ABOUT PREVENTION AND CONTROL*

Some conflict can be constructively prevented.

Some conflict can be controlled to the benefit of all concerned.

But, most conflict needs to be faced and resolved at the earliest possible moment.

*Dealing with conflict is not always comfortable. Dodging or avoiding conflict merely postpones the inevitable and the final results are often worse than if the issues were dealt with early and directly.*

## SUGGESTIONS FOR HANDLING CONFLICT

### 1. DEAL WITH THE EMOTIONAL ASPECTS FIRST

A. Remember "blinded by or blind to emotions"

B. When emotionally charged we are physiologically different

Well equipped for a fight, but very poorly equipped to solve problems

C. Once emotions subside, substantive issues can be handled easier

### 2. TREAT OTHERS WITH RESPECT

A. Conflict often degenerates into disrespect for both the other person's ideas and person him/herself

1. blocks communication
2. creates wounds that may never heal

B. In conflict, interpersonal gravity tends to pull us down to the lowest level of disrespect for the other person

### 3. LISTEN - TRY TO EXPERIENCE THE OTHER SIDE

A. The goal of listening is to understand the content of the message, the meaning it has to the other person, and how the other person feels about it

B. Put yourself in their shoes - if this was my child, mother, etc. in this situation, how would I like them treated

C. After you are able to do this, you are ready to begin talking about substantive issues

### 4. STATE YOUR POSITION

A. Be brief -- more talk does not = solving the problem

B. Avoid loaded words

C. Say what you mean and mean what you say (the truth as it really is for you)

1. remember coded messages and presenting problem peculiarities of communication

2. avoid extreme statements

D. Disclose your feelings

E. Control your natural inclination to prove the other person wrong or respond to side issues.

**5. THINGS TO AVOID**

A. Ignoring the emotions

B. Reacting to, rather than reacting on

C. Saying, "I know how you feel."

D. Asking "why" questions; ask "what" instead

**6. USING THIS PROCESS**

A. When the other person is not "following the rules"

B. Teach the other person this method when a problem is brewing

C. Teach this method when things are calm and peaceful

D. Help others resolve conflicts (third-party role)

***The best human relations often exist on the other side of conflict.***

## "THE BROKEN RECORD"

People in conflict tend to get bogged down in excessive verbiage. To communicate effectively in conflict you have to:

1. Be persistent

2. Stick to the point

3. Do not get angry, irritated or loud

4. Say what you want to say

5. Ignore side issues

Practice to speak as if we were a "broken record." A calm, repetitive voice will help you stick to your point while, at the same time, help you feel more comfortable in ignoring manipulative verbal side traps, argumentative baiting and irrelevant logic. Remember, don't allow yourself to get angry, irritated or loud.

## ASSERTION "I" MESSAGES

Behavior + Feelings + Effects

"When you _____ I feel, _____ because _____.

Non-judgmental description of behavior

Non-blaming description of behavior

Discloses my feelings

Clarifies tangible effect the other person's behavior has on me

## EXPECTED OUTCOMES

***The purpose of this process to improve communication in stressful situations.***

***It is important to remember that many times the other person will not significantly alter his/her beliefs or behaviors***

* Positive effect on the emotionality of an interaction
* Personal growth in understanding and change
* The other person **may** change
* The two people may be ready to jointly develop a creative solution to the issues of the conflict
* Deepen and enrich companionship (relations tend to falter because people don't know how to handle the differences between them)

***The effects of using a conflict resolution method skillfully are often usually positive. However, conflict is unpredictable and not method can be guaranteed.***

## EVALUATING THE CONFLICT

* Ideally we would like to process the conflict with the other person, but if that is not possible by yourself
* Look at:

  * What have I learned?
  * What triggered the conflict?
  * Am I aware of my own "triggers" or the other person's "triggers"?
  * How well did I use the process?
  * How badly was I hurt and how badly was the other person hurt?
  * How valuable was this conflict for letting off steam?
  * What did I learn about myself, the other person and the issues in contention?
  * Did either of us change our opinions?
  * What did I find out about the other person's fight style?
  * Are we closer together or farther apart as a result of this conflict?
  * What do I want to do differently the next time I am in conflict?
  * What would I like the other person to do differently the next time?

# HANDLING DIFFICULT ENCOUNTERS

When trying to communicate in difficult situations, people tend to get bogged down in excessive verbiage and respond to side issues. The following is a simple, yet effect template to deal with difficult encounters. Using this template in a calm, repetitive voice can help you stick to your point and, at the same time, help you feel more comfortable in ignoring manipulative verbal side traps, argumentative baiting and irrelevant logic.

1. Be aware of the emotional aspects first

2. Treat others with respect

3. Listen and try to experience the other side

   The goal of listening is to understand the content of the message, the meaning it has to the other person and how the other person feels about it.

4. State your position - "courage to confront"

   - Be brief
   - Stick to the issue
   - Say what you want to say
   - Avoid loaded words
   - Don't get angry, irritated or loud
   - Control your natural inclination to prove the other person wrong
   - Don't respond to side issues

5. THINGS TO AVOID

   - Ignoring the emotions
   - Reacting to, rather than reacting on
   - Saying, "I know how you feel."
   - Asking "why" questions; ask "what" instead

# MAINTAINING CONTROL ...
## Can it be done?

| WHAT I DO CONTROL | WHAT I DON'T CONTROL |
|---|---|
| ***(Empowered)*** | ***(Victimized)*** |

# STRENGTHENING LAW ENFORCEMENT MARRIAGES

## INTRODUCTION:

- Marriage is the foundation of the family. All of the other pieces of the family rest on the marital relationship. All of the goals of the family rest on the success of the marital relationship.

- No other relationship in the world has the capacity to generate the kind of intensity that is generated in a marriage. That intensity can be negative or positive and even in the most successful marriage there is some of both.

- Our roles as husbands and wives impacts all the other roles that we have and can influence our performance and our satisfaction with our lives.

- Marriages are made more complicated by the stresses of a law enforcement career. No small part of that stress is compounded by shift work.

- About 97% of people in the United States marry.

- The average length of first marriages is 7 years (Stuart);
  the average length of time between marriages is about 3 years;
  the average length of time in second marriages is 5.5 years.
  The divorce rate has gradually and consistently been rising since 1900.
  Currently the divorce rate is about fifty percent in that the half the marriages that people enter end in divorce.
  The rate at which people marry has been consistent over that period of time.

GOAL: TODAY WE WILL LOOK AT SOME OF THE WAYS THAT YOU CAN STRENGTHEN THAT MOST IMPORTANT RELATIONSHIP IN YOUR LIVES AND WE WILL GIVE YOU SOME PRACTICAL TOOLS THAT YOU CAN BEGIN USING RIGHT AWAY TO HELP IMPROVE YOUR MARRIAGE AND SUPPORT YOUR FAMILY LIFE.


DO IT YOURSELF SERIES IN LAW ENFORCEMENT PSYCHOLOGY

I. How a law enforcement career impacts a relationship.

Gilmartin hypothesis of the heat seeker/couch potato.

-Brotherhood of Biology
-Sympathetic nervous system: excitation and response
-Impact of this pattern on family life and marriages
-How much control do you have at work? Assignments, shifts, teams, supervisors?
-What do we call people who have no control over there lives and are at the mercy of others? VICTIMS.
-SOLUTION: do not be helpless and a victim; take charge of your life and control what you can control in your private life. Accept the parts of your life over which you have little or no control and get your self-esteem connected to your family and other parts of your private life that you can control.

Shift work. Its bad for you. Period. It takes a toll on you in terms of physical health. It restricts you social activities. It can interfere with your relations with your kids and your spouse.

SOLUTION:
1.) Do not try to shift back to a day schedule on your days off.
2.) Four hours seems to be the maximum that you can alter your internal clock without causing problems.
3.) Try to get in bed before the sun comes up if you are working a late shift.
4.) Accept that you will get about one to one and one-half less hours of sleep than you normally get and treat yourself accordingly.
5.) Make sure that you are getting consistent exercise while doing shift work.

7. What gets in the way of our best intentions at solving problems?

-Criticism

-Contempt

-Defensiveness

-Stonewalling

(From Gottman, 1994)

III. How the sexes are different in how they communicate and what their values are.

Boys play team sports in order to compete; girls compete in order to play team sports.

Activity vs. Relationship: Boys taught that emotions must be subjugated to the rules in order for the game to go on; girls are much more into the relationship and need to work out the emotional issues rather than referring to the rules as a way to manage their emotions.

Men and flooding:

Men and women have very different and specific grievances in conflict: Men see wives as complaining and nagging; women see men as withdrawing and to emotionally supportive.

Women are more likely to complain and criticize their spouse.

Many couples fall into a demand/withdrawal cycle in which the wife demands more emotional confrontation causing the husband to withdraw more and for then the wife to escalate her demands.

A wife, noticing that her husband is withdrawing, tends to increase the emotional intensity to try to keep the husband emotionally responsive.

When a wife gets engulfed in emotion, she will often start to kitchen sink the discussion and mix that with sarcasm and criticism.

Two more rules:

EMBRACE HER ANGER

CONFRONT HIM GENTLY

(From Gottman, 1994)

IV. How our family of origin impacts our marital relationships. (Family tree)

V. How couples are different than individuals.

1. Marital relationships are reciprocal.
   Marital relationships are set up to polarize because there are only two sides to every issue at first.
2. Everyone is responsible for their own behavior.
   It is easy to feel like a victim and to see your behavior controlled by the behavior of the other person but we always have choices and we are always responsible for what our behavior is.
3. Communication is central.

What are the basics of communication?

One person taking an idea and verbalizing the idea in a way that the listener fully and accurately understands the idea in the same way the speaker understands it

Four different parts of every communication

1.) The intention of the speaker
2.) The speaker's filters through which the words pass
3.) The listeners filters through which the listener hears the words
4.) The interpretation given the words by the listener

Skills necessary for successful communicating

1.) Listening and validating (paraphrasing)
2.) Leveling (for conflict avoiders)
3.) Editing (for conflict provokers)
4.) Negotiating
5.) Handling hidden agendas

4. The most important communication process is problem solving.
   Study showing that divorce can be predicted by how well couples solve problems.

THREE KEY ASSUMPTIONS (From Markman, p.75)

1.) All couples have problems.

- During engagement, couples have problems with jealousy and in-laws.
- Early in marriage problems tend to be communication and sex
- Later, these problems still important but biggest is money, no matter how much money the couple has.

2.) The couples who are best at working through their problems work together as a team, not against each other as adversaries.

- Cops tend to be competitive or they don't stay being cops.
- In competition there are winners and losers. By being competitive you insure that your partner is going to fight you, no one likes to lose.

3.) Most couples rush to find quick solutions that don't take into account the real concerns of each partner and therefore don't produce lasting solutions.

- Time pressure: no one has enough time, it has been said that , "Time is the currency of the NIneties," because it is so precious.
- Conflict avoidance

5. PROBLEM SOLVING AND HOW TO DO IT (From Markman, 1994):

I. **PROBLEM DISCUSSION**

- goal is to understand and feel understood in an atmosphere of mutual respect and cooperation.
- use Speaker-Listener technique

<u>LISTENER-SPEAKER TECHNIQUE</u>

RULES FOR BOTH OF YOU:

1. <u>The speaker has the floor.</u> Use something concrete to actually represent the floor like a book, the TV remote, a gavel, etc., to help remind each of you that the person who "has the floor," and therefore is the speaker. If you don't "have

the floor," you are the listener, so listen and try to really hear and understand.

2. Share the floor. At some point it is necessary to switch roles. This is not an invitation to have the floor and deliver a lecture.

3. No problem solving. The focus is on hearable communications and understanding what the other person is saying.

RULES FOR THE SPEAKER:

1. Speak for yourself, don't be a mind reader. Focus on your thoughts and feelings. Use "I" statements. "I think you are a jerk is not as "I" message.

2. Don't go on and on. Because you have the floor, you can afford to pause and think about what you are saying so you can put it in clear, concise language in a style that is hearable.
3. Stop and let the Listener paraphrase. This step insures that the other person is hearing you accurately and allows for corrections if you are not being hear or not communication accurately. This is not a test to catch the listener not paying attention, or not caring, etc.

4. Make an XYZ statement (not a non-specific attack)

X = the other person's behavior
Y = the situation
Z = your feelings

For example: When you don't greet me when you come home at night, I feel unloved.
(NOT: You are so unloving, why are you that way?)

RULES FOR THE LISTENER:

1. Paraphrase what you hear. Briefly repeat what you understand in your own words. Ask questions if there are parts that you don't understand but don't use this opportunity to sneak in and deliver your own message.

2. Focus on the speaker's message. Don't rebut. You will get your chance. Your

task as the listener is to work at what is being said to you so that you can understand it and demonstrate that you are being respectful. What you are hearing may be upsetting to you but you need to keep focused on your task and not try to make your points, even your disagreement which includes no faces, groans, etc.

II. **PROBLEM SOLUTION:**

1. Agenda setting - the order in which you're going to tackle the problems.

   What you are going to focus on-the more specific and limited the problem is, the more likely you will be successful.

   Try to cut them down in size to more manageable pieces of the larger problem. Work on making them an event, not an issue.

   Work on the easiest part of the problem first.

   Set a specific time to deal with the other pieces if you can't get to all of them at one time.

2. Brainstorming - it can help both of you think more flexibly.

   Any idea can be suggested. One of you should write down <u>all</u> of the ideas that you come up with.

   Don't evaluate the ideas as they come up as this only defeats the purpose of coming up with new ideas and stimulating both of you to think.

   Be creative. Let your mind run free. Try to think of alternatives beyond the polarized positions that each of you have stated at the start. For example, if you think your spouse spends too much time with their mother, suggest that the mother come to live with you. Remember, you are not trying to offer only solutions that work but to give each of you different ways of looking at the problem. Have fun with this part of the process. There will be plenty of time for being serious.

3. Compromise and Agreement - come up with a specific solution to your specific problem that both of you agree to.

Compromise means giving up something that you want to get something else that is more important to you.

If the solution means you have to give up something but is good (not perfect) for both of you, then you win as a couple and build a backlog of successful problem solving experiences.

III. Follow-up - This builds trust, allows plans to be fine tuned, and insures that there will be accountability.

Write down when you will again visit the issue and check up on its success.

Write down what the solution was and both agree on the statement.

6. GROUND RULES:

1. When conflict is escalating, call Time Out; and try it again with the speaker-listener technique or agree to talk about it at a later date. Do this early rather than late. Intervene when you thinks it might be getting out of hand rather that waiting until you are absolutely sure it is out of control.

2. When you are having trouble communicating, try the Listener-Speaker technique.

3. When using the Listener-Speaker technique, completely separate the discussion from the problem solution.

4. Any issue can be brought up at any time but the listener has veto power and can say that now is not a good time but them has an obligation to pick a time when the issue can be addressed.

V. How can we be empathic with our spouses?
-hard and soft emotions

-if we assume they good people, what would they have to be feeling to act the way they are acting.

RULE: ALWAYS ASSUME GOOD INTENTIONS ON THE PART OF YOUR SPOUSE.

VI. The central ingredients:

1. Commitment
2. Understanding/empathy
3. Forgiveness

VII. Positives must be added to the relationship:

"A friend is someone who is glad to see you and has no immediate plans for your improvement." (Mark Twain)

The Glue: How to take care of the other side of the equation:

1. What did you do before you got married?
2. What did you talk about?
3. How much time did you spend together?
4. What do you want to do today?
5. Listen like a friend.
6. Respect spouses opinion (even if you disagree)
7. Shares a mutual interest in what is happening to each other.
8. Protect time from conflict.

**LEARNING TO SOLVE PROBLEMS, HONORING COMMITMENTS AND PUTTING POSITIVES INTO A MARRIAGE ARE THE THREE INGREDIENTS IN A SATISFYING, SUCCESSFUL MARRIAGE.**

Suggested reading:

Markman, H. et al. Fighting for your marriage, Jossey-Bass, 1994.

Gottman, J. Why marriages succeed or fail ... and how you can make yours last. Simon and Schuster, 1994.

# LAW ENFORCEMENT FAMILIES

## DO IT YOURSELF SERIES IN POLICE PSYCHOLOGY:

## STEPFAMILIES IN LAW ENFORCEMENT

1) INTRODUCTION: Our society does not have realistic models to help stepfamilies (blended families) function effectively.

Purpose: At the end of this session you will know the following:

- you will know common myths about stepfamilies that interfere with successful functioning;
- you will learn concepts to help understand better how stepfamilies works;
- you will be able to identify how the law enforcement role impacts on parent's role in the family;
- you will recognize how law enforcement work can make parents less effective and what to do about it;
- you will be able to identify the structure of stepfamilies and the most common pitfalls associated with that type of stepfamily;
- you will better understand the challenges that children are experiencing;
- you will understand the crucial role played around how parents discipline in the stepfamily;
- you will better appreciate and be able to identify the satisfactions derived from being in stepfamilies; and
- you will better understand the central role the marital couple plays in the development of the family.

2) FACTS ABOUT DIVORCE, SINGLE PARENT FAMILIES AND STEPFAMILIES IN THE UNITED STATES:

- 50% of marriages in the United States will end in divorce; 50 years ago, children had only a 25% chance of seeing a divorce in their fame before the age of 18;
- In 1991, 25% of all children lived in a single parent family; one in eight families are single parent households (12 1/2 %);
- One in three families are stepfamilies and it is estimated that by 2000 50 % of all families will be stepfamilies;
- In California, 1/10 children will live with both parents together until they are 18 ;
- Ozzie and Harriet family of one working dad and one stay at home mom with children probably was only predominant in one generation, the generation following WW II;
- Current family structure is a continuation of trends started in the early 1900's:

  1) Decrease in the number of children;
  2) More woman working
  3) Single parents/single people increasing and
  4) Rise in the Divorce rate.

3) WHAT IS A STEPFAMILY ANYWAY?

**STEOP**: Old English/Middle English prefix

What does your stepfamily look like?

4) STEPFAMILY MYTHS

- Stepfamilies work just like nuclear families
- All stepfamily members will love each other
- Il stepfamily members will love each other instantly
- Stepfamilies are created instantly
- Part-time stepfamilies have it easier than full-time stepfamilies

5) STEPFAMILY DIFFERENCES

- The parent-child relationship predates the couple bond
- There is a biological parent somewhere that influences the family
- Children spend time in different households with different rules and different expectations
- The values and lifestyles may be very different and in conflict between two households
- Children may feel tremendous loyalty conflicts between their biological parents

6) SPECIAL PROBLEMS FOR STEPFAMILIES

- The role of step-parent is poorly and vaguely defined
- Too many tasks to do at once
- Relationships are complex
- No honeymoon
- Sibling relationships often demand time and attention
- Stepfamilies take on a whole set of extended kinship relationships that are also poorly defined and often demanding

7) VARIETY OF STEPFAMILY STRUCTURES

- Slave mother/wicked step-mother
- Deputy Dad
- Brady Bunch
- Glue Boy

8) SPECIAL VULNERABILITIES OF LAW ENFORCEMENT PARENT:

- Being in control works
- Don't make me come back here again - the myth of the single intervention
- Deviancy from norms must be meet with overwhelming force and punishment
- Deviancy from norms after continued interventions means that this is a bad person

9) CHALLENGES FOR THE CHILD

- Loyalty conflicts
- Loss of love/fear of rejection
- The threat of the loss of both parents
- Bodily harm

10) DISCIPLINE IN THE STEPFAMILY

- Discipline is more easily accepted by <u>all</u> ages if it comes from the biological parent
  **(1) Make a list of five important values in relations among members of your family that you feel should be followed; compare your list and your spouses list. (2) Pick two rules that you will work on over the next month.**
- Effective discipline can only be built on a solid relationship between step-parent and child
  **<u>Step-parent</u>: List activities that help build your relationship with your stepchild; what can your spouse, the biological parent do to help you.**
  **<u>Biological parent:</u> List six things that each of your children likes to do.**
- Relationships take a long time to build
  **Start a tradition of having a family meeting. In the first meeting engage your children by leading them as to what rules you all need to have in the family and agree to a set of rules that everyone can live with.**
- Stepfamily relations take between 2 to 4 years before they become stable

12) THE FOUNDATION OF THE FAMILY: The foundation of the family is the marital couple. Threats to the couple come from many different angles. Building strong boundaries around the couple and nurturing that relationship is crucial for your success.

- Dealing with ex-spouses
- Problem Solving
- Commitment
- Start your own traditions
- Set aside time that you schedule and that you treat as inviolate for couple activity
  **What was it like when you were dating?**
  **What did you talk about?**
  **How much time did you spend together?**

13) STRENGTHS AND REWARDS OF YOUR STEPFAMILY

**List five events in your stepfamily relationships that you felt happy about. Share those five things with your spouse.**

**List your hopes for your relationships with each of the family members. Share those with your spouse.**

**THE ONE MOST IMPORTANT THING TO TAKE FROM THIS SESSION:**

**YOUR GOOD RELATIONSHIP WITH YOUR MATE IS CRUCIAL TO YOUR STEPFAMILY SUCCESS**

(Session II)

## HANDOUT #5

## Guidelines for Stepfamilies

1. It is difficult to have a new person or persons move into your "space," and it is difficult to be the "new" person or people joining a pre-existing group. For these reasons it helps to cut down feelings involved with "territory" if stepfamilies can start out in their own house or apartment.

2. Parent-child relationships have preceded the new couple relationship. Because of this, many parents feel that it is a betrayal of the earlier parent-child bond to form a primary relationship with their new partner. A primary couple relationship, however, is usually crucial for the continuing existence of the stepfamily, and therefore is very important for the children as well as for the adults. A strong adult bond can protect the children from another family loss, and it also can provide the children with a positive model for their own eventual marriage relationship. The adults often need to arrange time alone to help nourish this important couple relationship.

3. Forming new relationships within the stepfamily can be important, particularly when the children are young. Activities involving different subgroups can help such relationships grow. For example, stepfather and stepchildren might do some project together, or stepmother and a stepchild might go shopping together.

4. Preserving original relationships is also important and can help children experience less loss at sharing a parent. So at times it is helpful for a parent and biological children to have some time together, in addition to stepfamily activities.

5. Caring relationships take time to evolve. The expectation of "instant love" between stepparents and stepchildren can lead to many disappointments and difficulties. If the stepfamily relationships are allowed to develop as seems comfortable to the individuals involved, then caring between step-relatives has the opportunity to develop.

6. Subsequent families are structurally and emotionally different from first families. Upset and sadness is experienced by the children and at times by the adults as they react to the loss of their nuclear family or to the loss of a dream of a perfect marriage. Acceptance that a stepfamily is a different type of family is important, as is the recognition that many upsetting behaviors result from these feelings of insecurity and loss.

7. Because children are part of two biological parents, they nearly always have very strong pulls to both of these parents. These divided loyalties often make it difficult for children to relate comfortably to all the parental adults in their lives. Rejection of a stepparent, for example, may have nothing to do with the personal characteristics of the stepparent. In fact, warm and loving stepparents may cause especially severe loyalty conflicts for children. As children and adults are able to accept the fact that children can care for more than two parental adults, then the children's loyalty conflicts can diminish and the new steprelationships improve. While it may be helpful to the children for the adults to acknowledge negative as well as positive feelings about ex-spouses, children may become caught in loyalty conflicts and feel personally insecure if specific critical remarks are made continuously about their other parent.

8. Courteous relationships between ex-spouses are important, although they are very difficult for many adults to maintain. If such a relationship can be worked out, it is especially helpful to the children. In such instances, the children do not get caught in the middle between two hostile parents, there is less need for the children to take sides, and the children are better able to accept and utilize the positive elements in their living arrangements.

   Direct contact between adults can be helpful since it does not place the children in the sometimes powerful position of being message carriers between the biological parents. Although it may be strained, many ex-spouses are able to relate in regards to their children if the focus is kept on their mutual concern for the welfare of the children.

9. Children, as well as adults, in a stepfamily have a "family history." Suddenly the individuals come together and their sets of "givens" are questioned. Much is to be gained by coming together as a stepfamily unit to work out and develop new family patterns and traditions. Even when the individuals are able to recognize that patterns are not "right" or "wrong," it takes time and patience to work out satisfying new alternatives.

   Values (the underlying approach to life and general ways of doing things) do not shift easily. Within a stepfamily, different value systems are inevitable because of different previous family histories, and tolerance for these differences can help smooth the process of stepfamily integration. Needs (specific ways individuals relate together, individual preferences, etc.) can usually be negotiated more quickly than general values. Having an appreciation for and an expectation of such difficulties can make for more flexibility and relaxation in the stepfamily unit. Negotiation and renegotiation is needed by all such families.

10. Being a stepparent is an unclear and at times difficult task. The wicked stepmother myth contributes to the discomfort of many women, and cultural, structural and personal factors affect the stepparent role. Spouses can be very helpful to one another if they are able to be supportive with the working out of new family patterns. Stepparenting is usually more successful if stepparents carve out a role for themselves that is different from and does not compete with the biological parents.

    While discipline is not usually accepted by stepchildren until a friendly relationship has been established (often a matter of 18 to 24 months), both adults do need to support each other's authority in the household. The biological parent may be the primary disciplinarian initially, but when that person is unavailable, it is often necessary for that parent to give a clear message to the children that the stepparent is acting as an "authority figure" for both adults in his or her absence.

    Unity between the couple is important to the functioning of the stepfamily. When the couple is comfortable with each other, differences between them in regards to the children can sometimes be worked out in the presence of the children, but at no time does it work out for either children or adults to let the children approach each adult separately and "divide and conquer." When disciplinary action is necessary, if it is not kept within the stepfamily household, many resentful feelings can be generated. For example, if visitation rights are affected, the noncustodial parent is being included in the action without his or her representation. Such a punishment, then, may lead to difficulties greater than the original behavior that caused the disciplinary action.

11. Integrating a stepfamily that contains teenagers can be particularly difficult. At this age adolescents are moving away from their families in any type of family. In single parent families teenagers have often been "young adults," and with the remarriage of a parent they find it extremely difficult or impossible to return to being in a "child" position again.

    Adolescents have more of a previous "family history" and so they ordinarily appreciate having considerable opportunity to be part of the stepfamily negotiations, although they may withdraw from both biological parents and not wish to be part of many of the "family" activities.

12. "Visiting" children usually feel strange and are outsiders in the neighborhod. It can be helpful if they have some place in the household that is their own. For example, a drawer or a shelf for toys and clothes. If they are included in stepfamily chores and projects when they are with the stepfamily, they tend to feel more connected to the group. Bringing a friend with them to share the visit and having some active adult participation in becoming integrated into the neighborhood

can make a difference to many visiting children. Knowing ahead of time that there is going to be an interesting activity (stepfamily game of monopoly, etc.) can sometimes give visiting children a pleasant activity to anticipate.

Noncustodial parents and stepparents often are concerned because they have so little time to transmit their values to visiting children. Since children tend to resist concerted efforts by the adults to instill stepfamily ideals during each visit, it is comforting to parents and stepparents to learn that the examples of behavior and relationships simply observed in the household can effect choices made by all the children later in their lives when they are grown and on their own.

13. Sexuality is usually more apparent in stepfamilies because of the new couple relationship, and because children may suddenly be living with other children with whom they have not grown up. Also there are not the usual incest taboos operating. It is important for the children to receive affection and to be aware of tenderness between the couple, but it may also be important for the couple to minimize to some extent the sexual aspects of the household, and to help the children understand and accept their sexual attractions to one another or to the adults.

14. All families experience stressful times. Children tend to show little day to day appreciation for their parents, and at times they get angry and reject them. Because stepfamilies are families born of loss, the mixture of feelings can be even more intense than in nuclear families. Jealousy, rejection, guilt, and anger can be more pronounced, and therefore expectations that the stepfamily will live "happily ever after" is even more unrealistic than it is in first families. Having an understanding and acceptance of the many negative as well as positive feelings can result in less disappointment and more stepfamily enjoyment.

15. Keeping even minimal contact between adults and children can lead to future satisfaction since time and maturity bring many changes. With some communication between stepfamily members, satisfying interpersonal relationships often develop in the future when children become more independent in their relationships with both biological parents and with stepparents.

Adapted from Stepfamilies: Myths and Realities, by Emily and John Visher. Secaucus, N.J.: Citadel Press, 1980.

(Session III)

HANDOUT #7

## Tips for Stepmothers

1. Accept the role of stepmother.

2. Don't be a non-parent.

3. Clarify role with spouse.

4. Learn to live with reality of ex-spouses.

5. Don't blame yourself for every misbehavior of your stepchildren.

6. You don't have to love your stepchildren--like and respect, yes.

7. Save time for your own activities.

8. Make yourself available.

9. Be patient--relationships take time to develop.

10. Be discreet with physical attention.

From Learning to Step Together. Palo Alto, CA: Stepfamily Association of America, 1982.

## HANDOUT #8

## Tips for Stepfathers

1. Develop relationship before attempting discipline.

2. Help partner establish rules, but don't enforce too soon.

3. Take side of stepchild if Mom is being unreasonable.

4. Remind children that they continue to be loved by the mother.

5. Get chore issues out into open and negotiate.

6. Talk to your wife if you feel undermined.

7. It's okay to ask for thanks from your stepchildren.

8. Discuss appropriate dress, privacy, and modesty standards of teenage stepchildren.

9. Share yourself, spend time with each stepchild.

10. Be discreet with physical attention.

From Learning to Step Together. Palo Alto, CA: Stepfamily Association of America, 1982.

## HANDOUT #9

### Tips for Remarried Parents

1. Give your partner time to develop a relationship with your children.

2. Give partner and children the chance to interact and do things alone.

3. Make "alone time" for you and your new partner.

4. Do things alone with your child from time to time and assure them of your love.

5. Treat all the children equally in terms of rules, rewards and responsibilities.

6. Be really honest with your feelings.

7. Allow partner to voice negative feelings.

8. Keep your responses under control.

9. Be discreet with physical attention.

From Learning To Step Together. Palo Alto, CA: Stepfamily Association of America, 1982.

(Session IV)

## HANDOUT #10

### Stresses for Children in Stepfamilies

1. Hearing their biological parents argue (over the phone, at the door, etc.) and say negative things. They may wonder if they're to blame for this.
2. Not being able or allowed to see their other biological parent, and resenting their stepparent for this.
3. Feeling blamed for everything that goes wrong.
4. Hearing their parent and stepparent fight, and fearing that this marriage will break up.
5. Having their parents do more for stepsiblings than for them.
6. Having stepsiblings get into their belongings and intrude on their space and privacy.
7. Dealing with feelings of not being wanted (often testing to see if either household wants them).
8. Feeling angry and depressed and wishing it could all be the way it was before the death or divorce.
9. Having a stepparent tell them what to do and resenting this.
10. Feeling that it's up to them to make the new household "work."
11. Feeling like pawns and messengers tossed between their biological parents who are still feeling bitter and angry towards one another.
12. Adjusting to all the new rules in the household.

From Learning to Step Together. Palo Alto, CA: Stepfamily Association of America, 1982.

# Some Facts About Stepfamilies

**CURRENT ESTIMATES SUGGEST:**
*60% of all first marriages eventually end in divorce.
*About 75% of divorced persons eventually remarry.
*About 40% of all marriages are remarriages for one of the adults.
*About 65% of remarriages involve children from the prior marriage and, thus form stepfamilies.
*60% of all remarriages eventually end in divorce.
*35% of all children born in the 1980s will experience life in a single- parent family for about 5 years total before the 18th birthday.

**CURRENT STATE OF FAMILIES WITH CHILDREN UNDER 18 YEARS:**
*72.5 of children under 18 live in 2- parent families.
Of these,
20.8% are in stepfamilies (two- thirds of the children in stepfamilies are stepchildren; 6.4% are half- siblings)
2.1% are in "other remarried families" (children born to the current union). *27.4% of children under 18 are in other families.
Of these,
24.7% are in single- parent households.
2.7% are with grandparent or other relatives, but not with either parent.

**OTHER FACTS**
*1 out of 3 Americans is now a stepparent, a stepchild, a stepsibling, or some other member of a stepfamily (Larson, 1992).

*More than half of Americans today have been, are now or will eventually be in one or mare stepsituations during their lives (Larson, 1992).

*65% of children living with a stepparent live with a stepfather.

*5.3 million married- couple households contained at least one stepchild under age 18 in 1990 compared to 3.9 million in 1980. This 5.3 million represents 20.8% of all married- couple households with children compared to 16.1% in 1980.

*In 1990, 72.5% of children under 18 were living with two parents (including step and adoptive parents), 24.7% were living with one parent, and 2.7% were living with neither parent. In 1970 these same figures were: 85.2%, 11.9% and 2.9%.

*14.6% of white children under 18 residing in married- couple families do so with a stepparent compared to 32.3% of black children and 16.1% of Hispanic origin children.

**DEMOGRAPHICS OF AMERICAN STEPFAMILIES**
*40% of all marriages now represent a remarriage of one or both of the parties.

*If remarriage rates continue as they are now, 35% of all children born now will live in a stepfamily household while 68.4% have stepchildren living elsewhere.

*There are 20.64 million, or 49.6 percent, of the stepchildren are under 19 years of age, while 10.41 million or 50.4%, are 19 or older.

*By 1990 3.1 million women 15- 65 years had ended first and second mariages in divorce; they represent about 29% of all women who remarried after a first divorce.

*1 out of 6 children under the age of 18 is a stepchild.

*5.3 million married- couple households contained at least one stepchild under 18 in 1990. This is almost twice the number of households with stepchildren in 1980 (3.9 million or 16.1%). This represents 20.8% of all married couple households with children.

*6,789,000 children are stepchildren. This represents 15% of all children in married- couple families.

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Featured Article

Featured Article -- Fall 1997

# Building Stepfamily Traditions

*Elizabeth Einstein*

Holidays should be joyful times, but as families come together they produce stress. Few married couples have escaped the argument as to with which parents they will celebrate the festivities. The stepfamily's widened sphere of relationships creates an even greater chance for stress because children may be expected to spend holidays with both families.

Moving between families means that youngsters can continue the traditions of the old family at the same time that they discover new ones within the stepfamily. The two sets of traditions that are common to most stepfamilies can become the source of an exciting learning experience for both adults and children. But molding the two requires careful negotiations. In multicultural families, is Christmas or Hanukkah celebrated? Or both? I thought everyone expected that stockings would be hung on Christmas Eve and gifts would be opened on Christmas morning, and that coloring Easter eggs was a family affair. But my new stepchildren expected to open gifts on Christmas Eve and assumed that a rabbit decorated eggs.

When the kinship system shifts, the debate over where to spend the holidays heightens. Just because everyone has always gone to Auntie Jane's for Christmas, that tradition holds little meaning for a new wife and her children, who have not yet established an emotional tie to the extended family. On the other hand, new spouses must understand the family kinship ties and traditions of their mates. To avoid such competition, the new stepfamily may want to have the first year's holiday meals alone at their house. This may provide the intimate time needed to establish new traditions and plan future gatherings.

A rather unusual idea that might be just right for some families is suggested by Dr. Irene Goldenberg, who believes that holidays include being in the bosom of one's family "because it feels good to be nurtured there." She recommends that the stepfamily's members celebrate holidays with different families of biological origin. "Rather than bicker over which place means family and tradition to whom, why not let them all be where they really want to be?" she asks, "Why should the stepfamily be forced to select one family of stay home?" Of course this suggestion is not traditional, but neither is the stepfamily, and such a solution will not work for everybody. "If such a plan is rooted in anger, or if someone feels distressed at not being with a spouse at holiday time," she cautions," then it will fail."

The time when a stepfamily identity is being built offers a perfect time to establish new traditions. Often during the breakdown of former families, few joint activities continue. Creating new traditions provides good chances for the new stepfamily to gain a hold on intimacy.

At our house we made birthdays special. Besides the usual presents and privileges, the dining area was festooned, best dishes and linens came out and the birthday person chose the menu. In contrast to Jeff's annual request for pizza, Bev's birthday dinner choice was prime rib, artichokes, and angel food cake.

We made Halloween into a big event too. After a long drive to the pumpkin farm with an autumn picnic, each of us selected the perfect pumpkin. These were then carved during a family affair complete with popcorn and cider. When they were adorned with flashbulb noses, yarn hair, and a potpourri of hats, the finished jack-o'-lanterns reflected our personalities as well as the fun we'd had.

As a stepfamily traditions are being built dilemmas can produce resentment. A tradition on my sons' birthday had been to unpack their baby books filled with hands of hair from their first haircuts, hospital ID bands, and snapshots of toddler birthday parties; and we reminded them about heir earlier years. Because I had had no part in the childhood history of my stepchildren, not only did I not have such a collection for them, I felt this display unfair and soon stopped it. But giving up a nice tradition hurt me.

Roots and memories are important, and sharing histories brings the stepfamily closer together. If baby books and mementos remain with the biological mother, a stepmother can reconstruct a history by gathering clips of achievements or snapshots from the father of from grandparents. Using this collection as a focus on a stepchild's birthday eliminates guilt and resentment, and nice tradition is continued. Elizabeth Einstein is a past SAA Board Member and a frequent presenter at stepfamily workshops. This article was excerpted from her book "The Stepfamily, Living, Loving & Learning by permission.

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# Interventions that work for stepfamilies

*Psychologists' interventions help stepfamilies sidestep common conflicts.*

The so-called "blended family" is no longer an aberration in American society: It's a norm.

Today, more than 33 percent of all U.S. children are expected to live in a stepfamily before age 18. Born of conflict and loss, newfound commitment and often heart-wrenching transition, these families confront myriad lifestyle adjustments and challenges. Children of stepfamilies face a higher risk of emotional and behavioral problems and are less likely to be resilient in stressful situations, psychologists' research has found.

Given their large numbers, it's clear that mental health professionals will encounter these types of families in therapy and it is imperative for clinicians to familiarize themselves with the basic issues prior to working with them.

James Bray, PhD, a researcher and clinician at the department of family medicine at Baylor College of Medicine, discussed five areas in which psychologists can help stepfamilies cope: planning for remarriage, marital relationships, parenting in stepfamilies, stepparent-child relationships and nonresidential parent issues. Most of Bray's work is based on a nine-year longitudinal study funded by the National Institute of Child Health and Human Development.

## Planning for remarriage

A marriage that brings with it children from a previous marriage presents many challenges. According to Bray, such families should consider three key issues as they plan for remarriage:

**Financial and living arrangements.** Adults should agree on where they will live and how they will share their money. Most often partners embarking on a second marriage report that moving into a new home_rather than one of the partner's prior residences_is advantageous because the new environment becomes "their home," Bray said. Couples also should decide whether they want to keep their money separate or share it. Couples who have used the "one-pot" method generally reported higher family satisfaction than those who kept their money separate.

**Resolving feelings and concerns about the previous marriage.** Remarriage may resurrect old, unresolved anger and hurts from the previous marriage, for adults and children. For example, hearing that her parent is getting remarried, a child is forced to give up hope that the custodial parents will reconcile. Or a woman may exacerbate a stormy relationship with her ex-husband, after learning of his plans to remarry, because she feels hurt or angry. But the

process of remarriage can be reframed as what Bray calls "final emotional divorce," an outlook that allows the new couple to clear the way for a new beginning.

**Anticipating parenting changes and decisions.** Couples should discuss the role the stepparent will play in raising their new spouse's children, as well as changes in household rules that may have to be made. Even if the couple lived together before marriage, the children are likely to respond to the stepparent differently after remarriage because the stepparent has now assumed an official parental role, said Bray.

## Marriage quality

While newlywed couples without children usually use the first months of marriage to build on their relationship, couples with children are often more consumed with the demands of their kids, he said.

Young children, for example, may feel a sense of abandonment or competition as their parent devotes more time and energy to the new spouse. Adolescents are at a developmental stage where they are more sensitive to expressions of affection and sexuality, and may be disturbed by an active romance in their family.

The psychologist's role, said Bray, is to educate the couple about the need to build a strong marital bond, which will ultimately benefit the children by creating a stable home environment. Couples should make priority time for each other, by either making regular dates or taking trips without the children.

## Parenting in stepfamilies

The most difficult aspect of stepfamily life is parenting, according to Bray's research. Forming a stepfamily with young children may be easier than forming one with adolescent children due to the differing developmental stages, said Bray.

Young children may have it easier because "both young children and the stepfamily as a unit need close, cohesive family relationships and the centripetal forces of stepfamily formation coincide with the need that young children have for affective involvement and structure," he said.

Adolescents, however, would rather separate from the family as they form their own identities. "The developmental needs of the adolescent are at odds with the developmental push of the new stepfamily for closeness and bonding," Bray said.

Recent research suggests that younger adolescents (age 10-14) may have the most difficult time adjusting to a stepfamily, Bray said. Older adolescents (age 15 and older) need less parenting and may have less investment in stepfamily life, while younger children (under age 10) are usually more accepting of a new adult in the family, particularly when the adult is a positive influence, he explained. Young adolescents, who are dealing with identity formation issues, tend to be more oppositional.

Stepparents should at first establish a relationship with the children that is more akin to a friend or "camp counselor," rather than a disciplinarian, Bray suggests. Couples can also agree

that the custodial parent remain primarily responsible for control and discipline of the children until the stepparent and children develop a solid bond.

Until stepparents can take on more parenting responsibilities, they can simply monitor the children's behavior and activities and keep their spouses informed, Bray recommends.

Bray also recommends that psychotherapists ask each spouse to develop a list of household rules. These may include, for example, "We agree to respect each family member" or "Every family member agrees to clean up after him or herself."

In the next session, the spouses should negotiate three to five rules that will be implemented in the family. The rules should be discussed with the children, then posted in a prominent place.

When the rules are explicit, the stepparent is detriangled from the custodial parent and the stepchild because he or she is simply following the house rules, rather than acting as a disciplinarian for the family, Bray said.

## Stepparent-child relations

Because the ties between stepparents and children tend more conflictual than those of nuclear families, they are well-suited for professional intervention, said Bray. While new stepparents may want to jump right in and to establish a close relationship with stepchildren, they should consider the child's emotional status and gender first, Bray's research has found.

Both boys and girls in stepfamilies have reported that they prefer verbal affection, such as praises or compliments, rather than physical closeness, such as hugs and kisses. Girls were particularly likely to say that they were uncomfortable with physical shows of affection from their father. Overall, boys appear to accept a stepfather more quickly than girls.

Frequently, a threat to the stepparent-stepchild relationship arises over questions of loyalty. For example, a stepfather may wonder whether his new wife is more loyal to her children or him. This attitude creates an inappropriate triangle involving the children, custodial parent and stepparent, and reveals that the stepfather assumes he and the children are at the same hierarchical level within the family, Bray said.

## Nonresidential parent issues

After a divorce, children usually adjust better to their new lives when the parent who has moved out visits consistently and has maintained a good relationship with them.

But once parents remarry, they often decrease or maintain low levels of contact with their children. Fathers appear to be the worst perpetrators: On average, dads drop their visits to their children by half within the first year of remarriage, according to Bray.

The less a parent visits, the more a child is likely to feel abandoned. Bray recommends that parents reconnect by developing special activities that involve only the children and parent.

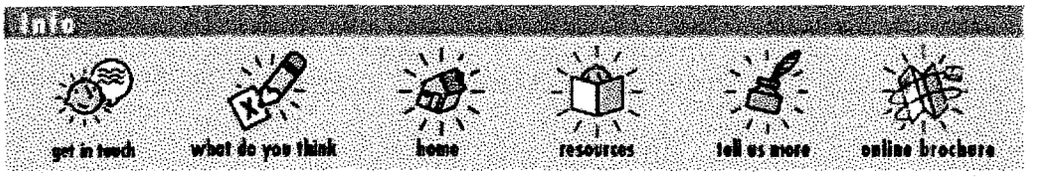
Bray also cautions that parents not speak against their ex-spouses in front of the child because it undermines the child's self-esteem and may even put the child in a position of defending a

parent.

Under the best conditions, it may take two to four years for a new stepfamily to adjust to living together, Bray said. But with psychological interventions, the process can go more smoothly. Bray said.



## Talk to someone who can help.



National Center for Injury Prevention and Control

Violence

# American Indian/Alaska Natives and Intimate Partner Violence

## Background

- There are 556 federally recognized American Indian and Alaska Native (AI/AN) tribes (330 American Indian tribes and 226 Alaska Native villages). Twenty-three tribes have state recognition only; numerous others have neither federal nor state recognition. [1]The total estimated AI/AN population is about 2 million persons. [2]
- In 1995 approximately 209 North American Indian languages were still spoken, roughly half the number that existed 500 years earlier. Nearly 80% of these languages face extinction within a single lifetime because they are spoken by only a few of the oldest persons in the community. [3]
- A 1977 joint resolution by the National Congress of American Indians and the National Tribal Chairmen's Association designated that people indigenous to North America be referred to as American Indian/Alaska Natives except when specific tribal designations are appropriate. [2]
- One-third of AI/ANs live on federal Indian reservations, the remainder in off-reservation rural areas/cities. Significant migration occurs between reservation and non-reservation settings.[2]
- To date, the problem of intimate partner violence (IPV) among AI/ANs has received little attention in the literature.[4] Association of IPV with child abuse, alcohol use, suicide, and homicide has been suggested. [5-11] Further research is needed to determine the statistical significance of these associations. [8, 12, 13]

## Culture, History and Ethnography: Risk and Protective Factors

- Traditional family structures, social and religious practices, 4 greater balance of power between men and women, and the role of women central to family organization in pre-reservation AI/AN societies likely served as protective factors for IPV in AI/AN communities. [7, 14-17]
- Community and family destruction brought on by forced change, changes in traditional

marriage systems and social controls, and constant economic and subsistence deprivation likely were and are risk factors for IPV among AI/ANs. [16, 18-20]

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**Homicide Among American Indian and Alaska Native Women**

- Approximately 75% of female AI/AN homicide victims are killed by someone they know; almost one-third are killed by family members. Among all U.S. female homicide victims, 65% are killed by someone they know. [21]

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**Incidence/Prevalence of IPV Among AI/AN Populations**

- No reliable data exist on the incidence/prevalence of IPV among AI/AN populations. The 1985 National Family Violence Resurvey determined one year prevalence rates in the general population. 15.5% of 204 American Indian couples sampled reported violence in their relationship and 7.2% of Indian couples reported severe violence compared to 14.8% and 5.3%, respectively, among American White counterparts.[12]

- The survey did not collect data on tribal affiliation or residence. Data were analyzed on AI/AN married/cohabiting couples only. "Violence" was limited to a range of physical behaviors. There was no representation of persons who did not have telephones, 12 persons in remote areas with no access to telephones, or non-English speakers. [13]

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**Intervention/Prevention Programs**

- IPV prevention in "Indian Country" is primarily a grass roots effort which began in 1977 with the formation of the White Buffalo Calf Woman Society, Rosebud Reservation, South Dakota. There are approximately 15 Indian-specific shelters, which are primarily reservation-based. [2, 13]

- Community-based AI/AN IPV intervention/prevention programs are based on the philosophy that IPV was not a traditional or common occurrence prior to European contact 500 years ago and subsequent colonization of North and South America. [17, 22-27]

- In 1995 the Department of Justice (DOJ) began funding STOP Violence Against Women Grants in AI/AN communities. A total of 98 AI/AN IPV programs will have been funded in FY98 .

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**American Indian/Alaska Native IPV Prevention Programs and Curricula**

**Mending the Sacred Hoop**, Violence Against Indian Women Technical Assistance Project. 4032 Chicago Ave. South, Minneapolis, MN 55407. TEL 1-800-903-0111, ext. 1. Eileen Hudon and Loretta Rivera, Coordinators. This program is part of the Minnesota Program Development, Inc.,

Duluth, MN. In Duluth, MN, TEL (218) 722-2781. Don Chapin, Coordinator.

**Family Violence Prevention Program**, Indian Health Service. 5300 Homestead Road, NE, Albuquerque, New Mexico 87110. TEL (505) 248-4245. Beverly Wilkins, Coordinator.

**Cangleska, Inc. (Medicine Wheel)**, Oglala Lakota Nation, P.O. Box 260, Porcupine, South Dakota 57772. TEL (605)-867-1035. Marlin Mousseau, Coordinator.

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**For more information, write or call : 770.488.4362**
**National Center for Injury Prevention and Control**
**Division of Violence Prevention**
**Mailstop K60**
**4770 Buford Highway**
**Atlanta, Georgia 30341-3724**

You may also send questions and comments to *DVPINFO@cdc.gov*

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*11.03.97*

PREP®

# Problem Solving

## Step One: Problem Discussion

*Premature problem solving leads to poor solutions and poor follow through.*
*The goal is to understand and to be understood.*
*Validation is very important in this step.*
*Create an environment of teamwork!*
*This is a good place to use the Speaker/Listener Technique*

## Step Two: Problem Solution

### Agenda Setting

- Pick a very specific piece of the issue you are working on to try to solve right now.
- Stay on this focus for solution ideas.

### Brain Storming

- Suggest any ideas at all and be creative.
- No criticism or evaluation.

### Agreement And Compromise

- Talk out the ideas you came up with.
- Try out different combinations.
- Try to find the trial solution that will have the best chance of working.

### Follow up on Trial Solution

- Set a time frame to see if the solution is working.
- Change solutions when necessary to help the "win-win" happen.

* (Some ideas adapted from A Couple's Guide to Communication. 1976 Key ideas are also expressed in works such as We Can Work It Out (Notarius & Markman, 1993 and all earlier PREP materials. This basic model, or forms of it, are common in many resources across a range of disciplines: psychology, business, etc.)

For more information on constructive tools for strong marriages, see: Markman, H.J., Stanley, S.M., & Blumberg, S.L. (1994) Fighting *for* Your Marriage: Positive Steps For A Loving and Lasting Relationship. San Francisco: Jossey-Bass, Inc. (PREP 303-759-9931)

# The "Time Out" Ground Rule

PREP®

*This is a crucial ground rule you can agree to use together!*

*Take control of your conflicts rather than letting them take control of you.*

**Keys to Effective TIME OUTs:**

Either can call a "Time Out" at any time.

Use the term "Time Out" or some other agreed upon phrase so you each know that the other is attempting to do something positive.

Agree to respect this as a cue things are not going right.

It is best to say "I think ***we*** need a time out" over "I think ***you*** should take a time out," which will start a bigger conflict for most people.

This is something you agree to use as a team!

**There are two options when you call a Time Out**

1) Decide together to drop the issue *for the time being.*

OR

2) Shift into a safer way to communicate; we recommend going to the Speaker/Listener Technique to help you handle the conversation better.

or more information on constructive tools for strong marriages, see: Markman, H.J., Stanley, S.M., & Blumberg, S.L. (1994) Fighting *for* Your Marriage: Positive Steps For A Loving and Lasting Relationship. San Francisco: Jossey-Bass, Inc. (PREP 303-759-9931)

## FACTS ON ALCOHOLISM

Alcohol is America's favorite recreational drug. It is also the nation's number one drug of abuse. Alcohol is a mood changer, as are tranquilizers, heroin, cocaine, barbiturates, and amphetamines. The chronic alcoholic is physically and psychologically addicted.

In 1956, alcoholism was recognized by the American Medical Association as a disease with identifiable and progressive symptoms. This position is endorsed by the American Hospital Association, the American Bar Association, the American Psychiatric Association, and the World Health Organization.

Thirty-two percent of all male admissions to state and county mental hospitals suffer from alcohol-related problems.

There are an estimated 14 million alcoholics and problem drinkers in America today. Of the adult Americans who drink, one in 10 is prone to alcoholism.

Alcohol abuse is one of the top three killer diseases, along with cancer and heart disease. Persons afflicted with alcohol problems are sick, as are people who suffer from heart disease or cancer. If not treated, alcoholism ends in permanent mental damage, physical incapacity or early death.

The average alcoholic is in his/her mid-forties with a responsible job and a family. Fewer than 5 percent of all alcoholics are found on skid row. Ninety-five percent are employed or employable, like many people you see every day.

Up to 59 percent of all fatal accidents occurring on the roads involve alcohol.

Alcoholism involves both sexes and crosses all ethnic, religious, economic and sociocultural groups. While there are as many women alcoholics as there are men, only 22.7 percent of the people receiving treatment for alcoholism are women.

Thirty-seven percent of all suicides involve alcohol. The risk of suicide among alcoholics is 30 times that of the general population.

Alcoholism costs the nation $65.5 billion annually. Industry alone picks up $49.6 billion for lost production and health and medical services.

More than half of all violence in the American home is alcohol-related.

Children of alcoholic persons are twice as likely to develop an alcohol problem as children of non-alcoholics.

Alcoholism is a treatable disease.

Education, early detection and community treatment facilities are the greatest forces operating today for the control and reduction of alcoholism. Prevention and Intervention through programs of information and education have been primary objectives of the National Council on Alcoholism since its founding in 1944.

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-Statistics are taken from material published by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute of Mental Health (NIMH), the U.S. Department of the Treasury and the U.S. Department of Health and Human Service, 1980-81.

A:\MANUAL\102797\ALCOHOL

## NATIONAL COUNCIL ON ALCOHOLISM-BAY AREA

## WHAT ARE THE SIGNS OF ALCOHOLISM?

The following questions will help you learn if you have some of the symptoms of alcoholism. You can also use this questionnaire as a rough checklist to determine whether you or someone close to you may need help.

| | | YES | NO |
|---|---|---|---|
| 1. | Do you occasionally drink heavily after a disappointment, a quarrel, or when the boss gives you a hard time? | ____ | ____ |
| 2. | When you have trouble or feel under pressure, do you always drink more heavily than usual? | ____ | ____ |
| 3. | Have you noticed that you are able to handle more liquor than you did when you were first drinking? | ____ | ____ |
| 4. | Did you ever wake up on the "morning after" and discover that you could not remember part of the evening before even though your friends tell you that you did not "pass out"? | ____ | ____ |
| 5. | When drinking with other people, do you try to have a few extra drinks when others will not know it? | ____ | ____ |
| 6. | Are there certain occasions when you feel uncomfortable if alcohol is not available? | ____ | ____ |
| 7. | Have you recently noticed that when you begin drinking you are in more of a hurry to get the first drink than you used to be? | ____ | ____ |
| 8. | Do you sometimes feel a little guilty about your drinking? | ____ | ____ |
| 9. | Are you secretly irritated when your family or friends discuss your drinking? | ____ | ____ |
| 10. | Have you often found that you wish to continue drinking after your friends say they have had enough? | ____ | ____ |
| 11. | Do you usually have a reason for the occasions when you drink heavily? | ____ | ____ |
| 12. | Have you recently noticed an increase in the frequency of your memory "blackouts"? | ____ | ____ |
| 13. | When you are sober, do you often regret things you have done or said while drinking? | ____ | ____ |
| 14. | Have you tried switching brands or following different plans for controlling your drinking? | ____ | ____ |
| 15. | Have you often failed to keep the promises you have made to yourself about controlling or cutting down on your drinking? | ____ | ____ |
| 16. | Have you ever tried to control your drinking by making a change in jobs, or moving to a new location? | ____ | ____ |
| 17. | Do you try to avoid family or close friends while you are drinking? | ____ | ____ |
| 18. | Are you having an increasing number of financial and work problems? | ____ | ____ |
| 19. | Do more people seem to be treating you unfairly without good reason? | ____ | ____ |
| 20. | Do you eat very little or irregularly when you are drinking? | ____ | ____ |

| | | YES | NO |
|---|---|---|---|
| 21. | Do you sometimes have the "shakes" in the morning and find that it helps to have a little drink? | ____ | ____ |
| 22. | Have you recently noticed that you cannot drink as much as you once did? | ____ | ____ |
| 23. | Do you sometimes stay drunk for several days at a time? | ____ | ____ |
| 24. | Do you sometimes feel very depressed and wonder whether life is worth living? | ____ | ____ |
| 25. | Sometimes after periods of drinking, do you see or hear things that aren't there? | ____ | ____ |
| 26. | Do you get terribly frightened after you have been drinking heavily? | ____ | ____ |

If you answered "yes" to any of the questions, you have some of the symptoms that may indicate alcoholism.

"Yes" answers to several of the questions indicate the following stages of alcoholism:

Questions 1 - 8 = Early Stage
Questions 9 - 21 = Middle Stage
Questions 22 - 26 = The beginning of Final Stage

Remember, alcoholics can and do recover. Treatment for alcoholism is available. For more information, contact your local office of the National Council on Alcoholism.

Reprinted from What Are The Signs
National Council on Alcoholism-New York

National Council on Alcoholism-Bay Area
1049 Market Street, Suite 507
San Francisco, CA 94103
(415) 861-4000

4/89

## NATIONAL COUNCIL ON ALCOHOLISM-BAY AREA

## ARE YOU A CO-ALCOHOLIC?

HAVE YOU EVER:

| | | YES | NO |
|---|---|---|---|
| 1. | Been embarrassed at the behavior of someone you know after he/she drinks? | ___ | ___ |
| 2. | Poured out liquor to keep someone from drinking? | ___ | ___ |
| 3. | Felt your behavior was making someone else drink? | ___ | ___ |
| 4. | Threatened to leave someone because of too much drinking? | ___ | ___ |
| 5. | Called work to give an excuse for someone who could not work that day because of high alcohol the day/night before? | ___ | ___ |
| 6. | Felt angry that your family was not being taken care of because so much money was being spent on alcohol? | ___ | ___ |
| 7. | Felt fearful at what would happen to you and/or your children if drinking continues in your family? | ___ | ___ |
| 8. | Gone looking for someone who you think is out drinking? | ___ | ___ |
| 9. | Called bars, neighbors, friends looking for someone you believe to be drinking? | ___ | ___ |
| 10. | Increased your own alcohol consumption to keep up with someone who is a heavy drinker? | ___ | ___ |
| 11. | Wished that alcoholic drinks could be outlawed? | ___ | ___ |
| 12. | Wanted to move and "start over" as a solution to heavy drinking? | ___ | ___ |
| 13. | Been revolted by others' drinking behavior? | ___ | ___ |
| 14. | Been unable to sleep because someone has stayed out late drinking or not come home at all? | ___ | ___ |
| 15. | Resented the fact that there is heavy drinking occurring in your family or with someone close to you? | ___ | ___ |
| 16. | Felt hopeless about a drinking problem? | ___ | ___ |
| 17. | Felt it was a disgrace to talk about a drinking problem? | ___ | ___ |
| 18. | Cut down on outside activities so that you could keep an eye on someone who is drinking? | ___ | ___ |
| 19. | Nagged or gotten into quarrels with someone who drinks? | ___ | ___ |
| 20. | Felt that if the drinker would just stop drinking, everything would be okay? | ___ | ___ |

☞ A co-alcoholic is someone who is close to, loves, cares for an alcoholic; someone who is involved with and affected by an alcoholic.

N.C.A. Estimates that every alcoholic affects an average of four other people.

National Council on Alcoholism-Bay Area
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# A SUBSTANCE ABUSE SCREENING CHECK LIST

Bruce D. Forman

The prevailing conception about substance abuse maintains it is a behavioral disorder evidenced by a pattern of misuse having harmful psychosocial consequences for the abuser (American Psychiatric Association, 1980; Chafetz, 1976). In essence, the substance abuser is preoccupied with the substance, has a lifestyle oriented toward using the substance, and experiences conflict emotionally, socially, occupationally, and/or legally as a result of the substance oriented lifestyle.

## DEVELOPMENT OF THE CHECKLIST

Richard Massey (a specialist in alcoholism) and I were asked to recommend a client screening procedure for use by counselors in a Pre-Trial Intervention Program in Columbia, South Carolina. After successful completion, program clients would not be prosecuted for first offense charges such as Driving Under the Influence, shoplifting, or possession of marijuana. Since many of these clients had a clear-cut substance abusing lifestyle or the potential for developing one, we suggested a self-report tool which could be completed in a short time with minimal threat to the client.

A criterion was established in constructing our screening tool - items selected could be worded for applicability to either alcohol or drug use. Thus, only one item set would be prepared. Items were constructed rationally (rather than empirically) to tap the orientation toward using substances and to have similarity to items contained in other instruments, such as the Michigan Alcoholism Screening Test (MAST) (Selzer, 1971). Unlike some instruments, the one we constructed does not rely on a system of differential weights, which complicate scoring and may be of questionable validity (Forman & Florenzano, 1978).

## INSTRUCTIONS

The substance abuse screening check list contains 15 equally weighted items. It was designed to be completed by clients at least 16 years of age. Administration is usually accomplished in two to three minutes. It has been helpful to allow the check list to be self-administered and self-scored. In this way a client can spend a few minutes examining his or her life style with respect to substances and can elect to raise issues related to potential or current problem areas with a clinician.

The check list can also be used as an aid to clinical interviewing. Items can be reworded into questions that are integrated into a diagnostic interview to determine how much a client's life revolves around substance use.

## INTERPRETATIONS

Rationale for scoring and subsequent interpretation are based upon clinical experience; validational data and scoring norms are not currently available. Scoring is accomplished by a simple counting of the number of items a client endorses as self-descriptive. A score of two or less suggests that substances are not a problem for the client. Endorsement of three to five items may indicate the beginning of a substance oriented lifestyle and a need for exploration to determine duration of substance misuse, tolerance to the substance, and the degree to which the substance is impairing the client's psychosocial functioning. A score in excess of five indicates that substances are possibly a major problem for the client. However, it should not be taken to mean that a substance abuse disorder is the primary problem for a client. It may be that other disorders are present and that substance abuse is a contributing or complicating factor. Thus, the user of this check list is cautioned to use it only as a rapid screening device and to rely on more sophisticated instruments along with clinical judgment when making comprehensive evaluations.

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## A CONFIDENTIAL PERSONAL CHECK LIST AROUND THE USE OF ALCOHOL AND OTHER DRUGS

Check (✓) as many of the following statements as fit you.

___ I frequently (once or twice a day) find that my conversation centers on drug or drinking experiences.

___ I drink or get high to deal with tension or physical stress.

___ Most of my friends or acquaintances are people I drink or get high with.

___ I have lost days of work (school) because of drinking or other drug use.

___ I have had the shakes when going without drinking or using drugs.

___ I regularly get high or take a drink upon awakening, before eating, or while at work (school).

___ I have been arrested for Driving Under the Influence of a substance.

___ I have periods of time that can't be remembered (i.e., "blackouts").

___ Family members think drinking or other drug use is a problem for me.

___ I have tried to quit using substances but cannot. (A good test is voluntarily going for six weeks without substances and not experiencing physical or emotional distress.)

___ I often double up and/or gulp drinks or regularly use more drugs than others at parties.

___ I often drink or take drugs to "get ready" for a social occasion.

___ I regularly hide alcohol/drugs from those close to me so that they will not know how much I am using.

___ I often drink or get high by myself.

___ My drinking or use of drugs has led to conflict with my friends or family members.

The above items are drawn from the clinical experiences of mental health professionals who have worked with people having alcohol or drug abuse problems. In general, the more items checked, the more likely there is a problem with using substances.

SCORING: If you checked as many as three of the statements you should be suspicious about the way you use substances.

If you checked as many as five you may have the beginnings of a problem and perhaps should start looking for some kind of help.

If you checked more than five, it would probably be a good idea to talk about your use of substances with a professional counselor.

## CONCERNED PERSON QUIZ

| YES | NO | | |
|---|---|---|---|
| ___ | ___ | 1. | Do you lose sleep because of a problem drinker/user? |
| ___ | ___ | 2. | Do most of your thoughts revolve around the problem? |
| ___ | ___ | 3. | Do you expect promises about the drinking/using which are not kept? |
| ___ | ___ | 4. | Do you make threats or decisions and not follow through? |
| ___ | ___ | 5. | Has your attitude changed toward this problem drinker/user, alternating between love and hate? Like and dislike? |
| ___ | ___ | 6. | Do you mark, hide, dilute, empty bottles of liquor or medication or other drugs, or find ways to protect the drinker/user from their chemical? |
| ___ | ___ | 7. | Do you think that everything would be okay if only the problem user would stop or control the using? |
| ___ | ___ | 8. | Do you feel alone, fearful, angry, anxious, frustrated most of the time? Are you beginning to feel dislike for yourself and to wonder about your sanity? |
| ___ | ___ | 9. | Do you find your moods fluctuating wildly as a direct result of the problem drinker/user's moods or actions? |
| ___ | ___ | 10. | Do you feel responsible and guilty about this person's problems? |
| ___ | ___ | 11. | Do you try to conceal, deny, or protect the person? |
| ___ | ___ | 12. | Have you withdrawn from outside activities and friends because of embarrassment and shame over the drinker/user? |
| ___ | ___ | 13. | Have you taken over many chores and duties that you would normally expect the drinker/user to assume, or that were formerly his or hers? |
| ___ | ___ | 14. | Do you feel forced to try to exert tight control over the family expenditures with less and less success, and are financial problems increasing? |

YES NO

___ ___ 15. Do you feel the need to justify your actions and attitudes and at the same time do you feel somewhat smug and self-righteous compared to the drinker/user?

___ ___ 16. If there are children in the house, do they often take sides with either the drinker/user or spouse?

___ ___ 17. Are the children showing signs of emotional stress, such as, withdrawing, having trouble with authority figures, rebelling, acting-out sexually?

___ ___ 18. Have you noticed physical symptoms in yourself, such as nausea, a "knot" in the stomach, ulcers, shakiness, sweating palms, bitten fingernails?

___ ___ 19. Do you feel utterly defeated -- that nothing you can say or do will move the user/drinker?

___ ___ 20. Do you believe that he or she can't get better?

There is no right number of answers. Three "yes" answers would be an indication that you are, indeed, concerned. Whatever your answers, if you have questions, attend Al-Anon, or contact a professional alcoholism counselor, or EAP.

Most suicide is dreary and dismal wintery storm within the mind, where staying afloat or going under is the vital decision being debated.

Edwin Schneidman ... Suicide Why by Adina Wrobleski

**WHAT:** The willful taking of one's own life

**WHO:** Anyone given reason and means shy a solution to a problem that has become too unbearable and for which no other resolution seems possible

- a long term solution to a short term problem -

an attempt to gain control

a major stress

any situation or event that is trivial to one person may be major to another

disease or injury
embarrassment
failure
loss of a love one
injury
divorce
rejection
job change

**HOW:** sometimes impulsive usually a series of steps covered in a variable period of time

1. a problem
2. seeking solutions - suicide becomes an option
3. methods are considered
   - any methods that the person thinks will get the desired results death, release of stress
4. preparations are made
   - a method is planned or acquired
   - good byes, giving things away
   - peacefulness sometimes evolves
5. the attempt is made

**INTERVENTIONIST**

**Purpose** To assess the person, to interrupt the process if possible and bring in professional help

get to know as much as possible, build trust
**Ask the questions:**

- are you thinking about KILLING yourself
- have you tried to kill yourself before
- are you under Dr's care or taking medications
- what happened recently or tonight that makes you want to kill yourself (get into now and away from past)
- do you want to kill yourself or just want tot stop the hurt
- when you have been hurting in the past, what has helped (look for positive and strengths - focus on these)

**Assess Lethality**

I understand that you see death as an option will you work with me/us to find another solution?. once you can id the problems, you can explore other solutions as options

**LETHALITY:** Ask if the person has a plan and what means of self-destruction they are contemplating. The means of self destruction is critical information:

gun
driving off cliff
hanging
jumping
poison
co2
driving reckless
slashing]
pills
drinking
heavy smoking
over-eating
starvation
holding breath

# POLICE SUICIDE:


INTERVENTION

CONFRONTING POLICE SUICIDES is a problem that NACOP is facing head-on. Suicide prevention is part of the curriculum for Regional Stress Seminars. In this touching photo from Alexandria, LA, Msgr. Ronald Hoppe (r.) tries to talk Rapides Parish Deputy Paul Broussard out of shooting himself. Tragically, the Deputy took his own life as did more than three hundred American law enforcement officers last year alone.

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*Continued from page 33*

# RESEARCH PROBLEMS: POLICE SUICIDE

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## ABSTRACT

Does being a police officer increase one's risk of committing suicide? The research is limited and scarce. Most of the studies on police deaths have been directed at police killings and assaults committed by citizens. There is a lack of empirical data and much of the information consists of anecdotal media reports. In addition, many of the police suicide studies are dated and fail to provide useful information. Police senior leaders need to apply the elements of social scientific thinking to this problem in order to evaluate police suicide, and develop appropriate policies and training programs. The purpose of this article is to emphasize the need for research to be directed at prevention and intervention training programs.

The search for answers concerning police suicide is an elusive one. Many issues remain unclear because the research studies are scientifically vague and inconclusive. We have been asking the wrong questions and much of the data is meaningless. For example, comments made concerning the use of weapons are less than helpful. Focus on prevention and intervention, not the means. The use of service weapons is the obvious and old news. From the first second a police officer is handed a police service weapon, the officer understands that life and death is just seconds away. Unfortunately, too many officers have taken advantage of the proximity and convenience of having a weapon in their possession. In the suicidal state of mind, without proper support, officers can find many ways to take their own lives. The repertoire is endless because of a police officer's experience and expertise. The question should be: What kind of support system exists within the police department that could have initiated the proper intervention before the officer used the weapon?

Police administrators deny researchers the opportunity to collect valuable information that would allow a better understanding of the problem (Burge, 1982). This is understandable because of the need to protect the privacy of the officer and family members. However, much of the information could be released without identifying data. Police managers rarely trust researchers because they fear Privacy Act violations. How can the data base on police suicide be improved without violating the rights of deceased police officers and their families?

The larger problem is the misclassification of suicide. It may be reported as accidental death or even homicide in order to protect the officer, family and department. Related directly to this misreporting is the fact that insurance companies will not pay benefits to families of individuals who commit suicide. Moreover, the motivation to change reports exists because of investigator denial, and financial loss to the family. The stigma to the officer and department is another motivation factor (Burge, 1982).

Police officers are members of a subculture and because of that sense of loyalty have the philosophy "we take care of our own." One study of the Chicago Police Department estimated that 67 percent of police suicides were misclassified as accidental or natural causes. This suggests that in some of those cases, investigators intentionally over-looked evidence of suicide (Wagner & Brazeczek, 1983). This kind of cover-up would distort the exact data base of police suicide statistics. How can we get accurate data on the frequency of police suicides?

There is conflicting information concerning the role of stress and police suicide. Lester, 1983, suggests that work associated stress does not influence a police officer to commit suicide. His analysis of 92 police suicide cases revealed that alcohol abuse and personal problems appeared to be the problem. This research seems to focus on the officer and not the police agency.

However, some researchers identify the stress and working conditions in police organizations as a major factor. These risks are related to police occupational factors and lifestyle. The police environment is high stress due to the nature of the work and irregularity of sleeping and eating patterns. It appears that stress-related alcohol dependency and the lack of exercise contribute additional stress to the social equation. "This study examined the disease rate and mortality among 2,376 po-

*Continued from page 35*

**lice officers in Buffalo, New York. Death certificates were obtained for 93% of their deaths. Based on standard mortality ratios, the study revealed that in comparison to the United States white male population, police officers have an increasing rate of death. Police officers have significantly higher mortality rates for cancer, suicide and heart disease with increasing years of police service"** (Violenti, Vena, & Marshall, 1986).

Hill & Clawson (1988) found that police officers were more likely than the average male to commit suicide and were considerably more likely to die by homicide. Violenti, Vera & Marshall (1986) found that suicide among police officers was three times higher than that of the general population. One new unpublished research grant recently revealed findings that individual police suicides may now be occurring at twice the rate they did in the past (Violenti & Vena, 1995). We may be seeing the "tip of the iceberg" of the police suicide problem. Perhaps the magnitude of the problem is greater than originally estimated.

Science is a process of thinking and asking the right questions. Police suicide research needs to be directed at the questions that support prevention and intervention training. The psychological autopsy should be redirected away from the officer and focused on police culture and organizational structure. We must understand the role of police organizations and the social milieu. With the exception of a few voices, police officials have remained silent about police suicide for years. Many have regarded mental health issues and suicide as the deviant behavior of a few. It is time to look beyond descriptive statistics describing the event. We must acknowledge and investigate the role police culture and organizations have in suicide prevention and intervention.

## POLICE SUICIDES INTERNATIONAL V. UNITED STATES

A survey conducted by INTERPOL concerning police suicide from 1980-1989, revealed that fewer countries monitored suicide in their police officers, than monitored the deaths of police officers from homicide. INTERPOL calculated police officer suicide rates for 26 countries. The overall suicide rate for police officers did not appear to be consistently higher (or lower) than the suicide rate for men in the general population in the countries reporting data (Lester, 1992). The United States police officers rank second when compared with 36 occupations (Labovitz & Hagedorn, 1971).

Our neighbor Canada has a low suicide rate for police officers (Lester, 1992). Even with a low reporting rate of police suicide for the 20,000 member Royal Canadian Mounted Police, the researcher recommended the development of a reliable long-term police suicide data base. The research data demonstrated that the average annual rate of suicide was approximately half that of the comparable Canadian population. However, the Canadian researcher identified the need for psychological services policy and suicide prevention programs for Federal Police Force (RCMP) in Canada (Loo, 1986). The United States should conduct some comparative research based on the Canadian experience. Why does Canada rank low on police suicide and the United States high?

## POLICE CULTURE: THE SOCIAL CLIMATE

Police officers must be strong, brave and willing to face danger. Many of them may have trouble expressing their fears. Demonstrating emotions is not consistent with the established role model. The expression of a suicidal ideation is not encouraged or acknowledged because of the external dangers an officer faces in the daily police work environment. Therefore, there is difficulty in expressing suicidal ideation, or even identifying the potential in others. The police culture has an unwritten motto, "We the brave, are not allowed any cracks in our armor." Suicidal behavior is not allowed in our vocabulary or professional lexicon. Therefore, police officers may fail to see symptoms and may miss an opportunity for appropriate intervention.

The expression of personal feelings is presently limited within the police culture. In addition, organizations that are tightly controlled often discourage communication up the chain of command. The police profession instills conduct norms dictating that officers must remain calm and in control. They must constantly be on guard in order to avoid displays of emotion. The "chain of command" and constricted emotional factors interfere with open communication.

**"Because of the police norms to refrain from displays of emotions, officers find few opportunities to deal directly with the pent-up feelings engendered by traumatic events. Consequently, the aftermaths of tragedies are rarely discussed in terms of the impact on the officers involved. Police officers find themselves unable to reveal their feelings to other officers, much less discuss them, for fear of being viewed as inadequate or not having what it takes to be a solid, dependable police officer. As a result, interpersonal barriers against seeking common solutions to problems of "emotion work" are created and maintained." (Progrebin & Poole, 1991).** This lack of communication may interfere with early identification and prevention of suicidal behavior.

Emotional expression is also complicated by alcohol consumption and the bravado of the "choir boy practice sessions" after the swing shift. Many of these officers will stay up to the early morning hours engaging in a pseudo-therapy that may add to their stress oriented environment. Domestic problems are aggravated because of this behavior and the cycle of stress is never interrupted because of inadequate sleep. The abuse of alcohol may contribute to a stressful environment and even suicidal ideation. Alcohol abuse has also been strongly connected to suicidal behavior (Schwartz & Schwartz, 1976); (Lester, 1993). The suicide rate among police officers that abuse alcohol is high and officers commit suicide because of various personal problems (Lester, 1993).

## THE NEW YORK CITY PHENOMENON

In recent years, we have started to focus on violence and suicidal behavior in the work place. During 1994, police suicides in New York have reached new highs statistically, with eleven deaths. Moreover, police suicide has been the leading cause of police fatalities in New York City. Only two officers were shot by criminals. At that rate, police officers are killing themselves faster than they are being killed by criminals (Bratton, 1994).

An early study conducted in the 1930's revealed that 93 officers killed themselves during the years 1934 to 1940 in New York City. This study revealed that psychological problems were the most common reason for police suicide (Friedman, 1968). This research was conducted during the political reform era of Fiorello LaGuardia and focused on the individual officer and the case study method. However, the case reports of the Zilboorg-Friedman files did provide the basis for one excellent research tool. The files served as the basis for what has become known as the "psychological autopsy." They include the actual police department records and interviews with significant friends, coworkers, and family members (Heiman, 1977). New York City and other large cities are in the unique position to use the psychological autopsy and act as vanguard for this kind of research . The 35,000 officers size of this large department may produce an adequate sample population. However, other modes of inquiry and systematic research should be directed at mid-size and smaller police agencies. Police organizations should be compared to determine if a large paradigm of understanding can be identified or common patterns can be established. The New York phenomenon should not serve as a scientific generalization. It may not be scientifically valid for the rest of the nation, and conclusions must be avoided. The focus should address regional and local variations and the nature of the police organizations.

## THE SUICIDE PREVENTION PROGRAM

A twenty-five year old female officer committed suicide with her service revolver; everyone was astonished. She was among the best and the brightest in her field. Could it have been prevented? A middle-aged officer with twenty years of service takes his own life for no apparent reason and is found in his police cruiser. How can police administrators plan the appropriate intervention?

Is there any common pattern to be found in police suicidal behavior? The truth is, under the right circumstances, any member of the department may become depressed or commit suicide. However, certain patterns do appear that make prevention and intervention possible. At the present time, a typical suicide typology is not available. Enough has been learned about attempters and completers that general observations about suicidal people can be documented. For example, depression has been linked to suicide. Depressed police officers may experience problems associated with employment performance. One Canadian study found a serious drop in work performance six months prior to a suicide (Aussant, 1984).

Additional theoretical research is needed to fully develop the applied practice of prevention and intervention. There is an abundance of helpful information available from professional counseling practice. General observations about suicidal people may be applied to police organizations. The basic principles discussed in the following paragraphs should be useful for developing police suicide training programs.

Police administrators must understand that client resistance will remain the chief obstacle to communication with troubled officers. The officer fears that if the help is sought, employment and economic security will be threatened. This myth can be dispelled through departmental policy and the approach supervisors use when dealing with potential suicides. Education on the topic of depression and suicide, should be implemented for all personnel. If the officer receives the help, the individual may even develop into a better officer. Seeking help is not the end of a career, but the start of improving a new career. Asking for help is not a sign of weakness, but one of strength. This information must serve as the foundation for every prevention program.

An officer contemplating suicide is besieged on all fronts and has no place of refuge. Generally, problems exist on the domestic front and within the department. The escape behaviors of alcoholism, corruption and suicide start to appear viable. It seems like the only way out!

The only hope for prevention exists in keeping the door open for help. Police administrators and supervisors must play a non-punitive role. How do we keep the door open to the prevention program? The message must be constantly communicated: (1) seeking help will not result in job termination or punitive action; (2) all information concerning the officer will be respected and kept confidential; (3) there are other ways of dealing with the situation, no matter how hopeless it seems at the time; and (4) someone is available to help you deal with your problems. These four items remain formidable obstacles for police administrators to overcome. Police training and policy must communicate these four messages consistently.

### *Suicide Warning Signs*

The suicidal police officer is experiencing multiple problems. Suicide is not an unplanned activity. Suicide is usually the result of a long term, gradual wearing away process that exhausts the resources of the officer. The erosion of emotional coping skills results in the officer's inability to cope with stressful events. The officer does not decide: "What a wonderful day to kill myself!" There is a long trail of evidence leading to the final act of suicide. Suicidal officers may even "practice" the act by holding a gun to their head.

Because suicidal officers may decrease their level of performance for long periods of time before they are actually in crisis, detection is quite possible. Therefore, it is imperative that the

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early warning signs be recognized. Many have mixed feelings about dying and actually hope to be rescued. About 75% of suicidal individuals will give notice of their intentions(Grollman, 1988). The early warning signs must be recognized and teated as a serious form of communication.

What you should look for is a clustering of warning signs: (1) recent loss; (2) sadness; (3) frustration; (4) disappointment; (5) grief; (6) alienation; (7) depression; (8) loneliness; (9) physical pain; (10) mental anguish; and(11) mental illness. The strongest behavioral warning is an attempted suicide. Generally, the more recent the attempt the higher the risk factor for the officer. Police training officers need to incorporate suicide warning signs training as a regular part of a mental health program.

Police senior leaders, managers, and supervisors have major responsibilities concerning human relations. The human side of the enterprise is generally more difficult to handle than the technical issues. When an officer is not performing his mission at the optimal level for an extended amount of time, the problem has depth and needs addressing. The lack of performance and increased irritability may be related to a major depressive episode. When an officer has persistent anger, a tendency to respond to events with angry outbursts or blaming others over minor events, those behaviors should be considered indicators of possible distress.

## POLICE SUICIDE AND DEPRESSION

DSM IV Diagnostic and Statistical Manual on Mental Disorders suggest that depression is often a major factor in suicide. The mood disorder may be characterized as the "climate" rather than the temporary "weather condition." "Most major depressive episodes are at least two weeks in duration. Generally, changes in behavior include: (1) changes in appetite or weight; (2) sleep and reduced psychomotor activity; (3) decreased energy; (4) feelings of worthlessness or guilt; (5) difficulty in thinking and concentration; (6) difficulty in making decisions; (7) recurrent thought of death or suicide ideation; (8) finally, plans or attempt to commit suicide" (DSM IV, p. 320).

Police managers and supervisors need to assess significant distress or impairment in social and occupational performances during the conduct of police responsibilities. Police alcohol abusers tend to have more job related performance problems (Lester, 1993). A follow-up interview should be scheduled when the officer can be described as depressed, sad, hopeless, discouraged or "down in the dumps." During the interview: (1) check the officer's body language; (2) look for sad facial expression; and (3) flat mood. The feelings of the individual can be assessed by statements that indicate mood: (1) complain of feeling down; (2) have nonfeeling; feeling anxious; and (3) complaints about bodily aches and pains may be reported to cover the officer's real feelings. The typically suicidal officer is experiencing multiple problems and possible loss of significant others. No one is constantly suicidal. Most individuals have mixed emotions about committing suicide. Suicidal feelings tend to be episodic, they come and go, often in cycles.

## THREE IMPORTANT TERMS ASSOCIATED WITH SUICIDE

### *Hopelessness*

Officers who suffers a sense of hopelessness are candidates for suicide. Police personnel who think and speak in terms of hopelessness are in a high risk category. They act when their lives are devoid of hope. One officer charged with corruption and scandal probably felt rather hopeless in the face of that kind of adversity. The finality of the act of suicide may serve as a technique to restore control and reduce the feelings of hopelessness.

### *Helplessness*

Officers may see themselves as being helpless to meaningfully alter their situation. Therefore, officers who think or talk in terms of helplessness are also in a high risk category. Charges of corruption or drunk driving can exaggerate the twin feelings of helplessness and hopelessness. The ultimate escape may be an attempt to restore feelings of former strength, courage and mastery over the environment (Bonafacio, 1990).

### *Strengths of Significant Others*

Suicidal officers may have negatives in their personal lives. Supervisors should look for histories which may include suicidal behavior, mental illness, chronic depression, multiple divorce and alcoholism. Look for the losses in the officer's life, drug abuse patterns and stress overload. The older officer may experience physical problems or impending retirement and feel socially isolated (Schwartz & Schwartz, 1976). Both of these losses can create feelings of hopelessness and helplessness.

## INTERVENTION: POLICE SUICIDE

The overwhelming majority of suicidal officers do not want to die! The typical officer wants to be rescued, but does not want to ask for assistance. Many are not certain how to address the plea for help and the officer doesn't know what they want specifically done. This state of confusion actually works to the advantage of the police leader because the suicidal officer is looking for a strong authority figure to direct his emotional traffic. Therefore, it is important that the supervisor quickly assure the suicidal officer that he/she is definitely capable of rendering support and assistance. The situational leadership style is one of directing and telling.

An officer in a suicidal state of mind is open to suggestion. Therefore, the officer is likely to respond to your direction. Don't ask: "What do you want to do?" You must be the voice of authority. Tell the officer what you expect and demand that the officer respond to your directions. Most suicidal individuals experience a suicidal episode only once in their lives (Grollman, 1988). It may last days, hours, minutes or seconds. If you can stop them with appropriate intervention, they probably will not kill themselves in the future. Some of course will,

*Continue on page 41*

*Continued from page 39*

but most will not if they can get past the crisis.

Planned supervision and intervention should concentrate on the assessment of specific behaviors that lead to a professional referral. This situation must be carefully thought out in order to avoid violence directed inward or outward at other employees. There may be a real danger of suicide or homicide followed by suicide. This is not always the case, but this response is possible with deep depression. The police leader interventionist must recognize early warning signs thus identifying those who are potentially suicidal. An appropriate referral must be made and followed through to see that the officer was actually evaluated and continued intervention is in place.

An individual contemplating suicide is not in the position to make an appropriate decision for themselves. The officer is asking you to make the decision for them. It's important to ask the question: "Are you having thoughts of hurting yourself?" Police managers and supervisors may find it difficult to ask that basic question. This is not a time for delegating... it is the time for direction, support and action! Do not leave the officer alone if he/she indicates they are having suicidal thoughts. All threats must be taken seriously. Others may not have heard the officer's request for help.

Many officers feel that referral to a mental health professional would mean the loss of their job. Police supervisors have a similar value system and because of this belief, fail to take the appropriate action. As a group, police officers and supervisors have often protected the officer experiencing depression. However, when it becomes an obvious cover-up, a disservice is done to the officer. Don't accept the notion that you should not confront the problem because of the officer's employment. The supervisor is not being disloyal when you help an officer in distress. The sergeant or lieutenant initiating the process may save a life. The position of being a police officer is only of value to the living, not the dead. Officers cannot handle the solution to this kind of problem alone. They need help! Many of these officers spend a great deal of time helping other people in tragic circumstances, but cannot seek help themselves.

Police supervisors need to be trained to recognize the warning signs of suicide. Hopefully, with this kind of training in a formal prevention program, there can be successful interventions. The police sergeant is in an unique position, in the organization, as a first-line supervisor to demonstrate the human relations and leadership skills necessary to take positive action. Excellent leadership has an opportunity to stop the "dance of death," poor leadership does not. The suicidal officer needs your help and support. The proper referral and follow-up is essential to a successful outcome.

Violenti (1995) cites several essential remarks concerning police suicide and the role of police agencies: (1) the first step is to recognize that the suicide problem exists; (2) police agencies should be at the forefront of developing suicide intervention programs; (3) police organizations must develop effective suicide countermeasures; (4) training police supervisors to recognize the warning signs of suicide can afford agencies an opportunity to intervene before it is too late; and (5) police agencies should ensure that appropriate referrals outside the organization are available. It is the authors' recommendation that the process of intervention be made as easy and supportive as possible.

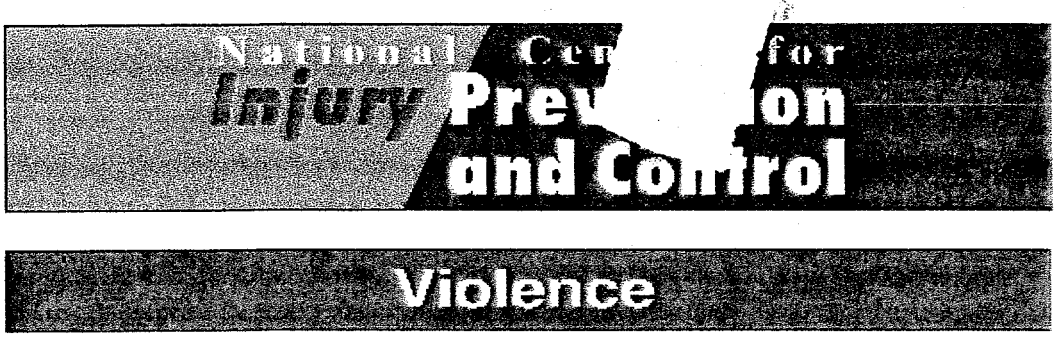
## DISCUSSION

The present state of research on police suicide is scarce and a paucity of data presents problems for the development of police intervention and prevention programming. The information tends to be descriptive and statistical. The chief weakness of the research appears to be the failure to focus on the role of police agencies. Most of the research does not reflect the role of the social environment and shifts the focus to the individual officer. Analyzing police organizational structure may help find a few of the elusive answers.

It definitely appears from the research, that being a police officer does increase one's risk of committing suicide. However, some of the data may not be accurate because of the concealment and misrepresentation of evidence concerning police suicide. The future research may indicate an even higher rate of police suicide than originally documented. Another key problem in obtaining accurate data is that some officers may commit indirect suicide. These individuals may consistently and deliberately expose themselves to unnecessary danger. This may be recognized as bravery by peers and even rewarded by the department. However, their unconscious intent may be the desire to be killed "in the line of duty." This high risk behavior may be quite purposeful and deadly.

The authors have raised several research questions that have not been answered concerning prevention and intervention. Hopefully, we will find some of the answers to those questions in the near future. Most of the applied research should be directed at prevention strategies: (1) counseling programs; (2) alcohol abuse programs; (3) stress management programs; (4) peer support systems; (5) recognizing the warning signs of suicide; (6) leadership and supervision development; and (7) the monitoring of police performance. We must apply the elements of social scientific thinking to these issues in order to develop appropriate policies. Excellent theoretical research may lead to the solution of many of our applied problems.

An appropriate intervention is possible during a specific time-frame, but denial plays a key role in the delay of assistance. Everyone must stop pretending that the problem does not exist or that it will go away. When an officer pulls a weapon out and threatens to use it to commit suicide, "the process" is in the advances stages. Someone must break the silence of denial, take action and stop the "dance with death." Without the research, prevention programs, and proactive training, the "suicide cycle" will continue to take its toll.




# Suicide in the United States

## The Problem

- Suicide took the lives of 31,284 Americans in 1995 (11.9 per 100,000 population).
- More people die from suicide than from homicide in the United States. In 1995, 22,552 Americans died from homicide (8.58 per 100,000 population).
- Overall, suicide is the ninth leading cause of death for all Americans, and is the third leading cause of death for young people aged 15-24.
- Although the age-adjusted suicide rate has remained constant since the 1940s, suicide rates have shifted for some groups during the period between 1980 and 1992. For example, suicide rates have increased among persons between the ages of 10 and 19, among young black males, and among elderly males. Suicide rates for middle-aged adults declined during this period, but, for the first time since the 1930s, increased among Americans over the age of 60.
- Nearly 60% of all suicides are committed with a firearm.
- In 1995, more than 90% of all suicides in this country were among whites, with males accounting for 73% and females 18% of all suicides. However, during the period from 1979-1992, suicide rates for Native Americans (a category that includes American Indians and Alaska Natives) were about 1.5 times the national rates. There was a disproportionate number of suicides among young male Native Americans during this period, as males 15-24 accounted for 64% of all suicides by Native Americans.
- Suicide among black youths, once uncommon, has increased sharply in recent years. In 1980, the rate of black suicide for teens 15-19 more than doubled from 3.6 per 100,000 to 8.1 per 100,000. Although white teens still have a higher rate of suicide, the gap is narrowing.

## CDC's Program in Suicide Prevention

The National Center for Injury Prevention and Control (NCIPC) is working to raise awareness of suicide as a serious public health problem, and is focusing on science-based prevention strategies to reduce injuries and deaths due to suicide. Current activities include the following:

- A case-control study that is examining possible risk factors for suicide, include alcohol use, exposure to previous suicides, and residential mobility that might lessen opportunities for developing social networks.

- Convening national conferences to exchange information about research and prevention strategies (a national suicide prevention conference in Reno in October 1998 and a conference on suicide prevention among American Indians and Alaska Natives in San Diego in November 1998).

- Support for extramural research that will examine risk factors for suicide in the general population.

- Development of a national suicide prevention center.

- Continued support for a Native American suicide prevention center.

- Evaluation of the effectiveness of current suicide prevention programs.

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**Suicide prevention resource materials available from CDC:**

Centers for Disease Control and Prevention. Suicide Prevention Evaluation in a Western Athabaskan American Indian Tribe–New Mexico, 1988-1997. MMWR 1998;47 (No. 13):257-261.

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Potter LB, Powell KP, Kachur SP. Suicide prevention from a public health perspective. Suicide and Life-Threatening Behavior. 1995; 25(1):82-91.

Click here to order the publications listed above

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**National Center for Injury Prevention and Control**
**Division of Violence Prevention**
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**Mailstop K60**
**4770 Buford Highway**
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*Revised 04.09.98*

San Francisco Suicide Prevention
America's Oldest Community Crisis Line

# Suicide Statistics

## In the United States and San Francisco – 1991

- There were 30,810 suicide deaths in the United States in 1991 representing 1.4% of total deaths.
- Suicide is the 8th leading cause of death in the United States.
- Every year, there are more suicide deaths in the United States than homicides.
- The state with the highest suicide rate was Nevada at 24.8 per 100,000 population. The lowest was the District of Columbia at 6.6 per 100,000.
- Suicide rates for the U.S. are average among industrialized nations and generally higher than developing countries.
- Generally, the suicide rate in the United States has been level over the past 90 years, peaking at a rate of 17.4 per 100,000 population in 1932 and ranging from 12.0 to 14.0 per 100,000 over the past ten years.

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What You Can Do
Plaid Pals
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## Gender

Men are much more likely to kill themselves than women.

- Men account for 80% of all suicides in the United States.
- Generally, women are more likely than men to make suicide attempts, as over 50% of suicide attempts are made by women. However, men are much more likely to be successful at killing themselves as they choose more lethal methods of suicide.

## Age

Suicide rates increase with age.

- People 75-84 years old have the highest suicide rate of any age group at 23.5 per 100,000

- Elderly, white men over the age of 65 have a high risk of suicide with a rate of 42.7 per 100,000 population. Non-white elderly men have a suicide rate of 16.7 per 100,000.
- In comparison, women over age 65 have a suicide rate of 6.0 per 100,000 population.

## Ethnically

Whites have the biggest suicide rates among ethnic groups.

- Generally, communities of color have lower rates of suicide than whites. However, these differences in suicide rates are much more dramatic in older adults.
- Adolescents and younger adults representing communities of color have lower suicide risks than whites, but usually only 30% to 40% lower.
- Some Native Americans in certain tribes have dramatically high suicide rates, particularly among male adolescents, reaching rates of 44.0 per 100,000 population.
- White males account for 70% of all suicides.

## Mental Disorders and Substance Abuse

Major risk factors.

- Mental and addictive disorders are central risk factors for suicide. More than 90% of completed suicides are associated with these disorders.
- 20% of men and women with unipolar depression or bipolar disorder commit suicide, 13% of schizophrenic patients commit suicide, and 10% of patients with personality disorder commit suicide. This is 10 to 15 times the rate of the general population.
- Only 3% of alcoholics commit suicide, but since alcoholism is so prevalent in society, 33% of all suicides involve alcoholism. Most alcoholics who commit suicide have over 20 years of alcohol abuse before dying. Few suicides are reported in alcoholics under age 40.

## Adolescents

Suicide is the third leading cause of death, and climbing.

- Generally, suicide rates decrease with age. However, since fewer young people die of health related causes, suicide is a leading cause of death among adolescents.
- Suicide rates among adolescents have significantly increased over the past forty years. In 1950, the rate for people ages 15-24 was 4.5 per 100,000 population. In 1990, the rate tripled to 13.2 per 100,000.
- As with adults, the majority of adolescent suicides are committed by males. Among 15-24 years olds, 73% of suicides are committed by males. As with adults, female adolescents are far more likely to attempt suicide. For youth hospitalized after a suicide attempt, 1 out of 12 males succeed in committing suicide while only 1 in 300 females are successful in committing suicide .
- Among 15-24 year olds, suicide is the third leading cause of death with a suicide rate of 13.1 per 100,000 population.
- Suicide rates at college campuses tend to be lower than the age adjusted general population.

## Suicide Methods

Most suicides are committed by firearms.

- Over 60% of all suicides are committed by firearms, and 80% of all firearm suicides are committed by white men. Hanging is the second most common method of suicide.
- Drug overdose accounts for over 70% of suicide attempts, although the vast majority of overdose attempts are unsuccessful.

## Jails and Prisons

High suicide rates.

- Suicide is the most frequent cause of death in U.S. jails. A high rate of 90 to 230 per 100,000 population commit suicide in jail or prison. That is 16 times the rate for the general population.
- Most people who commit suicide in jail were arrested for non-violent crimes.
- 90% of suicides in jails are by hanging and 50% of suicide victims in jail or prison are intoxicated with drugs or alcohol at the time of death.

## San Francisco Statistics

July 1, 1992 through June 30, 1993.

- During the 1992-93 fiscal year, 133 suicides were recorded among San Francisco residents.
- In San Francisco, there are more suicides than homicides.
- Similar to national averages, 81% of San Francisco suicides were among whites and 73% among males.
- While the Golden Gate Bridge has a long history of people committing suicide by jumping, the actual number of suicide deaths from the bridge is relatively low compared to firearms, drug overdose and hanging. However, well over 1,000 people have died from jumping during the history of the Golden Gate Bridge. The actual number is not known. San Francisco has a history of attracting residents from other counties and states who come to San Francisco to attempt suicide. These suicides are not recorded in the above statistics.

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Sources: Suicide & Life --Threatening Behavior, Volume 25, Number 1, Spring 1995. Annual Report, Medical Examiner's Office, City and County of San Francisco, 7/1/92 -- 6/30/93

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# Pitfalls: What to Avoid

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Do not shy away from the topic of suicide. Suicide is ugly. It reminds us of a whole world of things that we do not wish to think about. Because suicide arouses great fear and anxiety, we actively avoid the topic. Feelings of guilt and responsibility haunt us. Our emotions are intense and so we deny the reality of the suicidal person's concerns.

The person in crisis is troubled and has problems that need to be discussed openly. If not taken seriously the suicidal crisis could worsen. By not asking obvious questions or avoiding the topic, it and may seem as if you are not interested. He will probably feel rejected, guilt ridden, and more deeply disturbed.

**Avoid moralizing.** It is ineffective to tell the person that it is wrong and against God's will to commit suicide, or to remind him of obligations to family and society. The suicidal person carries a heavy load of guilt and moral arguments only add to this burden.

**Do not be aggressive.** Suicidal people sometimes make us feel hopeless and impotent, to which we often respond by becoming belligerently helpful. We urge the potential suicide to live in order to justify ourselves. Emotional exhortations based upon our own needs are futile.

Do not try too hard to reassure the person. You may be tempted to rescue the potential suicide by telling him that he is a good guy and that life is worthwhile. Your efforts will only succeed in making the individual feel rejected, misunderstood, and dismissed. The suicidal person does not like himself nor does he feel life is meaningful. Telling him that he is a good guy and that there is hope is worse than useless.

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# STATISTICAL INFORMATION

**Incidence of suicide among Native American young people, ages 15-24, is nearly three times that of the U.S. national rate (Indian and Alaskan Native rate is 37.5 per 100,000 vs. 13.2 per 100,000 U. S. all races according to the Indian Health Service Trends 1989-91).**

**Although rates per 100,000 are good indicators of trends and the problem within large populations, they do not adequately measure the emotional and social impact of suicides among small Indian communities.**

HOME (Frames) (No Frames)| SUICIDE PREVENTION | CRISIS INTERVENTION | ART & HEALING | WISDOM OF THE ELDERS |

SITE MAP & RESOURCES

# FOUR TYPES OF DANGER SIGNALS

**Look for a clustering of warning signs within a context of: recent loss, sadness, frustration, disappointment, grief, alienation, depression, loneliness, physical pain, or mental anguish.**

## I. Suicidogenic Situations--the situation itself is conducive to suicidal thoughts and feelings.

## II. Depressive Symptoms --the person has several symptoms which are commonly associated with the syndrome of depression:

- **Insomia**
- **Inability to concentrate**
- **Anorexia**
- **Weight loss**
- **Loss of sex drive**
- **Anhedonia (can't experience pleasure)**
- **No energy or hyperactive**
- **Apathy no desire to socialize**
- **Seems withdrawn**
- **Seems preoccupied**
- **Often appears bored**
- **Agitated easily**
- **Poor personal hygiene**
- **Crying**
- **Feeling worthless**
- **Low frustration tolerance**
- **Dwells on problems**
- **Morbid views**
- **Appears sad**

## III. Verbal Warnings--

- **"I'm going to kill myself!"**
- **"I wish I were dead!"**
- **"It hurts too much."**
- **"The only way out is for me to die."**
- **"I just can't go on any longer."**
- **"You won't be seeing me around any longer."**
- **"You're going to regret how you've treated me."**

- **"It's too much to put up with."**
- **"Life has lost its meaning for me!"**
- **"Nobody needs me anymore."**
- **"I'm getting out of here."**
- **"Here, take this (valued possession); I won't be needing it anymore."**

**IV. Behavioral Warnings--**

- **The giving away of a cherished object in a casual manner.**
- **The strongest behavioral warning is an attempted suicide!!!**
- **It has been estimated that about 45% of the people who kill themselves have previously attempted to do so before.**

TOP

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# ASSESSMENT

## D - I - R - T

## An assessment of the past suicide attempt.

**D - Dangerousness - the greater the dangerousness in the attempt.**

**I - Intent - If she honestly believed that she would die, then the present risk is higher.**

**R - Rescue - If she aided in her own rescue in any way, even at the last minute, then the present risk is lower.**

**T - Timing - The more recent the attempt, the higher the current risk.***

**Note: Any unexplainable deviation from an ingrained behavioral pattern or sudden unexplainable recovery from a severe depression.**

## S - L - A - P

## An assessment of the degree of risk.

**After you realize the person is at risk, assess the degree of risk. Always begin an assessment with "how?", i.e., "How would you harm or kill yourself?" If the person has a plan of attack, use the acronym SLAP.**

**S - Specific - details in the "plan of attack."**

**L - Lethality - level of the proposed method.**

**A - Availability - of the proposed method.**

**P - Proximity - of helping resources.**

**Note: This approach may not be a reliable technique with alcoholics, drug addicts, psychotics, or others with highly impulsive personalities.**

*** Remember the 3-month guide; the person may gain energy after an initial exhaustion in the first 3 to 4 months.**

TOP

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HOME (Frames) (No Frames)| SUICIDE PREVENTION | CRISIS INTERVENTION | ART & HEALING | WISDOM OF THE ELDERS

SITE MAP & RESOURCES

*Tuberculosis Morbidity — Continued*

promptly identifying HIV-infected contacts of persons with infectious TB and ensuring that contacts who may be infected with *M. tuberculosis* complete appropriate preventive therapy. Other important strategies include screening for *M. tuberculosis* infection among persons with recently identified HIV infection, ensuring completion of preventive therapy among those with *M. tuberculosis* infection, and periodic monitoring and education of those who are not infected with *M. tuberculosis* (*7,8*).

Outbreaks of MDR-TB, particularly among HIV-infected persons, contributed to the resurgence of TB in the late 1980s and early 1990s. Since CDC began monitoring anti-TB drug resistance through the national TB surveillance system in 1993, levels of isoniazid resistance have been relatively stable, and the number and proportion of MDR-TB cases has decreased (*9*). Nevertheless, 43 states and the District of Columbia reported at least one MDR-TB case during 1993–1997. All health departments should be prepared to promptly identify persons who have active TB disease, to ensure that standards of care are met with respect to diagnosis and treatment (including prompt initiation and completion of therapy), and to identify and appropriately treat those who may have been infected through close contact with persons who have infectious TB.

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## Suicide Prevention Evaluation in a Western Athabaskan American Indian Tribe — New Mexico, 1988–1997

Since 1979, suicide and homicide have alternated as the second and third leading causes of death* among young American Indians and Alaska Natives (AI/ANs). From 1979 through 1992, suicide rates for AI/ANs in all age groups were approximately 1.5 times the rates for the overall U.S. population. During 1991–1993, suicide rates for AI/ANs aged 15–24 and 25–34 years were 31.7 and 26.6 per 100,000 population, respectively; males aged 15–34 years accounted for 64% of all AI/AN suicides (*1*). In the overall U.S. population during 1991–1993, the rates for persons in these same age

*The leading cause of death has been injury resulting from motor-vehicle crashes.

*Suicide Prevention — Continued*

groups were 13.0 and 14.5, respectively (*2*). Since 1980, suicide has been either the second or third leading cause of death for persons aged 15–24 years in the overall U.S. population (*3*). Although knowledge about suicide among AI/ANs has increased (*4*), information about the efficacy of suicide prevention and intervention programs in general, and specifically in AI/AN communities, is scarce. In January 1990, following concern raised by tribal officials in 1988 about suicide among youth, a Western Athabaskan tribe in rural New Mexico implemented a suicide prevention and intervention program that targeted tribal members aged 15–19 years (*5,6*). This report summarizes the results of the program through 1997 and indicates that rates of suicide and attempted suicide among this target population decreased substantially after the program was implemented.

From 1988 to 1997, the tribal population increased from 2762 to 3225. The population of tribal members aged 15–19 years increased similarly, from 283 to 328. Ninety percent of the population lived on the reservation, primarily in the one reservation town. Approximately 80% of persons aged ≥16 years were unemployed, with some seasonal variation (Western Athabaskan Tribe, unpublished data, 1998).

The prevention and intervention program included previously unavailable services for the entire community. CDC guidelines for containing suicide clusters (*7*) and developing suicide prevention programs among adolescents and young adults (*8*) were incorporated into program activities.

School-based "natural helpers," comprising 10–25 youth per year, were trained to respond to young persons in crisis and to notify mental health professionals of the need for assistance. Natural helpers also provided education in both the school and community on alcohol and drug prevention, self-esteem and team building, and suicide prevention. Prevention of alcohol abuse, child abuse, and violence between intimate partners was included in the program because these behaviors have been associated with suicidal behavior (*4*). Other program components included outreach to families after a suicide or traumatic death or injury, immediate response and follow-up for reported at-risk youth, community education about suicide prevention, and suicide-risk screening in mental health and social service programs.

A surveillance form developed by IHS in 1988 was revised and used by local professional staff to collect information about suicide completions and attempts. Attempts included both self-inflicted injuries requiring medical or other intervention to prevent death and injuries that may have required medical intervention but were not potentially lethal. Program staff assessed all persons who made suicide attempts. Information about suicide completions was obtained from police records, health clinic records, tribal emergency medical services records, and family and community members. Rates of suicidal acts before and after program implementation for persons aged 15–19 years were compared to assess program effectiveness.

Demographic information obtained about persons who committed a suicidal act included age, sex, marital status, tribe, employment, education, and living arrangements. Other pertinent information collected included method used, number of previous suicidal acts, location of suicidal act, alcohol and/or substance abuse, family history of suicidal behaviors, loss of job, break-up with or death of a significant other, and suicide of a friend.

During 1988–1997, a total of 118 persons in all age groups accounted for 237 suicidal acts (i.e., all suicide completions and attempts). Sixty-four (54.2%) of these

*Suicide Prevention — Continued*

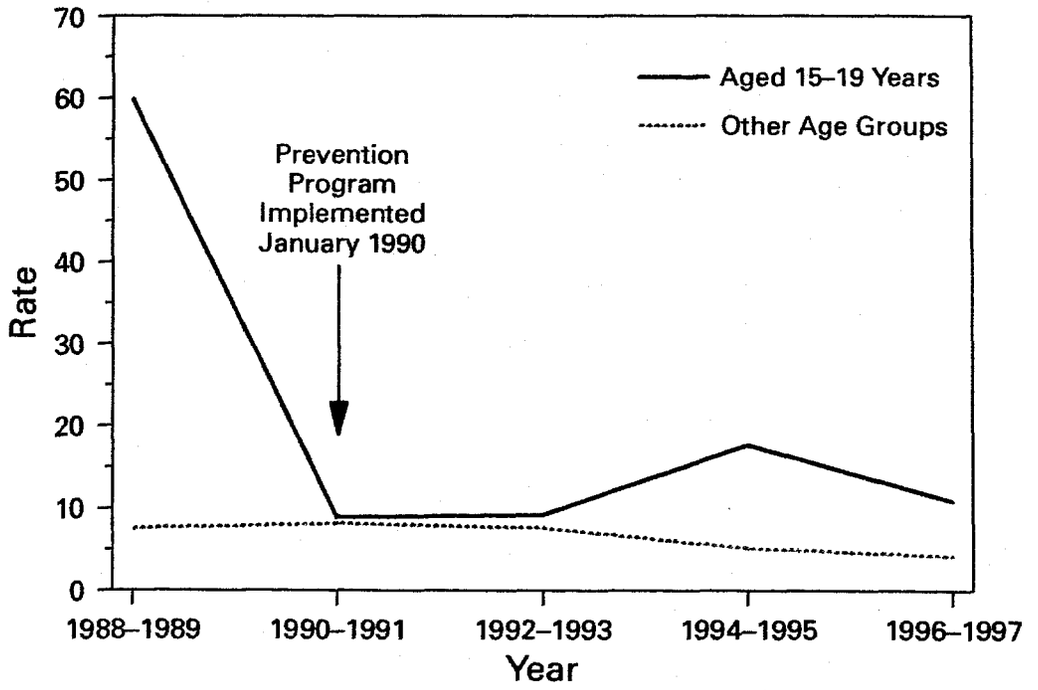
persons had previously exhibited suicidal behaviors; 165 (69.6%) of all acts involved alcohol use. Of all suicidal acts, 15 (6.3%) resulted in death; all suicide completions were among males. The ratio of suicidal attempts to suicidal completions was 14.8:1. Males accounted for more attempts than females (114 males, 108 females). Of all these suicidal acts, 61 (25.7%) occurred among persons aged 15–19 years.

Rates of suicidal acts for persons aged 15–19 years and for all other age groups were calculated in 2-year intervals for rate stability (Figure 1). The numbers of suicide completions were too small to calculate separate rates by age group. During 1988–1989 (i.e., before program implementation), the suicidal act rate for persons aged 15–19 years was 59.8 (n=34) per 1000 population, compared with 7.5 (n=38) per 1000 for all other age groups. During 1990–1991, the rate for persons aged 15–19 years decreased to 8.9 (n=5) per 1000 population. This rate increased slightly to 9.2 (n=5) during 1992–1993, rose to 17.6 (n=10) during 1994–1995, and decreased to 10.9 (n=7) during 1996–1997. Although rates varied after implementation of the program, they remained substantially lower than before the program was initiated. During these same time periods, rates for all other age groups demonstrated considerably less variation.

*Reported by: Western Athabaskan Tribe. P Serna, MSW, American Indian/Alaska Native Suicide Prevention Center and Network; PA May, PhD, Univ of New Mexico, Albuquerque, New Mexico. M Sitaker, MPH, Office of Epidemiology and Assessment, The Combined Health District of Montgomery County, Dayton, Ohio. Indian Health Service, Albuquerque, New Mexico. Div of Violence Prevention, National Center for Injury Prevention and Control, CDC.*

**Editorial Note:** Since this program was implemented in 1990, rates of suicidal acts substantially decreased for members of the Western Athabaskan tribe aged

**FIGURE 1. Rates* of suicidal acts† for persons aged 15–19 years compared with persons of all other age groups, by year§ — Western Athabaskan Tribe, 1988–1997**




*Per 1000 population.
†Includes suicidal attempts and completions.
§Rates calculated in 2-year intervals for rate stability.

*Suicide Prevention — Continued*

15–19 years. Aspects of the program that possibly contributed to the decrease in rates included multiple prevention and intervention strategies within a centralized population and full-time program staff dedicated to suicide prevention and intervention. A decrease in suicidal behaviors coincident with community education and heightened screening suggests an actual program effect. This decrease in suicidal behaviors occurred despite consistent surveillance and heightened community education about suicide prevention.

The results of the program evaluation are subject to three limitations. First, the program was not implemented simultaneously in a comparison group or population, which made determination of program effectiveness difficult. Second, it could not be determined which program prevention components were associated with the reduction in suicidal acts. Finally, during 1958–1987, Athabaskan tribes in New Mexico demonstrated a cyclical increase and decrease in the rate of suicide completions every 5–6 years (*9*). An analysis of suicide prevalence rates since 1987 for other Athabaskan tribes in New Mexico will be necessary to compare populations who have not implemented suicide prevention activities and to determine 1) whether cyclical patterns of suicide completions have continued in Athabaskan tribes, 2) whether the suicide prevention program was implemented during a downward cycle or has had the suggested impact in reducing suicidal behaviors, and 3) whether patterns of suicide completions (i.e., excluding nonfatal suicidal acts) adequately measure the success of local prevention programs.

Additional research is needed to determine both risk and protective factors for suicide and the reasons for higher suicide rates in some AI/AN communities. Sociocultural factors that might be involved include the availability of employment and educational opportunities, the role of alcohol in AI/AN communities, community history of suicidal behavior, and loss or maintenance of traditional spiritual practices and indigenous languages.

During 1993–1994, suicide prevention activities in this community were expanded to include persons aged 20–24 years. Further evaluation will be necessary to determine the effect of the program on persons in this age group. CDC guidelines for prevention of suicide among adolescents and young adults suggest avoiding reliance on any one strategy (*8*). Additional investigation is necessary to determine which strategies are most effective in preventing suicidal behavior among AI/ANs. The suicide prevention program in this American Indian community underscores the value of consistent surveillance to track trends in suicidal behaviors and assess program effects. Replication and evaluation of similar programs are needed to further develop effective suicide prevention strategies for adolescents and young adults.

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## Rift Valley Fever — East Africa, 1997–1998

In December 1997, the Kenya Ministry of Health and the World Health Organization (WHO) in Nairobi received reports of 478 unexplained deaths in the North Eastern province of Kenya and southern Somalia. Clinical features included acute onset of fever and headache associated with hemorrhage (hematochezia, hematemesis, and bleeding from other mucosal sites). Local health officials also reported high rates of illness and death resulting from hemorrhage among domestic animals in the area. This report describes the preliminary results of the outbreak investigation and the results of a serologic survey.

From late October 1997 through January 1998, torrential rains occurred in most of East Africa, resulting in the worst flooding in the region since 1961 and rainfall that was 60–100 times the seasonal average (National Climatic Data Center, unpublished data, 1998). Diagnostic testing of the initial 36 specimens received at the National Institute of Virology, South Africa, and at CDC confirmed acute infection with Rift Valley fever (RVF) virus in 17 (47%) persons from whom specimens were obtained; confirmation was made by detection of IgM antibodies, virus isolation, reverse-transcriptase-polymerase chain reaction for viral nucleic acid, or immunohistochemistry.

Active surveillance conducted by WHO, the Kenya Ministry of Health, and international relief organizations during December 22–28 in 18 villages (population: 200,000) in Garissa district, North Eastern province, Kenya, identified 170 deaths resulting from a "bleeding disease." Severe flooding and large distances between settlements complicated case ascertainment and subsequent evaluation. Despite these constraints, the surveillance system received reports and blood specimens for 231 cases of unexplained severe febrile illness with onset from November 25, 1997, through February 14, 1998. Of the 231 reported cases, 115 met the case definition for hemorrhagic fever (i.e., fever and mucosal or gastrointestinal bleeding). Of the 115 patients with hemorrhagic fever, 58% were male (median age: 30 years [range: 3–85 years]); diagnostic testing demonstrated acute RVF viral infection in 27 (23%) (Figure 1). Of the 116 persons whose illnesses did not meet the case-definition for hemorrhagic fever, 26 (22%) had acute infection with RVF virus. Of these 26 persons, 14 had symptoms compatible with complications of RVF viral infection, including nine with neurologic

# THE PSYCHOLOGY OF SUICIDE



## IDLE TALK ABOUT POWERFUL SYMBOLS:

**I spent some time with an Navajo elder some years ago and he told me that his people did not talk about death. There had just been nine young people that had taken their lives on the Wind River Reservation in Wyoming. I kept thinking, "How can you not talk about death when our young people are taking their lives?" Some friends and I were working with young Indian students at Southwestern Indian Polytechnic Institute in Albuquerque and we wanted to address this problem. In our Native ways we are taught to respect elders and not question them. It took some time to think about what he meant and when the understanding came, it turned my life around.**

**Death is a very powerful symbol and we cannot talk about it in an idle, or casual way, as it will bring "bad energy" around and people will become ill. In our Native ways, we are provided guidelines for dealing with death and loss--IN CEREMONY!. We are told that when the ceremony is completed, that we must "let go" so that the spirit can cross over. If we hold on too much, or too long, we prevent the spirit from going to the "spirit world". It will hang around and may make us, or someone else in our family or community, sick.**

## IT GROWS INSIDE YOUR HEAD:

**Last year, I was conducting some research at the Newberry Library in Chicago and I came across "Iroquois Suicide", by William Fenton (Anthropological Papers -- Vol.14, Smithsonian Institute; Bureau of Ethnology, 1941), a reference to Iroquois suicide in the mid-1800's.**

**Fenton points out that the Iroquois used various social controls (i.e., sayings) to express displeasure or, disapproval as a way of controlling (taboos such as suicide). One such story was clearly about the taking of one's own life. Fenton said that the Iroquois believed that we are given an allotted life span. This view of natural death, as the departure on the long trail leading westward to the spirit world, marshalled Seneca public opinion against suicides. "We have an allotted time and when it's time, you will go, no matter what"...and "if through violence (against self), the spirit will be earthbound".**

**My interest was piqued by the reference to the primary method used to commit suicide. Evidently it had become a tradition, a choice, to take their life by ingesting the root of the water hemlock. The death was quite painful.**

**The story that accompanied the tradition was about a plant, with delicate white flowers (the water hemlock), that would "grow upon the grave" of those who committed suicide in this manner. Fenton indicated that the Iroquois believed that "hemlock compels the potential suicide to seek it and that the plant is said to call and show itself". This was contrary to "curing plants who reveal themselves to help people".**

**One powerful message for understanding about the psychology of suicide came when Fenton referred to an interview with an elder about the story of the white flower growing on the grave. The old man told him, "No, no! It grows in the head of its victim until he takes it, and then it comes up later from his grave!"**

**One difficulty in working with people that are depressed, or are suicidal, is that "their pain and/or hopelessness" does not seem rational to US -- to THEM it is no less painful or hopeless. The depression or suicidal ideation "grows in their head" and while WE may not feel the pain, or hear the "call of the hemlock", they DO. We must take ALL suicidal guestures seriously.**

**It would seem that there are also clues to possible therapy, prevention and intervention in these "teachings" We see them in almost all healing principles: 1. We have to "want" to become well (as in the curing plants who reveal themselves to help people) and willing to listen and be open to the possibility. 2. Both individuals and communities are subject to "being in their heads" when in crisis. It is a form of hysteria. Subsequently, in order to think straight, plan, and begin a healing process, it is critical to affect some radical shift of consciousness. Unfortunately, for many, this often means "hitting bottom" before they are ready to do something about it. Our responsibility, as a caring community is to be there for them and to help them choose healthy alternatives.**

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HOME (Frames) (No Frames)| SUICIDE PREVENTION | CRISIS INTERVENTION | ART & HEALING | WISDOM OF THE ELDERS |

SITE MAP & RESOURCES

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# ALTERNATIVES TO SUICIDE:

## Exploring Options

**Think about a time in the past year when you have felt sad and hopeless. . .**

**Think about a time in the past year when you've been so excited that your joy spilled out to others. . .**

**Have you ever noticed how "nothing lasts forever?"**

**Just when you're certain you'll never get over this - along comes something or someone you never anticipated. . .**

**Just when you're certain you're "on top of the world" things take a bad turn. . .**

**This is a picture of life:**

**When we are young, we lack experience in life. Our emotions are very much "in the moment". We respond to exactly what is happening to us at that moment in life. We do not have enough experience to know that the next day or the next week may be different. For example, if a young person loses a girl friend or boy friend that they are very much "in love" with, it does not matter what we think or tell them. They respond to "the moment" as though there will be no tommorrow or another love of their life. The loss is emotionally devastating. They do not have the experience to know that life has it's ups and downs and that they will likely have many relationships come and go--for them, in that moment, the loss is extremely painful. They do not know how to deal with it. At this time, they are extremely high risk.**

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# HOW TO HELP:

**TAKE threats seriously. The person is asking for your attention.**

**WATCH for clues.**

**ANSWER cries for help by listening with understanding. Try to listen for the "feeling" which the person is expressing. Let him/her know you hear. . . and care that they're hurting now. Share with your friend an experience you have had in which you felt sad and hurt, or scared. Help him/her to realize other options to relieve the bad feeling.**

**CONFRONT the problem directly. Don't be afraid that you will "goof up." You might ask, "Is it feeling so hopeless right now that life doesn't seem worth it anymore?" You needn't offer advice - just listen and care. Discussing it may help lead the person away from actually committing suicide. Because one thinks it, one doesn't have to do it. Talking it out helps lift the clouds.**

**ENCOURAGE the person to seek help through parents, counselors, social workers, etc. You may know someone he/she is particularly fond of. Suggest that, and offer to make the call while your friend is with you. You may even offer to accompany him/her to see someone, if that seems helpful. If you get stuck, or scared, talk to someone yourself and find out what you might do next - don't be afraid to help your friend.**

**YOU are not responsible for your friend's life. The choice if theirs. But you may give hope and remind your friend that SUICIDE IS A PERMANENT SOLUTION TO A TEMPORARY PROBLEM.**

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# WHERE TO GET HELP:

**Feel free to contact any of the following:**

- **school counselor, teacher, parent - family physician**
- **emergency mental health facility - psychiatrist, psychologist**
- **local hospital emergency - clergyman**

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# Wisdom of the Elders

**This section will evolve. Stories will be added and changed periodically. Each will reflect different perspectives of the same issue -- the human journey**



## WISDOM OF THE ELDERS:

**by: Black Bear from the Blackfeet Tribe in Montana--an artist/scholar**

**The drum stopped and the plaintive song ended. The circle of dancers slowed and came to a halt, looking at each other with bright shining eyes, still breathing hard, not wanting to cease.**

**Napi knew in his heart that a healing of the people had occurred. This circle had come together in pain and fear, wanting to pray and lift the darkness that covered their community. Now elders and young people hugged and laughed, and for a moment thoughts of those relatives who had taken their own lives were gone. Napi knelt before the altar and smudged himself with the pungent sage and gave thanks to the Creator.**

**The curling smoke carried him to a night some years before, to the Chuska Mountains of Arizona. A wizened Navajo elder squatted over a crackling juniper fire and sipped his black coffee. Napi asked him, "Why are our young people taking their lives?" Napi waited for him to respond. Some fifteen minutes passed before the old man replied, "We do not talk of death." Napi waited for more, but none came. His mind raced, thinking of the many young lives lost to the people of the Wind River reservation. How could you not talk about death?**

**Napi remembered talking with a Wind River social worker about the clustering of suicides--all young people. There were many reasons given--alcoholism, poverty, joblessness, abandonment, loss of culture, sexual abuse and other forms of violence. Napi knew that these were superficial and only symptoms of a deeper hurt. The social worker said that many experts on suicide and prevention came to Wind River offering assistance and money for studies. The tribes began turning away outside offers of assistance--unless there was something offered that the people did not already know.**

**The tribal government tried to mandate that there would be no more suicides. There were many community meetings, but nine young lives were lost in two months! It wasn't until they became very afraid that they began looking "inside" for the answers and turned to their traditional ways. The spiritual leaders and pipe carriers performed a ceremony that had not been performed for sixty years. The pattern was broken. There have been suicides since then, but not the hysteria or clustering**

**Suddenly, Napi understood what the Navajo elder had told him about not "talking about**

**death". Our traditional ways give us guidelines for living and for dealing with death. Our elders tell us that "to speak it will make it happen". Death was such a powerful symbol that it was not good to speak casually about it. There were ceremonies to help the people grieve and honor the passing of the spirit to the other side. When the grieving was over, the people were to get on with their lives. There were other ceremonies that helped the people to heal. There were also ceremonies to celebrate life and its passages.**

**But, we had forgotten our ways. Today, we mostly talked about them--we no longer lived them.**

**With a rush, Napi came back into the circle of dancers now. Tears came to his eyes. Thank you Creator, thank you for showing us the way.**

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## LOOKIN' EVERYWHERE BUT AT OURSELVES:

**by: Black Bear**

**When Napi walked into the community meeting at the Tribal building, the room was packed. Smoke filled the air and rose in little columns, like smoke from many campfires. The room buzzed with the sound of voices, all clamoring at once. Their young people were killing themselves. "Why?" "What can we do about it?" Napi had been to similar meetings on many reservations. The people were looking for answers and ways to stop the pattern of self-destructive behavior their youth were caught in. They had many people calling and offering help -- psychologists, sociologists..."experts", people wanting to give money to do research. Their leaders had gone to Washington, DC, to meet with congressional committees and ask for money -- money for youth programs, a community center, and more "experts".**

***Napi remembered another time when he had traveled up north and had met with a group of parents that were concerned with "youth acting out". In this particular community, there were high rates of alcoholism, children hurting other children, deaths by car accidents, and suicide among the young people. The rates were no better among the adults, especially the alcoholism.***

***The tribe had secured a $375,000 grant for youth programs. The money was enough for the tribe to create four or five programs for the young people. They built a youth center for recreational activities. The youth were now provided outreach programs that took them into the wilderness and taught them survival techniques and leadership. During the school year, high risk youth stayed at a boarding school during the week and then went home on weekends.***

***One program that the tribe was proud of was located in a remodeled "old jailhouse". Napi went there and visited and found Hawk, an old friend that he had gone to Haskell with. Hawk was the director of this youth program. The jailhouse had been painted bright colors, even pink, but the cells were still cells. Behind the bars were young people 9-19 years old. They were sitting there reading or sleeping or talking with one another. Napi asked Hawk why they were there. Hawk said they were there for their own welfare--they were one step away from the state reform school. Napi asked Hawk again, "What are they in for?" Hawk told him that they were there for truancy, for possession of booze or for smoking marijuana. Napi said "Oh!", and sadly left the old jailhouse.***

*As he walked away, Napi recalled that this same tribe had only a small alcoholism program for the adults. Certainly money and programs weren't the whole answer, but it seemed that the priorities were upside down*

**It was now Napi's turn to speak at the community meeting. When he had finished speaking, there were many questions. Several people asked him what he thought could be done about the suicides among the young people of their community. Napi told them three things could be done that would drastically reduce the rate of suicide, violence and death by car accidents:**

**1. "WE must stop OUR drinking!--Nobody can do it for us." Nearly 75% of the suicides, violence, and deaths by car accidents were alcohol-related.**

**2. Many of the adults were alcoholic. There were many single mothers and the young people had no adult male role models. The youth were being left home while the adults went out to party or to play bingo or to the bright lights and good times at the Casino. "We are telling the young people to not do the same things we ourselves are doing. We must hold the adults accountable for the raising of their children."**

**3. "We must find the answers within ourselves. Don't be lookin' for others to solve our problems--only we can solve our problems. Many of the answers are there in our traditional ways--they need to be used. We can seek advice and assistance from others, but until the community is committed to changing its own behavior, our young people will continue to act out."**

**Napi stood there for a moment, but no one spoke or responded. The little columns of smoke continued to rise to the ceiling. He felt as though the people did not "hear" him, or think that these were "choices" that they had some power over.**

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## LOOK AT HOW THE ANIMALS CARE FOR THEIR YOUNG:

**Paul Ortega is a longtime friend, and is a Mescalero Apache. Although Paul is best known for his music, he was raised by his elders teaching him "medicine ways", and these teachings help link traditional understandings with contemporary human problems. When we see each other, here and there, we often talk about suicide prevention, healing, music, and art--he believes in the healing power of art. I asked him several years ago about what was going on with young people and the violence--kids killing kids. Paul told me that when I got confused and couldn't figure these things out, that I should "look at how the animals care for their young".**

**The Apache elders began teaching Paul at a very early age and for the first four years, he was told to learn everything he could about water. After water, Paul was instructed to learn everything he could about plants for four more years. Then he spent another four years learning about animals. The last four years of teaching was spent in the study of human behavior. Paul Ortega reminded me that we human beings ARE animal. He said that human beings are always thinking about themselves and justifying what they WANTED to do. Animals, he said, aren't like that. When they have young ones, their primary responsibility is to**

**care for those young.**

**As we visited, it became easier to see what Paul meant. From the time that the young are "in the nest" (in the home), the parent is firmly in control. Sure, the little ones are allowed to play and explore, however, they quickly learn what they can and cannot do. This is reinforced with a growl or a cuff of the paw that will roll them over and over--it gets their attention, but does not injure them. The young are not allowed to stray far and will quickly scurry to the mother if there is danger. Also, the mother will protect her young with a ferocity that far exceeds defending of territory or food.**

**Paul Ortega pointed out that there is no wavering or waffling about the parent wanting to go play bingo, or hang out with friends. He said that although we often say we have to work to support the family, this is also justifying what we want to do. We justify our lifestyle--what used to be luxury items are now necessities.**

**In conclusion, this Apache elder reminded me, that for the animals there are no ambiguities in the role of the mother or parent--no bingo, new cars, or fancy clothes. Their sole purpose is to raise, care for, and teach the young how to survive.**

HOME (Frames) (No Frames) | SUICIDE PREVENTION | CRISIS INTERVENTION | ART & HEALING

| SITE MAP & RESOURCES

Jicarilla Mental Health & Social Services
P.O. Box 546
Dulce, NM 87528
(505) 759-3162 or toll free 1-800-942-7440

E-Mail: cspcn@cnm.com



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| • CSPCN History | • CSPCN Project Abstract |
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# Click here to register for the 1998 San Diego Conference.

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## CSPCN History

Since the 1960's when serious study of American Indian and Alaska Natives suicide began, suicide rates among AI/AN's have been almost two times the national average. However, suicide rates among specific AI/AN communities vary greatly. Highest suicide completion's and attempt rates are found primarily in rural western, northwestern and mid-western regions of the United States. Suicidal behaviors among urban American Indian and Alaska Natives in these regions also should not be overlooked, given their high mobility of American Indian/Alaska Natives individuals and families.

AI/AN male adolescents and young adults have been particularly vulnerable to completed suicides while young female AI/AN's have been highly susceptible to suicide attempts. In 1968 and 1985 severe suicide epidemics in American Indian tribes in Idaho and Wyoming, respectively, brought

national attention to the high rates of suicide in some American Indian communities.

In 1996 the Indian Health Service formed a special team to respond to suicide crises in American Indian/Alaska Native communities. Since the late 1980's a number of AI/AN communities have developed ongoing and successful community based suicide intervention and prevention programs.

In 1989, Dr. Phil May, University of New Mexico, annotated all published and unpublished materials on AI/AN suicide in a bibliography that has been available to tribes and others throughout the United States. The bibliography was revised in 1990 and 1996. Dr. May has done extensive research since the 1970's on American Indian suicide rates and community interventions. Additionally, the American Indian/Alaska Native Mental Health Research Center, University of Colorado Health Sciences Center, has published considerable information on American Indian/ Alaska Native suicide and related issues.

Based in the continuing problem of high AI/AN suicide rates, the success of a number of AI/AN tribes in addressing suicide in their respective communities, and the extensive literature on AI/AN suicide that has become available since the 1960's, the present project is proposed. The Centers for Disease Control and Prevention, Division of Injury Control and Prevention, and the Indian Health Services, propose to enter into partnership with the Jicarilla Apache Tribe to develop a network of AI/AN communities that have addressed suicide successfully or are in the process of developing suicide prevention programs. The purpose of the network is to assist each other and other tribes throughout the United States in responding to and developing programs that address suicide and related issues.

In July 1996, 300 persons from AI/AN communities throughout the United States gathered for the **Standing Together to Heal Our Spirits: Preventing Suicide Among American Indian/Alaska Natives** conference, held in Albuquerque, New Mexico in conjunction with the Indian Health Service Mental Health/Social Services Program's annual national conference. At that time, focus groups discussed the necessity for developing a national AI/AN community suicide prevention network to assist AI/AN communities in developing suicide intervention and prevention programs, crisis response capacities, information sharing tools, and funding resources. The activities posed in the project are largely from the suggestions made by those groups.

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## CSPCN - Project Abstract

The focus of the network is to develop suicide prevention and intervention programs, crisis response teams and information sharing between Native communities throughout Indian Country. Ten (10) adults and five (5) youth have been selected and trained to help other native communities in development of crisis response, intervention/prevention programs, data collection, surveillance systems, team building, program evaluation and dealing with grief.

The selection of the Community Trainers was based on their answers to the questionnaire they submitted. During the training we refined and expanded their expertise in dealing with suicidal issues

and team building. We also have included a section on dealing with diverse populations and awareness of our own limitations in dealing with sensitive issues. Our goal was to unite a group of people with a common concern who will help others in dealing with the issue of suicide and its effects on others with a caring nurturing attitude.

Other activities that the Center will be involved with:

- Information gathering from other Tribes, who have developed intervention/prevention strategies for distribution to other communities.
- Newsletter - published twice in the first year.
- Development of a manual on creating suicide intervention/prevention programs; strategies developed by core group.
- Establishment of a Web site for easy access to information.
- Library - gathering and distributing relevant material on suicide intervention/prevention in Indian country and other communities.
- Identification of funds for planning a national conference on AI/AN suicide prevention for the second year of the project.

The purpose of the project is to address American Indian and Alaska Native suicide with a combination of intervention/prevention strategies that are different in each respective community. During the process strategies may emerge that will be useful to other communities throughout the United States, who are experiencing suicide.

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## CSPCN Consultant Locations

Currently we have 11 adults and 5 youth who have been trained and can response to community needs. They are located in the following areas: (A-adult) (Y-youth)

- Onieda, Wisconsin - A
- San Carlos, Arizona - A/Y
- Chinle, Arizona - A
- Salamanca, New York - A
- Espanola, New Mexico -A

- Kyle, South Dakota - A/Y
- Belcourt North Dakota - A/Y
- Kingston, Washington - A/Y
- White Earth, Minnesota - A
- Kaltag, Alaska - A
- Dulce, New Mexico A/Y

During our second year we will train another 3 adults and 2 youth from other locations. For information to become a Community Trainer please contact the CSPCN Coordinator.

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## Request for CSPCN Information

**Name:**

**Organizaton:**

**Address:**

**State/Zip Code:**

**Telephone number:**

**E-Mail address:**

**Information requested:**

Send | reset

# INTERVENTION STRATEGIES

**(THESE PAGES ARE UNDER CONSTRUCTION)**

*** The elements listed are critical for the development of an intervention plan and strategies. The specifics of each element vary from tribe to tribe and from community to community**



## TRIBAL SUPPORT:

**The Tribe must support the efforts of an Intervention Team, or, any individual or organization that is working on intervention in a tribal community. It is NOT necessary that the Tribe be the one directing the work or doing the work. The Tribe must, however, explicitly or implicitly support any intervention work.**

**Tribal support may be shown by: 1. A resolution passed by the Tribe, 2. Other written evidence by the Chairperson and/or Tribal Council, 3. The selection and/or appointment of a Tribal Council member to serve on the Intervention Team.**

**Personally, I prefer #3, because a Tribal Council member serving on the Intervention Team facilitates and promotes good communication between the Intervention Team and the Tribal government, and is a visible symbol of tribal involvement.**

**The White River Apache in Arizona have had an organized Intervention Team for a number of years. They have a tribal councilman serving on the Team. In addition, Tribal Chairman, Ronnie Lupe has demonstrated tribal support by personally airing public service announcements about suicide prevention on the White Mountain Apache radio station.**

## INCLUSION OF ELDERS:

# WARNING SIGNS



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## FACTS ABOUT SUICIDE:

**Four out of five people who commit suicide have talked about it or threatened it previously. It is a myth that someone who talks about it won't do it. Most often that is a very clear call for help.**

**Drugs or alcohol are involved in two out of three suicides. Use of these chemicals intensify the already-existing feelings of helplessness and hopelessness that the person is experiencing.**

**A suicidal person is not necessarily mentally ill. He/she may be simply seeing things through a very distorted and constricted lens - there seems to be only two choices for this individual: continuation of a powerful sense of pain, or a cessation of that pain.**

**The act of suicide is not seen as a moving TOWARD something, but as a moving AWAY from an unbearable pain. Most suicidal people are undecided about living or dying. Happily, most are suicidal for only a limited time and, if saved from self-destruction, go on to lead useful lives.**

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## CLUES TO SUICIDAL BEHAVIOR:

**Most people give cludes to others through their behaviors. Some of the things we can be aware of are:**

- **Marked changes in personality, behavior, appearance**
- **Participation in new and self-destructive behaviors**
- **Talk of death**
- **Signs of depression such as insomnia or a noticeable loss of appetite**
- **Preparation for dying, such as giving away important and treasured objects**

TOP

## CONFIDENTIALITY

Confidentiality is a quality of a communication in psychotherapy/counseling that maintains that the communication will not be shared with others. Psychologists and those that psychologists supervise are legally and ethically bound to extend confidentiality to clients. In fact, it can be argued that mental health professionals do not extend confidentiality to clients as much as it is a right that clients have regardless of the attitude of the mental health professionals.

Confidentiality is one of the pillars of good mental health service. It allows clients to talk about important things that they have strong feelings about without having to worry that this information will be shared with others. In this regard, confidentiality is part of the process to assist in creating a truly safe environment for individuals to explore their thoughts and feelings and eventually work out some resolution about those troubling situations.

It is important that officers who are talking with the Peer Support personnel are clearly informed about confidentiality and the limits of confidentiality. Thus, as a Peer Support Officer, you are asked to explain to each officer that you are responsible for both what confidentiality is and what the limitations of confidentiality are. These exceptions are dictated by common sense but also have the purpose of preventing harm and keeping people safe. Those exceptions are listed below:

(1) If a person is a danger to himself or others, the mental health professional is bound legally and ethically to take action to reduce the potential for harm. This action may include notifying law enforcement, relatives, employers, potential victims, etc.

(2) If there is reason to suspect psychological, physical or sexual abuse of children through direct examination, or of incapacitated adults, or the elderly. This action may include notification of law enforcement, protective services and other agencies or parties who might be of assistance in investigating and preventing harm.

(3) If you give written consent to allow information to be shared with specified others.

For the purposes of this National Institute of Justice Grant, it is especially brought to your attention the fourth exception:

(4) If you report a felony committed by you, that information will be forwarded to Internal Affairs who will determine further action.

Additionally, records may be subpoenaed by a valid court order. While this action and the admissability of those records would be opposed by the mental health professional citing the records as being covered under the client-professional privilege, there is no guarantee that such a claim would be honored by the court.

Finally, each officer needs to be informed that their circumstances will be staffed with the members of the professional psychological staff of the National Institute of Justice Grant under which these services are provided. The purpose of these staffings is to insure the best possible service. Information in these staffings is considered and treated as confidential.

As the Peer Support Officer, it is important for you to understand confidentiality and to fully explain this concept to the officers with whom you are working. There is a form included in your notebook that you will be expected to get each of the officers that you are responsible for to sign and date and be witnessed.

## CONFIDENTIALITY

Confidentiality is a quality of a communication in psychotherapy/counseling that maintains that the communication will not be shared with others. Contracted behavioral health providers are legally and ethically bound to extend confidentiality to clients.

There are some exceptions to confidentiality that exist and those are listed below:

(1) If a person is a danger to himself or others, the mental health professional and the Peer Support personnel whom he supervises is bound legally and ethically to take action to reduce the potential for harm. This action may include notifying law enforcement, relatives, employers, potential victims, etc.

(2) If there is reason to suspect psychological, physical or sexual abuse of children through direct examination, or of incapacitated adults, or the elderly. This action may include notification of law enforcement, protective services and other agencies or parties who might be of assistance in investigating and preventing harm.

(3) If a person gives written consent to allow information to be shared with specified others.

For the purposes of this National Institute of Justice Grant, it is especially brought to your attention the fourth exception:

(4) If you report a felony committed by you, that information will be forwarded to Internal Affairs of your department who will determine further action.

Additionally, your records may be subpoenaed by a valid court order. While this action and the admissability of those records would be opposed by the mental health professional citing the records as being covered under the client-professional privilege, there is no guarantee that such a claim would be honored by the court.

Finally, your case will be staffed with the members of the professional psychological staff of the National Institute of Justice Grant under which these services are provided. The purpose of these staffings is to insure the best possible service. Information in these staffings is considered and treated as confidential.

I have read and understand the foregoing and signify my understanding with my signature below.

Name_____ Witness_____

Date_____

# ASSESSING EARLY WARNING SIGNS OF STRESS

# A GUIDE FOR PEER SUPPORT LAW ENFORCEMENT OFFICERS

## DESCRIPTION OF EARLY WARNING SIGNS OF STRESS

Early warning signs of stress usually fall into three categories: emotional, behavioral, and physical.

### *EMOTIONAL SIGNS*

Under this category expect to see symptoms of apathy (not caring about much of anything), anxiety, irritability, mental fatigue, overcompensation or denial, restlessness, agitation, over-sensitivity, defensiveness, preoccupation, and difficulties in concentration. Some officers overwork to exhaustion and may become suspicious and paranoid.

### *BEHAVIORAL SIGNS*

Behavioral signs of stress are usually easier to detect than emotional symptoms. They typically include withdrawal from family members or friends, alcohol abuse, compulsive gambling, promiscuity, spending sprees, frequent domestic disputes, and domestic violence. Some officers show a reluctance to accept responsibilities and/or begin to neglect current responsibilities of the job. This type of behavior often produces an increase in being tardy for assignments and an overall decrease in job performance, as well as a poor appearance and poor personal hygiene on the job.

### *PHYSICAL SIGNS*

Health professionals warn that physical effects of stress can be potentially very dangerous to the overall health of the individual. Warning signs include headaches, problems in getting to sleep, recurrent awakening, early morning rising, changes in appetite resulting in either weight loss or gain, indigestion, nausea, vomiting, and diarrhea. A preoccupation with illnesses, including minor ailments, may also be present. These officers often take excessive sick leave and complain frequently of exhaustion on the job.

## ASSESSING EARLY WARNING SIGNS OF STRESS

## SAMPLE QUESTIONS

### *ASSESSING EMOTIONAL WARNING SIGNS*

**1. Increasing inability to cope with daily activities or problems**

Have you noticed any changes in how you feel about yourself?

Tell me about any changes in how you feel about yourself?

Have you noticed any changes in how you feel about your job?

Tell me about any changes in how you feel about your job?

Do you think you handle problems now as well as you have in the past?

Do you think that you can talk to family members about how you are feeling about your job?

Do you talk to family members about how you are feeling about your job?

Do you think anybody will understand how you are feeling?

Do you think you should be feeling the way you are about your job?

How often do you feel that you can no longer accept things that you cannot change?

How often do you feel that you can't give in to someone, even though it would be best for you and the person if you did?

**2. Prolonged feelings of being depressed, apathetic or fatigued**

Do you feel more tired these days than you normally do?

Do you feel mostly sad or happy these days?

Overall, do you care about things as much as you used to?

Do you feel sad or happy most of the time?

Do you feel like there is no hope most of the time?

Do you feel rested after sleeping?

Do you look forward to starting a new day?

Do you dread starting a new day?

Do you think people don't like you or are out to get you?

**3. Thinking or talking about suicide**

Have you felt like life wasn't worth living?

Have you ever had thoughts about hurting yourself?

Have you ever told anyone that you might hurt yourself or take your own life?

Have you ever thought about doing things to yourself which could have taken your life?

Do you care if you are hurt or killed on the job?

Do you sometimes think about doing things on the job which might put you in a position to get hurt even when you know the risk is not necessary?

**4. Thinking or talking about harming others**

Have you ever had thoughts about hurting someone?

Have you told anyone that you were going to hurt someone?

Do you feel like you want to hurt someone?

**5. Increasing feelings of anxiety**

What kinds of things make you nervous?

Do you feel jumpy or relaxed most of the time?

Have you noticed that you feel more nervous or anxious than you used to?

How irritable do you usually feel?

Do you feel like you must always be on the move?

Do you have trouble keeping your mind on one thing at a time?

How do you feel when you have a painful or unwanted thought?

Do thoughts about something painful come back to you even though you don't want to think about them?

***ASSESSING BEHAVIORAL WARNING SIGNS***

**1. Abuse of alcohol and other drugs**

Do you drink (or use drugs) more or less than you used to?

How much do you usually drink (or use drugs)?

Do you drink (or use drugs) more than you want to?

Do you think that you drink (or use drugs) more than you should?

What do you usually do when you drink (or use drugs)?

Have you ever gotten into trouble because of your drinking (or using drugs)?

What kind of trouble do you usually get into when you drink (or use drugs)?

Why do you drink (or use drugs)?

**2. Increasing anger and hostility**

When you get angry on the job, what do you do?

When you get angry at home, what do you do?

Do you have more or fewer arguments or fights with family members?

Do you get angry more or less than you used to?

If your anger gets out of control, what do you do?

If somebody interrupts what you are doing at home (or on the job), what do you do?

Have you ever tried to do anything to hurt somebody else while you were angry?

**3. Any form of inappropriate acting-out behavior**

Have you gotten into trouble with your family because of something you did that you know you should not have done?

What kinds of things do you do that you know you should not do?

Do you gamble more than you think you should?

Are you faithful to your (girlfriend, wife, boyfriend, husband)?

Do you spend money on things that you know you really don't need or can afford?

Do you have trouble stopping yourself from doing things you know you shouldn't do?

Do you get into more trouble these days because of your behavior?

**4. Personality changes**

Would other people describe you as being easier or more difficult to get along with?

Have people told you that you seem to be different than you used to be?

Do family members tell you that you have changed since becoming an officer?

Do family members tell you that you seem more distant than you used to be?

Do fellow officers tell you that you seem to be more difficult to get along with than you used to be?

Do fellow officers tell you that you don't seem as happy as you used to be?

Do people tell you that they worry about changes in you?

What kind of changes do people say they see in you?

**5. Overall poor stress management skills**

What is your favorite thing to do when you are not on the job?

Do you get to do it as often as you would like?

Do the things you do to reduce stress work for you?

What else do you think you could do to reduce your stress?

How much time do you spend with your family?

Do you spend as much time with your family as you would like?

When you feel stressed, what do you do to unwind?

How often do you exercise?

Do you have a regular exercise pattern?

Do you have a hobby?

Would you rather spend time on the job than with family members?

Have you made any new friends in the past few months?

What kind of fun things have you done in the past few months?

What kind of things do you and your friends like to do?

***ASSESSING PHYSICAL SIGNS***

**1. Preoccupation with illness**

Do you think about being sick a lot of the time?

Do you think you are sick a lot of the time?

Do you spend a lot of time worrying about your health?

How many things do you think are wrong with your health?

Do you worry about your health more than you used to?

How often are you sick?

**2. Physical exhaustion while on duty**

Do you feel tired most of the time on the job?

When you go to work, how tired are you?

When you finish your shift, how tired are you?

Most of the time do you feel you are too tired to keep working?

Do you get more tired on the job than you used to?

**3. Changes in sleeping pattern**

How many hours of sleep do you like to get?

How many are you getting?

Do you sleep more or less than your usual pattern?

Do you have trouble staying asleep?

Do you wake up before you want to?

If you dream, what kind of dreams do you have?

**4. Changes in eating pattern**

Do you eat more or less than you used to?

What kinds of things do you eat for (breakfast, lunch, dinner, snacks)?

What kinds of things do you drink for (breakfast, lunch, dinner, snacks)?

Do you drink more beverages with caffeine than you used to do?

Do you eat the same kinds of food that you usually do?

What are some of your favorite foods.

Have you gained or lost weight since becoming an officer?

How much would you like to weigh?

How much should you weigh?

How much do you weigh?

**5. Indigestion, nausea, vomiting, and diarrhea**

Do you feel like you have problems with digesting your food?

How often do you feel sick to your stomach?

How often do you feel like you are going to throw up?

How often do you feel like you have to go to the bathroom too much?

How often do you have diarrhea?

## ASSESSING EARLY WARNING SIGNS OF STRESS

## A CHECKLIST

| | NO | UNSURE | YES |
|---|---|---|---|
| ***EMOTIONAL WARNING SIGNS*** | | | |
| 1. Increasing inability to cope with daily activities or problems. | ___ | ___ | ___ |
| 2. Prolonged feelings of being depressed, apathetic or fatigued. | ___ | ___ | ___ |
| 3. Thinking or talking about suicide. | ___ | ___ | ___ |
| 4. Thinking or talking about harming others. | ___ | ___ | ___ |
| 5. Increasing feelings of anxiety. | ___ | ___ | ___ |
| ***BEHAVIORAL WARNING SIGNS*** | | | |
| 1. Abuse of alcohol or other drugs. | ___ | ___ | ___ |
| 2. Increasing anger and hostility. | ___ | ___ | ___ |
| 3. Any form of inappropriate acting-out behavior. | ___ | ___ | ___ |
| 4. Personality changes. | ___ | ___ | ___ |
| 5. Overall poor stress management skills. | ___ | ___ | ___ |
| ***PHYSICAL WARNING SIGNS*** | | | |
| 1. Preoccupied with illness. | ___ | ___ | ___ |
| 2. Physical exhaustion while on duty. | ___ | ___ | ___ |
| 3. Changes in sleeping pattern. | ___ | ___ | ___ |
| 4. Changes in eating pattern. | ___ | ___ | ___ |
| 5. Indigestion, nausea, vomiting, or diarrhea. | ___ | ___ | ___ |

## ASSESSING EARLY WARNING SIGNS OF STRESS

## A CHECKLIST

| | NO | UNSURE | YES |
|---|---|---|---|
| ***EMOTIONAL WARNING SIGNS*** | | | |
| 1. Increasing inability to cope with daily activities or problems. | ___ | ___ | ___ |
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| 3. Thinking or talking about suicide. | ___ | ___ | ___ |
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| 5. Increasing feelings of anxiety. | ___ | ___ | ___ |
| ***BEHAVIORAL WARNING SIGNS*** | | | |
| 1. Abuse of alcohol or other drugs. | ___ | ___ | ___ |
| 2. Increasing anger and hostility. | ___ | ___ | ___ |
| 3. Any form of inappropriate acting-out behavior. | ___ | ___ | ___ |
| 4. Personality changes. | ___ | ___ | ___ |
| 5. Overall poor stress management skills. | ___ | ___ | ___ |
| ***PHYSICAL WARNING SIGNS*** | | | |
| 1. Preoccupied with illness. | ___ | ___ | ___ |
| 2. Physical exhaustion while on duty. | ___ | ___ | ___ |
| 3. Changes in sleeping pattern. | ___ | ___ | ___ |
| 4. Changes in eating pattern. | ___ | ___ | ___ |
| 5. Indigestion, nausea, vomiting, or diarrhea. | ___ | ___ | ___ |

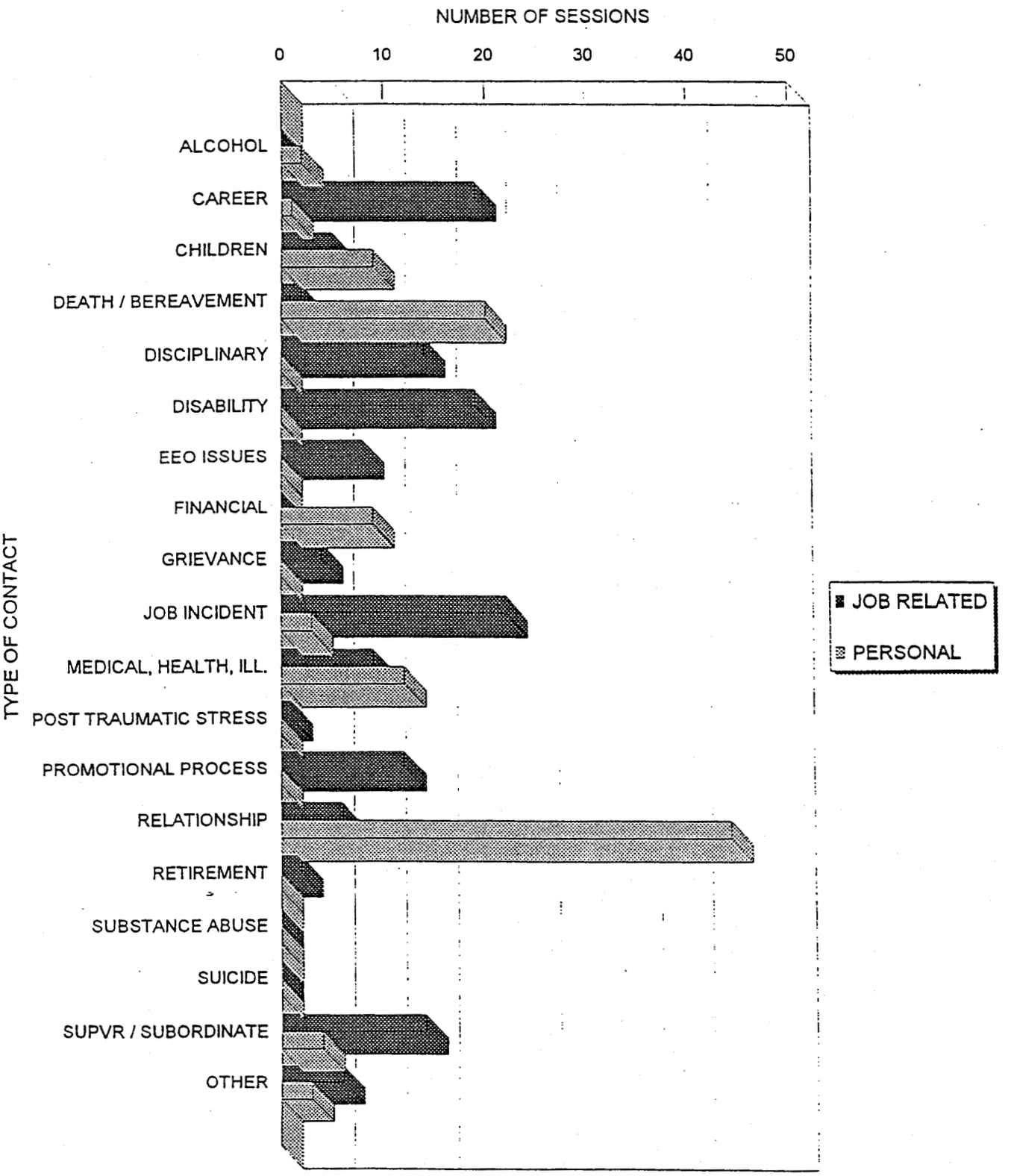
Officer's Name_____ Date_____

## EFFECTIVE STRESS MANAGEMENT
## A GUIDE

1. Eat three HEALTHY meals a day, including breakfast. (Avoid or reduce sugar, salt, animal fat, and processed white flower. Include dietary supplements as needed.)
2. Stop smoking.
3. Avoid or limit caffeine intake.
4. Avoid or limit alcohol intake.
5. Avoid self-medication with any type of drugs.
6. Get at least 6 to 8 hours sleep each night.
7. Exercise on a regular basis.
8. Make time for and participate in outside interests.
9. Practice relaxation procedures and abdominal breathing.
10. Identify and accept YOUR emotional needs.
11. Pace yourself and allow for an even flow of demands, such as taking one thing at a time.
12. Learn to accept things you cannot change.
13. Learn to give in once in a while.
14. Make yourself emotionally available to family members.
15. Learn to talk to someone you trust about your worries.
16. Form relationships with people who will support your efforts to reduce stress in a HEALTHY way.
17. Avoid relationships with people who encourage you to deal with your stress in UNHEALTHY ways.
18. Schedule time and activities for yourself by yourself.
19. Schedule time and activities with others socially.
20. Learn to recognize the early warning signs of stress.

# TUCSON POLICE DEPARTMENT

OCTOBER 1994



# A PRESCRIPTION FOR BURN-OUT

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Police stress has long been an explored topic in the various professional journals and periodicals. Unfortunately, much of the material is set forth in the form of "ain't it awful sessions," telling the police officer the many maladies they suffer and the unpleasant results of job stress, i.e., divorce, ulcers, etc. Perhaps the most popular stress-related topic in the police field today is that condition referred to as "burn-out." Burn-out is many things: psychological withdrawal from work in response to excessive stress; loss of enthusiasm, energy, and sense of job mission; feeling "locked" into a job; loss of concern for other officers with whom one works and for the public in general; and becoming increasingly uncaring and apathetic, to name a few. This training tip will expose the officer, in a cursory fashion, to some of the symptoms of burn-out but more importantly, will provide some suggestions to combat it. Burn-out is reversible. It is caused by outside factors but is a self-inflicted "attitudinal" injury. There is a prescription for treatment.

There are innumerable police stressors which can contribute to burn-out, such as role conflict, role ambiguity, excessive overtime, deadly force policies, excellence being expected, not rewarded, life "on-the-line," the courts, and budget reversals. When these and other stressors become too frequent or long-lasting, one may observe the affected officer becoming much more detached from his work, cynical, mentally and physically fatigued all the time, paranoid, irritable, impatient, and uncaring. When an officer succumbs due to the impact of these various stressors, he may "fall apart." Someone will usually come along and tell him to pull himself together. It would be much more beneficial to the officer to learn the names of the parts and find out why they fell to pieces. This segment of the helping process would include learning more about the individual, his values, motivations, and goals and identifying the stressors which caused his eventual problems.

This is only part of the helping process and one which is addressed in available literature. The last additive to the helping process is that of providing remedies; establishing personal goals to aid the officer in preventing stress and/or subsequent burn-out.

Burn-out has been referred to as a disease of overcommitment, ironically causing a lack of commitment. There are three stages of burn-out: (1) imbalance between resources and demands (stress); (2) immediate, short-term emotionally response to this imbalance (strain); and (3) changes in attitude or behavior (defensive coping). In the police profession it is not unusual for an officer to be "juggling" many cases simultaneously. While some officers seem capable of doing this on a continual basis, others simply burn-out. Thus, there is a differential response in officers to the same stressors. The burned-out officer may be heard to say "Who cares what I do anyway?" "I hate to go to work." "What's it all for?" "Society will never change regardless of my efforts." In statements such as these, role conflict, together with other police stressors, is evident as well as an idea of how this officer perceives his job and the environment in which he works. Paradoxically, the more negative the attitudes and approach of the officer become, the more his burn-out symptoms intensify. Thus, he reinforces his own counterproductive behavior.

Many things can be done to rid the officer of the burn-out syndrome. He must move from the position of helpless victim to a position of active participant. Some suggestions: share your worries and frustrations with a trusted friend; avoid "ain't it awful" sessions over coffee, etc,; avoid self-medication (alcohol, drugs, etc.); eat properly and get an adequate amount of rest; take things one at a time; do something of value for someone else; learn to accept those things you cannot change; find something to look forward to each day; and balance your activities. Your days must be divided into time for business, time for family, and time for you.

The best defense against stress is an understanding of its symptoms and causes. The best defense against burn-out is personal growth. The FBINA Associates is a fortunate group in that each region fosters in its membership a determined effort to grow - personally and professional; to be the best law enforcement officers in the world. A review of the accomplishments of graduates of the FBINA illustrates the success attained in this endeavor. It is important that you realize that what you are doing for yourselves, through retraining sessions, is a great remedy for burn-out and is highly infectious. It affects the entire law enforcement community. Burn-out can be equally epidemic. The FBINA Associates is the main line of defense against burn-out, the fortress for caring, energized, motivated, and responsible professionals in the police service.

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U.S. Department of Justice
Federal Bureau of Investigation

# Management Quarterly

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## Bureaucratic Burn-out: A Challenge to Managers

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The complexities of tasks and the many demands, responsibilities, and deadlines placed on Special Agents of the Federal Bureau of Investigation necessitate that they be fully functional throughout the workday. Each is expected to be energetic and self-motivated. The very nature of the job requires team work yet each agent should also be somewhat independent and task oriented. Due to this necessary team work, agents are constantly evaluating each other. While supervisory evaluations are important, particularly now in performance appraisal system of evaluation, most agents agree that acceptance by, and recognition of, their peers is the ultimate goal and the one which provides the greatest amount of feedback and, consequently, job satisfaction. When an agent fails to function at acceptable levels he is often labeled a "slug" or "an empty suit." Agents resent having an individual like this on their squad. This agent has, in essence, "retired in place." His only crime, one obviously tied with his survival, is his failure to formally advise the Bureau. This reference to retiring is in no way intended to imply that this attitude exists only in certain, older age categories. It can be found at any age and at any stage of a career.

In many cases this lack of energy and/or interest in one's work is the result of a condition popularly known as "burn-out." The responsibility to allev-

FBI/DOJ

iate burn-out and make this agent a productive member of the squad again is a management challenge. Discussed herein are definitions, causes, and symptoms of burn-out, and some suggested remedies. A burned-out agent is not only non-productive, but he lowers the morale of the entire squad. It is essential that supervisors accept the challenge and actively deal with the problem.

**What is burn-out?**

Burn-out is much easier to observe than to define; however, a typical definition would include the following: "To fail, wear out, or become exhausted by making excessive demands on energy, strength, or resources."[1] Unfortunately, definitions such as this pay little attention to the emotional and attitudinal effects of burn-out. Burn-out often includes the psychological withdrawal from work in response to excessive stress or dissatisfaction; loss of enthusiasm, excitement, and a sense of mission in one's work;[2] and, moving from an attitude of empathy to apathy.[3] It can be unscientifically measured by the extent to which a worker has become separated or withdrawn from the original meaning or purpose of his/her work; the degree to which a worker expresses estrangement. The employee begins to feel "locked" into a job routine, the joy of the job slips away, and there is a loss of concern for the people with whom one works. Burn-out may be so gradual that the employee may feel nothing is wrong. Burn-out is not affordable in the Federal Bureau of Investigation due to the very nature and importance of our societal role.

Burn-out has been referred to as a disease of overcommitment, ironically, causing a lack of commitment. Table one illustrates a transactional definition of burn-out. This table shows the three stages of burn-out as (1) imbalance between resources and demands (stress), (2) immediate, short-term emotional response to this imbalance (strain), and (3) changes in attitude and behavior (defensive coping). Burn-out is in fact a counter-productive way of coping with occupational stress and emphasizes the use of intrapsychic defenses such as projection (blaming others), withdrawal, detachment (isolation of emotions), avoidance-oriented behavior (never being available), and a lowering of goals (to decrease the chance of failure), to name but a few.

**Causes of burn-out**

Burn-out is one of many inappropriate responses to stress. The term stress refers to "the generalized, nonspecific response of the body to any demand made upon it."[4] This nonspecific response differs from one individual to another due to basic differences in personality traits, coping mechanisms utilized, and career-related goals and attitudes. Of importance is the number of stressors experienced by an individual or group and the duration of these stressors. The time frame during which these stressors are experienced is also important together with the perceived importance of them by the individual. A person serving in the position of Special Agent of the FBI, like others in law enforcement, is "required to handle many cases within a limited timespan. Investigating several cases concurrently, the detective (agent) receives numerous stimuli which require him to be well-organized and master juggler of information...and, although he works out of an office, (he) is continually thinking about his cases. His ideas in solving cases are constantly with him. His office, then, is himself."[5] Based on basic personality characteristics and career attitudes, many agents are able to handle this type of caseload without any problem while others look at the"juggling routine" involving their caseload as a hassle. This leads to discouragement and burn-out.

The FBI, traditionally a conservative organization, is somewhat resistant to change, particularly by its agent personnel. The term "change" has been used synonymously with stress. This Bureau has undergone substantial changes which include, but are not limited to:

- — Frequent turnover in executive policy-making posts.
- — Frequent rotation of supervisory personnel.
- — Devaluing "traditional" Bureau work.
- — Placing high priority in work areas where many veteran agents have inadequate experience or skill.
- — The adoption of affirmative action programs.
- — Adaptation of the management by objectives philosophy/concepts.
- — Frequent rotation of SACs and ASACs.
- — Perceived lowering of Bureau's public image.
- — Fluctuation of transfer policies and career development paths.
- — Legal liabilities and increased civil suits.
- — Specializations such as SWAT and undercover.
- — Most recently, Performance Appraisal/Merit Pay System.

These changes (stressors), if they are perceived as threatening, combined with decreasing manpower, all contribute as background sources for burn-out in agents. This list of stressors does not end here. Other stressors, which have been identified by agents on an informal basis while attending in-service training at the FBI Academy, are such items as public scrutiny, increased assaults on agents, budget reversals, limited range of income potential, lack of mobility, lack of control of transfers, and the mandatory retirement. It has also been stated time and time again that there is no reinforcement for creative investigation in that it merely inundates the agent with paperwork and, excellence is expected, not rewarded.

**The symptoms of burn-out**

"What's it all for?" "Why am I doing this?" "I hate to go to work!" "I have nothing to offer anymore." Statements such as these are frequently made by victims of burn-out. They are not adjusting, or coping, well. They remain in a state of disequilibrium and strain to make it through the day. Often their attempts at coping are counter-productive and result in self-medication or alcoholism. Studies have indicated that burn-out correlates with other damaging indexes of human stress, such as alcoholism, mental illness, marital conflict, and suicide.[6] The alert manager may be able to intervene in a timely manner by looking for burn-out symptoms. The many symptoms are grouped in three major categories: (1) emotional, (2) behavioral, and (3) physical.

Within the emotional realm of symptoms one finds apathy, anxiety, irritability, mental fatigue, and over-compensation or denial. The end results are agents who are restless, agitated, overly sensitive, defensive, preoccupied, and who have a great amount of difficulty in concentrating. These agents overwork to exhaustion or become suspicious and paranoid. From the managerial standpoint it is important to note that these same employees may become arrogant, argumentative, and insubordinate and hostile to your demands and/or requests. Their feelings of insecurity and worthlessness have set the stage for their own defeat.

Behavioral indicators are often more easily detected. Among these are withdrawal or social isolation. These individuals are reluctant to accept responsibilities and/or neglect current reponsibilities. They tend to act out their misery through alcohol abuse, gambling, promiscuity, and spending sprees. Much of this desperate acting out is a cry for help and should be recognized as such by managers. Administrative infractions such as being tardy for work, poor appearance, and poor personal hygiene may be observed. These behavioral indicators will be reflected in not only his behavior at work but also within his family structure. This can lead to domestic disputes and child/spouse abuse.

The physical ramifications of burn-out are extremely dangerous. The individual may become preoccupied with illness or may dwell on minor ailments. A manager may note frequent illness, monitored by the amount of sick leave taken, and physical exhaustion when the agent is on duty. There are many somatic indicators which include headaches, insomnia, recurrent awakening, early morning rising, change in appetite resulting in either weight gain or weight loss, indigestion, nausea, vomiting, and diarrhea, to name but a few. These maladies are psycho-physiological and are the result of excessive stress upon the individual.

Together with all these symptoms, the manager will see the employee's self-esteem dropping and frequently, in the FBI, cynicism develops. Agents begin to feel and act like robots. They do as they are told; but no more. The manager is taxed to the limit trying to get a day's work out of the employee. Between the employee's depression, changing moods, and paranoia, the whole squad id affected. Due to his negative attitude, he may even feel guilty about collecting his salary. A sound, responsible manager has an obligation to this employee, his squad, and the Bureau, to get the employee involved again. This is no easy task and will not be accomplished overnight, but it is possible; burn-out is reversible. It takes a mature manager, considerable thought, and some personal involvement.

**Coping strategies and "cures"**

Prior to discussing possible remedies for the burned-out employee, it is necessary to understand the model of stress (see table two). An employee is confronted with a situation and almost immediately he appraises it. His response is based solely on his perception of the problem during the appraisal and thereafter his behavior is affected by this response. Thus, much of the problem lies in perception. A problem is perceived in the mind, analyzed, and then a decision is made.[7] A paradox exists in that perceiving situations in a positive, more favorable light, tends to alleviate stress and subsequent burn-out. The more burned-out an individual becomes, the more negative and/or threatening are his perceptions of situations, therefore, his burn-out is increased and reinforced.

Suggestions to remedy this situation begin with counseling. To motivate people in the work place, management must understand them, their values and their motivations.[8] Managers should talk to the employee and attempt, initially, to alleviate guilt, although none may be admitted due to the rigid posture he has developed and due to the gradual nature of his burn-out. The employee must be convinced that he/she is only responsible for how he/she responds to any crisis, not necessarily for the external factors that cause the burn-out. Overload and/or overcommitment comes from outside - not within.[9] It is necessary to get the employee to recognize symptoms and to adequately cope, not self-medicate, drink, tranquilize, or withdraw. Attempt in your role as manager to move him/her from a helpless victim to an active participant. In many cases change, while being a stressor, can be a very positive motivator. Even if this burned-out employee has been working the same types of cases for years and is the expert, is it not better to have him/her energized and involved as a novice in something new than as an expert doing nothing? Another option is to let the agent use his/her expertise to train other agents, perhaps new agents in certain skills. Determine the date of the last in-service attended by this agent and find out his/her interest regarding future training. It is important to note that

change must come about in an orderly way, not upheaval.

In many cases, burn-out comes from trying to work off stress. Suggest an outside activity or hobby to him/her. Empasize the need for personal and family time as well as occupational time. The manager may suggest that the agent take a day or two off, or read some books on relaxation to help in decompression. It should be emphasized to the agent that failure to do this will not be viewed as his failure to the manager, but rather that he has failed himself.[10] An important key to counseling in the work place is the ability to unlock the skills, attitudes and motivations of the employee. Studies have shown that people are more diverse in their work values and motivational patterns than managers suspect.[11] A manager's success in determining what these values and motivations are and his ability to redirect and energize an employee will depend largely on his counseling skills.

The term counseling, as it is being used here, may be interchanged with the term helping. While there are many theories, and subsequently approaches, to helping, the manager in the FBI will probably feel most comfortable with the client-centered approach. This approach "assumes that human beings are rational, good, and capable of assuming responsibility for themselves and making their own choices that can lead to independence, self-actualization, and autonomy."[12] This client-centered approach is founded upon an empathetic relationship between the helper (manager) and the client (employee). It strives to allow the employee to experience spontaneity, genuineness and here-and-now feelings. This approach, together with the psychoanalytic, behavioral, cognitive-behavioral, transactional-communicative, and other major approaches utilizes certain initial steps in the counseling process.[13]

**Steps in counseling**

Most managers in the FBI are very familiar with step number one, initiation-entry. This familiarity is based on the fact that this step is an interview, a get-down-to-business approach of identifying issues and concerns. Counseling, however, adds a new dimension to this interview technique. Rather than attempting to solve a case or learn facts which may lead to possible prosecution or other disciplinary forms of action, the interviewer/counselor must build trust, show genuine concern, and have some plan for helping the employee. With a proper initial interview, the manager should then be able to proceed to step two, clarification of the problem.

It is noted that t is not unusual for an employee to present several different concerns or problems. It then bebecomes the responsibility of the manager/counselor to help sort and subsequently rank these concerns by priority. These priorities are established in concert with the client feelings. By prioritizing the presenting problems, step three, the structure for the helping relationship, becomes a natural evolvement.

Having identified and clarified the presenting problem, the manager must now decide whether or not this problem in which he can provide help. If the problem presented is such that the manager feels his skills are inadequate to effectively help the employee, it becomes the manager's obligation to assist by encouraging assistance from another source. A referral such as this does not mean the manager has failed. Failure would be for the manager to pretend he is wiser than he is; to deceive himself by saying he understands the client's values, beliefs, attitudes, defense and coping strategies, as well as hopes and ambitions, when in fact he is doubtful; and/or to state unequivocably that the problem is solvable within the confines of their relationship. If the manager feels capable of helping, then this step includes stating clearly that which he can and cannot do and, what he expects from the employee.

An intensive exploration of the problem becomes a necessary fourth step in those cases where the manager feels he can be of assistance in the resolution of the problem. While exploring this problem, the manager must continually assist in the development of trust, genuineness, and empathy, so that the employee will continue to feel free to explore his/her self-awareness.

Following the identification of the problem, the decision concerning whether the manager can help and further intensive exploration of the problem, the manager then finds himself at the final step, having to decide possible goals and objectives. Empathy becomes important at this point in that it is not a helpful setting if the Bureau's, or the manager's, needs are met while the employee's needs are secondary. In most cases, many goals and objectives become obvious. It should be a joint venture on the part of the manager and the employee to determine which goals are feasible and what the conditions of obtaining these goals should be. It is also important to set immediate goals as well as long-range goals.

Once these steps have been fulfilled and goals and objectives determined, it then becomes the joint responsibility of this dyad to proceed at a reasonable pace in efforts to solve the problems as presented. While this manager/employee counseling model may be somewhat innovative in the FBI, it is not a new concept in police work.[14]

Of the many helpful suggestions possible to the burn-out victim, they should include adequate sleep, exercise, proper diet, learning not to worry - to accept things one cannot change, and to always find something to look forward to each day. The employee should be encouraged to volunteer and

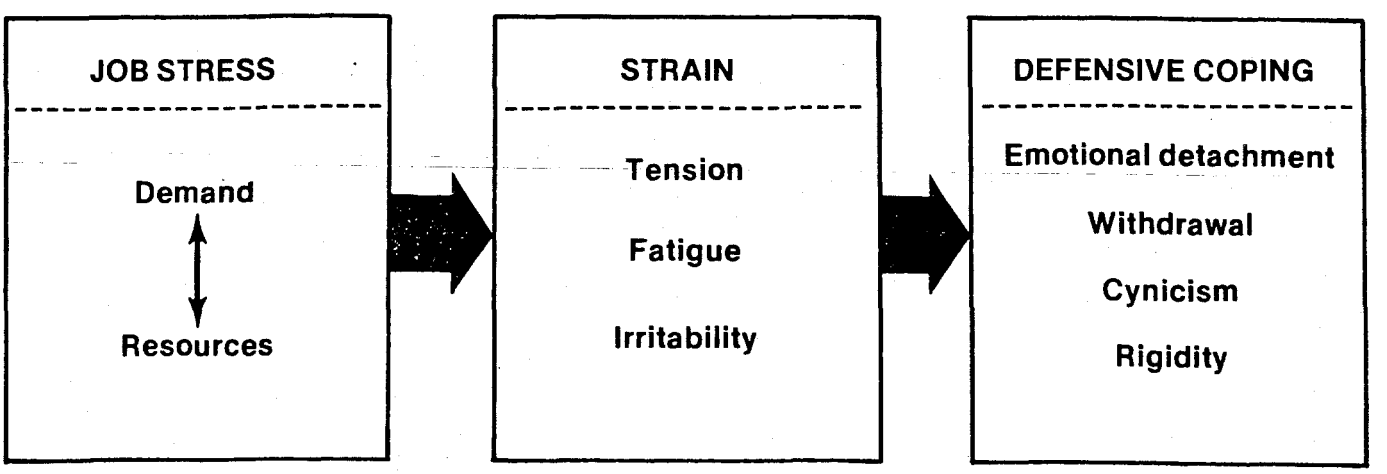
make himself available for assignments and to attempt to continue his personal and professional growth. Due to the varied causes of burn-out and resulting behavior, many times the manager may have to put these suggestions in the form of directives. The empathetic approach is encouraged but does not always work with the burned-out employee. Often, the manager has to forcefully change the employee's position, attitude, or work structure in order to get results. A manager should also evaluate to the best of his ability whether the burn-out symptoms are due to the problems of the individual or due to pathology of the working environment. If this is determinable, a more structured approach to the reduction of burn-out is possible by concentrating on the appropriate stressors. It is important to remember that while many complaints will center on the FBI or the working environment as the cause of burn-out, they may merely be scapegoats.

Prior to your becoming a supervisor/manager you may have suffered certain burn-out symptoms of your own. This can be very helpful and useful to you in your role as counselor in that you are able to empathize somewhat with the employee's feelings. You, however, as a supervisor are not immune to burn-out. Burn-out often becomes inevitable when the supervisor is forced to provide care for too many people. Managerial burn-out is also treatable.[15] Perhaps it would be beneficial for you to reread this article with your personal situation in mind. Remember, the best defense against burn-out is personal growth.

A great majority of the employees of the FBI are self-motivated and believe that the reward of a job done well is to have done it. Yet, some employees still need assistance and guidance. Using the information provided herein, a manager can get his/her squad to become more productive and satisfied. The benefits are many: people will begin, once again, to look forward to going to work; less time will be lost on sick leave; the squad will be rejuvenated and become more productive; your job will become easier, you will act as a monitor rather than an initiator; and finally, your squad, and subsequently the Bureau, will become a more efficient and better place to work.

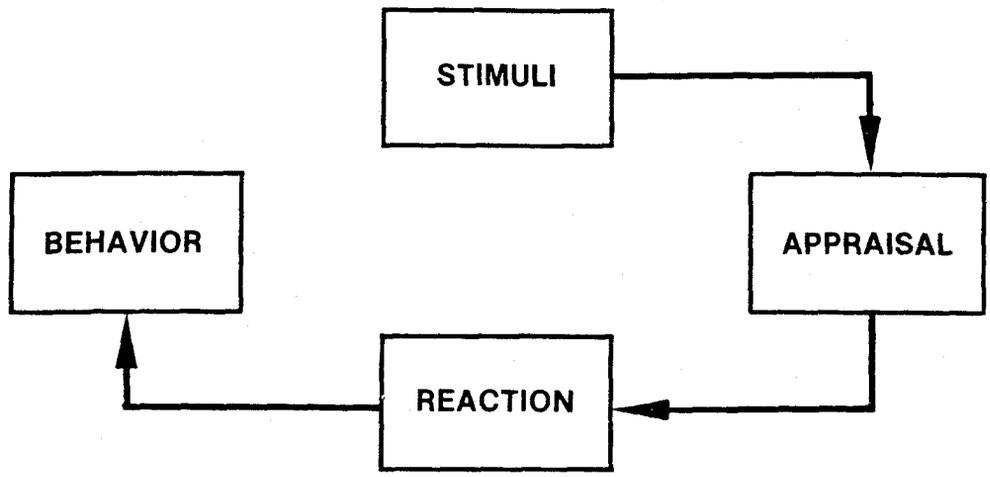
The FBI, through the Training Division, has taken steps to begin exposing managers to the concept of burn-out. Instruction is provided, or in somes cases being initiated, in training programs such as the Management Aptitude Program (MAP), Executive Development Institute (EDI), Senior Executive Program (SEP), and National Executive Institute (NEI). Training is also provided during selected in-service programs. Ultimately, every employee of the FBI should be made aware of burn-out, its causes, hazards, and the remedies available.

## Table 1.
## TRANSACTIONAL DEFINITION OF BURN-OUT




**(TABLE 1 taken from Cherniss, Cary. STAFF BURNOUT: JOB STRESS IN THE HUMAN SERVICES. Beverly Hills, California: Sage Publications, 1980, p.18)**

## Table 2.
## MODEL OF STRESS




**Footnotes**

1 Cary Cherniss, STAFF BURNOUT (Beverly Hills, Cal: Sage Publications, 1980), p. 16.
2. Ibid.
3. Jerry Edelwich, BURN-OUT (New York: Human Sciences Press, 1980), p. 164.
4. Hans Selye, STRESS WITHOUT DISTRESS (New York: J.B. Lippincott Company, 1974), p.14.
5. John G. Stratton "Police Stress and the Criminal Investigator" in THE POLICE CHIEF, February 1979, p. 23.
6. Christina Maslach, "Burned-out" in HUMAN BEHAVIOR, September 1976, p. 16.
7. Walter McQuande and Ann Aikman, STRESS (New York: E. P. Dutton and Company, 1974), p. 95.
8. E.F. McDonald, "E.F. McDonald Links Motivation and Incentives", TRAINING, April 1981, p. 62.
9. Barbara Hendrickson, "Teacher Burn-out: How to Recognize It; What to do About It", LEARNING, January 1979, p. 38.
10. Jay Haley, PROBLEM-SOLVING THERAPY (New York: Harper and Row Publishers, 1976), p. 64.
11. McDonald, p. 62.
12. Barbara F. Okun, EFFECTIVE HELPING: INTERVIEW AND COUNSELING TECHNIQUES (North Scituate, Mass: Duxbury Press, 1976) p. 96.
13. Ibid, pp. 74-84; See also Lawrence M. Brammer, THE HELPING RELATIONSHIP: PROCESS AND SKILLS, 2nd Edition (Englewood Cliffs New Jersey: Prentice-Hall, Inc., 1979) pp. 52-66.
14. Roger Depue, "TURNING INWARD: THE POLICE OFFICER COUNSELOR" in Leonard Territo and Harold J. Vetter, STRESS AND POLICE PERSONNEL (Boston, Mass: Allyn and Bacon, Inc., 1981), pp. 304-313.
15. Mark B. Sibler, "The Burned-out Manager: Hidden Organization Cost" in PACE MAGAZINE, September/ October 1978, pp. 14-17.

## Suggested Readings
(In addition to those footnoted)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Matthew J. Culligan and Keith Sedlacek, HOW TO KILL STRESS BEFORE IT KILLS YOU (New York: Grosset and Dunlap, 1976).

Rosalind Forbes, CORPORATE STRESS (New York: Doubleday and Co., Inc., 1979).

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Edmund Jacobson, YOU MUST RELAX (New York: McGraw-Hill Publishing Co., 1978).

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Hans Selye, THE STRESS OF LIFE, Revised edition (New York: McGraw-Hill Book Co., 1978).

Gail Sheehy, PASSAGES (New York: E.P. Dutton and Co., Inc., 1974).

# Life in the High-Speed Lane: Managing Police Burnout

By JAMES T. REESE

The complexities of tasks and the many demands, responsibilities, and deadlines placed on law enforcement officers necessitate that they be fully functional throughout the workday. Each is expected to be energetic and self-motivated. The very nature of the job requires teamwork, yet each officer should also be somewhat independent and task oriented. Due to this necessary teamwork, officers are constantly evaluating each other. While supervisory evaluations are important, most officers agree that acceptance by, and recognition of, their peers is the ultimate goal and the one which provides the greatest amount of feedback and, consequently, job satisfaction.

When an officer fails to function at acceptable levels he is often labeled "an empty suit." Officers resent having an individual like this on their squad. This officer has, in essence, "retired in place." His only crime, one obviously tied with his survival, is his failure to formally advise the department. This reference to retiring is in no way intended to imply that this attitude exists only in certain, older, age categories. It can be found at any age and at any stage of a career.

In many cases, this lack of energy and/or interest in one's work is the result of a condition popularly known as "burnout." Burnout is a common affliction to those employed in the human services. The police profession, like many others, is laden with job-related stressors such as role overload, role confusion/conflict, and low job satisfaction. While being a helping service, officers rarely receive positive reinforcement from those they help or protect. They live life in "the high-speed lane," responding to calls ranging from domestic disturbances to homicides; child abuse to kidnappings.

JAMES T. REESE is a Supervisory Special Agent of the Federal Bureau of Investigation. Since 1978, he has been assigned as a member of the faculty of the FBI Academy, Behavioral Science Unit, Quantico, Virginia 22135, and teaches stress awareness and management in law enforcement. He holds a B.A. degree in social science from Arkansas State University; an M.A. in criminal justice studies, American International College; and is a Ph.D. candidate at American University. Reese has published numerous articles and has taught law enforcement courses throughout the United States. He is co-manager of the FBI's hypnosis program and managed the Bureau's pilot program for psychological services.

They confront human beings who are emotionally charged and often at their worst behavior. The officer must respond, on a routine basis, to situations others would consider emergencies.[1] He has an image to uphold and must become psychologically hardened in such emergencies. He is not allowed to show natural human emotions such as fear, anger, or sadness while doing his duty. This "image armor" becomes difficult to shed when worn so often. The police cruiser may leave the "high-speed lane" but the officer remains there emotionally, burning-out.

The responsibility to alleviate burnout and make this officer a productive member of the squad again is a management challenge. Discussed herein are definitions, causes, and symptoms of burnout, and some suggested remedies. A burned-out officer is not only nonproductive, but he lowers the morale of the entire department. It is essential that managers accept the challenge and actively deal with the problem.

## What Is Burnout?

Burnout is much easier to observe than to define; however, a typical definition would include the following: "To fail, wear out, or become exhausted by making excessive demands on energy, strength, or resources."[2] Unfortunately, definitions such as this pay little attention to the emotional and attitudinal effects of burnout. Burnout often includes the psychological withdrawal from work in response to excessive stress or dissatisfaction; loss of enthusiasm, excitement, and a sense of mission in one's work;[3] and moving from an attitude of empathy to apathy.[4] It can be unscientifically measured by the extent to which a worker has become separated or withdrawn from the original meaning or purpose of his work. The employee begins to feel "locked" into a job routine, the joy of the job slips away, and there is a loss of concern for the people with whom one works. Burnout may be so gradual that the employee may feel nothing is wrong. The very nature and importance of the societal role of police makes the burned-out officers a major concern of managers.

Burnout has been referred to as a disease of overcommitment, ironically, causing a lack of commitment. The transactional definition of burnout defines three stages: (1) imbalance between resources and demands (stress); (2) immediate, short-term emotional response to this imbalance (strain); and (3) changes in attitude and behavior (defensive coping).[5] Burnout is

[1]James Q. Wilson, *Varieties of Police Behavior: The Management of Law and Order in Eight Communities* (Cambridge, MA: Harvard University Press, 1968), p. 24.
[2]Cary Cherniss, *Staff Burnout* (Beverly Hills, CA: Sage Publications, 1980) p. 16.
[3]Ibid.
[4]Jerry Edelwich, *Burn-out* (New York: Human Sciences Press, 1980), p. 164.
[5]Op. Cit., Cherniss, p. 18.

in fact a counter-productive way of coping with occupational stress and emphasizes the use of intrapsychic defenses such as projection (blaming others), withdrawal, detachment (isolation of emotions), avoidance-oriented behavior (never being available), and a lowering of goals (to decrease the chance of failure). Police managers have a responsibility to identify burnout, determine its causes, and take remedial action.

## Causes of Burnout

Burnout is one of many inappropriate responses to stress. The term stress refers to "the generalized, non-specific response of the body to any demand made upon it."[6] This non-specific response differs from one individual to another due to basic differences in personality traits, coping mechanisms utilized, and career-related goals and attitudes. Of importance is the number of stressors experienced by an individual or group and the duration of these stressors.

The time frame during which these stressors are experienced is also important, together with the perceived importance of them by the individual. A person serving in the position of a police officer, like others in law enforcement, is "required to handle many cases within a limited timespan. Investigating several cases concurrently, the detective receives numerous stimuli which require him to be well organized and a master juggler of information...and, although he works out of an office, (he) is continually thinking about his cases. His ideas in solving cases are constantly with him. His office, then, is himself."[7]

As a result of basic personality characteristics and career attitudes, many officers are able to handle this type of caseload without any problem while others look at the "juggling routine" involving their caseload as a hassle. This leads to discouragement and burnout.

Dr. Michael Roberts, San Jose, California, Police Department psychologist, refers to a primary personality feature of police officers as "responsibility absorption behavior." Dr. George Kirkham advises that this responsibility which the officers feel for people takes its toll. Testifying in Canada he stated:

> **The police officer is unique, unfortunately unique in the whole criminal justice system in that he alone really has to confront the worst manifestations of human behavior as they are actually happening and as they are actually unfolding.[8]**

Dr. Kirkham adds that the public expects all officers to be "super-cops," never emotional, always professional, never making mistakes, and always getting their man. In light of these beliefs, the public views "real cops" as woefully inadequate.[9]

Police departments, traditionally conservative organizations, are somewhat resistant to change, particularly by officer personnel. The term "change" has been used synonymously with stress. Law enforcement has undergone substantial changes which include, but are not limited to:

- ☐ Turnover in executive policy-making posts.
- ☐ Frequent rotation in supervisory personnel.
- ☐ Policies regarding deadly force.
- ☐ Adoption of affirmative action programs.
- ☐ Perceived or actual lowering of entrance requirements.
- ☐ Perceived or actual lowering of the department's public image.
- ☐ Fluctuation in promotional policies and qualifications.
- ☐ Increased legal liabilities and civil suits.
- ☐ Specializations such as SWAT and undercover.
- ☐ Police unions.
- ☐ Devaluing traditional police work.
- ☐ Failure to adopt psychological services programs for officers.
- ☐ Reduced manpower.

These changes (stressors), if they are perceived as threatening, all contribute as background sources for burnout in officers. Other stressors, which have been identified by officers on an informal basis while attending training at the FBI Academy are such items as public scrutiny, increased assaults on officers, budget reversals, limited range of income potential, lack of mobility, and lack of control of intradepartmental transfers. It has also been stated time and time again that there is no reinforcement for creative investigation in that it merely inundates the officer with paperwork, and excellence becomes expected, not rewarded.

## The Symptoms of Burnout

"What's it all for?" "Why am I doing this?" "I hate to go to work!" "I have nothing to offer any more." Statements such as these are frequently made by victims of burnout. They are not adjusting, or coping, well. They remain in a state of disequilibrium and strain to make it through the day. Often their attempts at coping are counter-productive. Studies have indicated that burnout correlates with other damaging indexes of human stress, such as alcoholism, mental illness, marital conflict, and suicide.[10] The alert manager may be able to intervene in a timely manner by looking for burnout symptoms. The many symptoms can by grouped in three major categories: (1) emotional, (2) behavioral, and (3) physical.

Within the emotional realm of symptoms one finds apathy, anxiety, irritability, mental fatigue, and overcompensation or denial. The end results are officers who are restless, agitated, overly sensitive, defensive, preoccupied, and who have a great amount of difficulty in concentrating. These officers overwork to exhaustion or become suspicious paranoids. From the managerial standpoint, it is important to note that these same employees may become arrogant, argumentative, and insubordinate and hostile to orders and/or requests. Their feelings of insecurity and worthlessness have set the stage for their own defeat.

Behavioral indicators are often more easily detected. Among these are withdrawal or social isolation. These individuals are reluctant to accept responsibilities and/or neglect current responsibilities. They tend to act out their misery through alcohol abuse, gambling, promiscuity, and spending sprees. Much of this desperate acting out is a cry for help and should be recognized as such by managers. Administrative infractions such as being tardy for work, poor appearance, and poor personal hygiene may be observed. These behavioral indicators will be reflected in not only behavior at work but also within the family structure. This can lead to domestic disputes and child/spouse abuse.

The physical ramifications of burnout are extremely dangerous. The individual may become preoccupied with illness or may dwell on minor ailments. A manager may note frequent illness, monitored by the amount of sick leave taken, and physical exhaustion when the officer is on duty. There are many somatic indicators which include headaches, insomnia, recur-

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[6]Hans Selye, *Stress Without Distress* (New York: J.B. Lippincott Company, 1974), p. 14.

[7]John G. Stratton, "Police Stress and the Criminal Investigator," *The Police Chief* (February 1979), p. 23.

[8]George L. Kirkham, testimony before The Royal Commission, Toronto, Ontario, Canada, 1 15 76.

[9]Ibid.

[10]Christina Maslach, "Burned-out," in *Human Behavior* (September 1976), p. 16.

[11]Walter McQuande and Ann Aikman, *Stress* (New York: E.P. Dutton and Company, 1974), p. 95.

[12]E.F. McDonald, "E.F. McDonald Links Motivation and Incentives," *Training* (April 1981), p. 62.

[13]Barbara Hendrickson, "Teacher Burn-out: How to Recognize it; What to do About It," *Learning* (January 1979), p. 38.

[14]Jay Haley, *Problem-Solving Therapy* (New York: Harper and Rowe, Publishers, 1976), p. 64.

rent awakening, early morning rising, changes in appetite resulting in either weight gain or weight loss, indigestion, nausea, vomiting, and diarrhea. These maladies are psychophysiological and are the result of excessive stress upon the individual.

Together with all these symptoms, the manager will see the employee's self-esteem dropping, and frequently, cynicism develops. Officers begin to feel and act like robots. They do as they are told, but no more. The manager is taxed to the limit trying to get a day's work out of the officer. Between the officer's depression, changing moods, and paranoia, his whole squad is affected. Due to his negative attitude, he may even feel guilty about collecting his salary. A responsible manager has an obligation to this officer, his squad, and the department to get the officer involved again. This is a difficult task and will not be accomplished overnight, but it is possible; burnout is reversible. It takes a mature manager, considerable thought, and some personal involvement to reverse burnout.

## Coping Strategies and "Cures"

Prior to discussing possible remedies for the burned-out officer, it is necessary to understand the model of stress. An officer is confronted with a situation and almost immediately he appraises it. His reaction is based solely on his perception of the problem during the appraisal, and thereafter his behavior is affected by this reaction. Thus, much of the problem lies in perception. A problem is perceived in the mind, analyzed, and then a decision is made.[11] A paradox exists in that perceiving situations in a positive, more favorable light, tends to alleviate stress and subsequent burnout. The more burned-out an individual becomes, the more negative and/or threatening are his perceptions of situations; therefore, his burnout is increased and reinforced.

Suggestions to remedy this situation begin with counseling. To motivate people in the work place, management must understand them, their values, and their motivations.[12] Managers should talk to the officer and attempt to assist him to understand the nature of the difficulty. The employee must be convinced that he is only responsible for how he responds to any crisis, not necessarily for the external factors that cause the burnout. Overload and/or overcommitment comes from outside—not within.[13] It is necessary to get the officer to recognize symptoms and to adequately cope, not self-medicate, drink, tranquilize, or withdraw. The manager in his role should move the officer from a helpless victim to an active participant.

In many cases change, while being a stressor, can be a very positive motivator. Even if this burned-out officer has been working the same types of crimes for years and is the expert, is it not better to have him energized and involved as a novice in something new than as an expert doing nothing? Another option is to let the officer use his expertise to train other officers, perhaps recruits, in certain skills. Determine the date of the last in-service training program attended by this officer and find out his interest regarding future training. It is important to note that change must come about in an orderly manner and not involve sudden upheaval.

In those cases in which burnout comes from trying to work off stress, suggest an outside activity or hobby to the employee. Emphasize the need for personal and family time as well as occupational time. The manager may suggest that the officer take a day or two off, or read some books on relaxation to help in decompression. It should be emphasized to the officer that failure to do this will not be viewed as his failure to the manager, but rather that the employee has failed himself.[14]

An important key to counseling in the work place is the ability to unlock the skills, attitudes, and motivations of the employee. Studies have shown that people are more diverse in their work values and motivational patterns than managers suspect.[15] A manager's success in determining what these values and motivations are and his ability to redirect and energize an employee will depend largely on his counseling skills.

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## Steps in Counseling

Most managers in the law enforcement profession are very familiar with step number one—initiation-entry. This step is an interview, a get-down-to-business approach of identifying issues and concerns. Counseling, however, adds a dimension to this interview technique. Rather than attempting to solve a case or learn facts which may lead to possible prosecution or other disciplinary forms of action, the interviewer/counselor must build trust, show genuine concern, and have some plan for helping the employee. With a proper initial interview, the manager should then be able to proceed to step two—clarification of the problem.

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Once these steps have been fulfilled and goals and objectives determined, it then becomes the joint responsibility of this dyad to proceed at a reasonable pace in efforts to solve the problems. This manager/officer counseling model is not a new concept in police work.[17]

Of the many helpful suggestions possible to the burnout victim, they should include adequate sleep, exercise, proper diet, learning not to worry—to accept things one cannot change, and to always find something to look forward to each day. The employee should be encouraged to volunteer and make himself available for assignments and to attempt to continue his personal and professional growth. Many times the manager may have to put these suggestions in the form of directives.

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## Conclusion

Thousands of intelligent, mature adults are employed in various law enforcement capacities at local, state, and federal levels. Thousands more compete daily for positions in law enforcement. More than ever, colleges and universities are teaching and/or offering degrees in the criminal justice field. Maybe the attraction is the fact that there are rewards in policing—satisfaction in living life in the "high-speed lane."

Prior to becoming a supervisor/manager, you may have personally sufffered certain burnout symptoms. This can be very helpful and useful in your role as counselor in that you are able to empathize somewhat with the officer's feelings. You, however, as a supervisor are not immune to burnout. Burnout often becomes inevitable when the supervisor is forced to provide care for too many people. Managerial burnout is also treatable.[18] Perhaps it would be beneficial for you to reread this article with your personal situation in mind. *Remember, the best defense against burnout is personal growth.*

A great majority of law enforcement officers are self-motivitated and believe that the reward of a job done well is to have done it. Yet, some officers still need assistance and guidance. Using the information provided herein, a manager can assist his squad to become more productive and satisfied. The benefits are many: people will begin, once again, to look forward to going to work; less time will be lost on sick leave; the squad will be rejuvenated and become more productive; your job will become easier as you act as a monitor rather than an initiator; and finally, your squad, and subsequently the department, will become a more efficient and better place to work. ★

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[15]McDonald, p. 62.

[16]Barbara F. Okun. *Effective Helping: Interviewing and Counseling Techniques* (North Scituate, Mass.: Duxbury Press, 1976), p. 96. See also Lawrence M. Brammer, *The Helping Relationship: Process and Skills*, 2d Edition (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1979), pp. 52-66.

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# STRESS MANAGEMENT:

# A Proactive Approach

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Stress has been defined as "the nonspecific response of the body to any demand placed upon it."[1] It has been more simply referred to as wear and tear on the body caused by living. The very obvious clue regarding stress lies within this more simple definition, namely, to eliminate all stress one must die. There are, however, ways to comfortably cope with stress. The following article is an attempt to explain the stress reaction, to provide some clues for self-monitoring physiological and psychological reactions, and to introduce the techniques of stress management.

### Adaptation

The one thing that all stressors have in common is that they increase the demand for readjustment. Alvin Toffler, author of *Future Shock*,[2] estimates that man has faced this readjustment demand through 800 lifetimes since the beginning of human existence. Toffler credits man's unique ability to adapt to change as the source of human survival. Yet, while man has adapted, his adaptation has not caught up with modern times. Looking historically, as far back as the period in which men lived in caves, mankind possessed the "fight or flight" response. This response prepared man either to fight his enemy or to flee. Because of the rapid social change today, man's response frequently seems more appropriate for fighting or fleeing in a prehistoric fashion. Therefore, today's reactions to stress in many cases are inappropriate and counterproductive.

> "FOR AN EVENT TO BE STRESSFUL, IT MUST BE PERCEIVED AS SUCH IN THE MIND"

An example of this primitive response is a police officer involved in a 90 mile-an-hour chase. After ten minutes of "hot pursuit" the subject vehicle is stopped. The officer, due to his altered psychological and physiological state, may not approach the subject vehicle and ask, "May I see your driver's license and registration?" Rather, the officer may approach the vehicle, shout "Get out," and thereafter physically handle the subject in a rough manner. The vulgar language, the high pitch of the voice combined with increased volume, and the officer's aggressiveness are all part of the stress reaction. In some instances, this type of reaction may be necessary and considered protective. In still others, as here, it is extremely inappropriate and counterproductive.

If a complaint is filed against the officer, a later investigation may find his behavior exaggerated, abusive, and unjustified. While other officers understand why he acted as he did, his reactions cannot be justified because his behavior has been investigated out of the context of the stress reaction. The reactions to stress, therefore, must be monitored.

### Physiological Change

When confronted with a stressful situation, the body goes through many adaptive changes. One does not have to be a physician to recognize them. The nostrils flare, pupils dilate, heart beat increases, hands become cold and clammy, mouth dries, breathing becomes faster and irregular and the body begins to shake somewhat. Physicians will also note other changes including increased blood pressure and changes in blood content. These are caused by a flood of chemicals in the body, maximally preparing it for fight or flight.

Due to the very nature of the police officer's role, flight is not usually an option. Therefore, all energy is directed toward the fight response, much like it was 800 lifetimes ago. It has been stated that man goes through the fight or flight response 15 to 50 times a day. Dr. Hans Selye has named this physiological change during fight or flight reactions as the General Adaptation Syndrome.[3]

The General Adaptation Syndrome is in three stages. The first stage is known as the alert stage, during which time the body begins to prepare itself for fight or flight. Stage two is called the stage of resistance. During this time the body is maximally prepared. The final stage, exhaustion, initiates the body's attempt to repair the damage caused by the General Adaptation Syndrome and to regain a state of homeostasis or equilibrium.

### Psychological Aspects

For an event to be stressful, it must be perceived as such in the mind. Perception is paramount in the stress reaction and the body will respond based on it. Therefore, perception is the most important "key" with regard to one's reaction to stress. How one perceives the situation will largely dictate one's response.[4] The mind goes through three basic steps when confronted with a problem or situation. First the problem is perceived, then an analysis is conducted, and finally, a decision is made.[5] Step number one, perception, is a skill. It is something that is learned and can be altered or changed.

Unfortunately, it has become very popular to regard all stress in a negative sense, as harmful, and something to avoid. This negative stress has been named *distress*.

Selye, "the father of modern stress," who has published over 40 textbooks and 1700 technical articles on stress, states all stress is not bad and should not be viewed negatively. He terms the positive side of stress, *eustress.* He argues that since stress is a fact of life, one must attempt to view it in a more positive manner. Stress is what keeps the heart beating, the body functioning, and it should, therefore, be viewed as a positive agent whenever possible. Selye further states that stress causes the activation of the General Adaptation Syndrome, be it negative (distress) or positive (eustress) stress.[6] Thus, the body cannot make a distinction between good and bad stress. This General Adaptation Syndrome can be altered, however, through proper perception and by monitoring one's own bodily reactions.

An example of the effects of positive and negative stress is demonstrated by the Holmes-Rahe Social Readjustment Rating Scale. This scale is made up of 43 events which cause change in people's lives. These events range from marriage to divorce, from birth of a child to death of a loved one. No distinction is made in this scale between positive and negative events, thus inferring that the bodily reactions are similar, based on change alone.

When confronted with stress, an indivdual moves from a state of mental and physical equilibrium to a state of disequilibrium. The General Adaptation Syndrome is an attempt by the body to regain physiological balance, the fight or flight response. Mentally, one can consciously *attack* the problem, *compromise,* or *withdraw.* On an unconscious level, individuals use defense mechanisms such as rationalization, denial, and projection to deal with stress.[7]

While it is not possible to entirely eliminate the stress reactions, one can and must monitor them. For example, the General Adaptation Syndrome may be altered through training to reduce its duration; breathing can be altered; and fine-motor coordination can be regained. Mentally, the effects of stress can be altered through proper perception. One must also recognize the use of defense mechanisms and determine if they are being used constructively or destructively.

Monitoring the stress reaction, combined with learning skills to effectively cope with stress, will enable the officer to perform maximally under stress and reduce his chances of falling prey to a stress-related disorder.

### Stress-Management

Taking steps to effectively manage stress is frequently met with resistance. One of the reasons is that people either consciously or unconsciously associate stress management with staying on an "even keel." The resistance that police officers sometimes display with stress management training results from the conflict between managing stress and the attraction to, and excitement associated with, police work.

Learning to manage stress and turn it into positive energy *does not* teach an individual to become uninvolved and easy going. Instead, one learns how to appropriately react when confronted with stressful situations. For example, to become involved in a high speed chase and to experience an accompanying increase in blood pressure, heart rate, and respiration, as the adrenalin races through the body, is appropriate. The same physiological response, however, when one must wait in line at the gas station is inappropriate. Responding appropriately in situations is a skill that must first be *learned* and then *practiced.*

The skills that are applicable to police work also apply to athletics. Athletes, like police officers, are expected to "react" in a variety of situations. The degree of effectiveness with which one reacts to situations is what differentiates the professional from the amateur. The professional has acquired the skill of learning to be an "intentional reactor." An intentional reaction involves assessing a situation in advance so that, even though the individual's reactions appear natural, they are purposeful and appropriate.

"MONITORING THE STRESS REACTION, COMBINED WITH LEARNING SKILLS TO EFFECTIVELY COPE WITH STRESS, WILL ENABLE THE OFFICER TO PERFORM MAXIMALLY UNDER STRESS AND REDUCE HIS CHANCES OF FALLING PREY TO A STRESS-RELATED DISORDER"

The amateur, on the other hand, is an "unintentional reactor." His style of reacting can be likened to a football team which is trying to execute a play without first getting into a huddle. The difference involves learning various proactive skills necessary for greater self-control. Acquiring these proactive skills is of greater significance to the police officer than the athlete because police work often deals with life and death matters.

It is important to look at some of the proactive skills used by professionals to put them in the category of intentional reactors. A common occurrence in police work is having to stop a citizen for speeding. Assume that an officer has been chasing a vehicle for several blocks. After stopping the violator, and before opening the car door, the officer must adjust his body to the situation. Adjusting involves getting "in line" emotionally and physically. One of the most important areas in which to regain control is breathing. When racing after the citizen, the body's natural defenses were in operation. As a result, the respiratory rate increased and breathing became short and choppy. This reaction was appropriate for preparing to catch the citizen. It is inappropriate, however,for subsequent communication with the individual.

An effective skill for returning breathing to an even and more regular state involves inhaling smoothly through the nose. Hold momentarily and then slowly exhale through the nose. At the same time one is expelling the air from the lungs, he should relax the muscles in the body and create a "wave" of calm feeling that begins at the head and travels throughout the body. Practicing this skill and regaining control over breathing is important, because when breathing is short and choppy, less air enters the body. Less oxygen, therefore,

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reaches the brain; the result is that thinking and the ability to make decisions are impaired. Keeping breathing smooth and regular during highly stressful situations is important for enabling the officer to think more clearly, and thus handle situations more appropriately.

Another proactive step to take is for the officer to ask himself as he is exhaling, "What do I want out of this situation?" For instance, does the officer want to irritate the citizen or let the citizen irritate him? Does he want to give a ticket or give a warning? Before approaching the citizen, it is important that the officer clarify how he wants to handle the situation.

The above two skills help one to better manage his own stress. Learning to handle the citizen's stress, however, requires the utilization of other skills. Developing some hard, fast, proactive skills to deal with a citizen who has just been stopped for a moving violation is difficult. People are complex, and any two situations are never the same. This is important for the officer to keep in mind, when looking at various approaches for dealing with other people during stressful conditions. Selecting the appropriate proactive skills is left up to the descretion of the officer involved.

First, if the citizen is upset, it may be best to keep quiet. Let the citizen finish talking before speaking. Agree with the person when appropriate and relate to him or her on a feeling level whenever possible. Dealing with the citizen as suggested is advantageous because it lowers stress. The officer is giving the person an opportunity to vent frustrations. Agreeing with the citizen on a feeling level minimizes the chances of argument. The officer has thus removed the "fuel from the fire."

It is important at the onset for an officer to understand not to personalize what the citizen is saying. The citizen suffers from feelings of anxiety and fear, which can quickly give way to feelings of anger and frustration. The citizen reacts more out of a function of his style, rather than personally against the officer. If the citizen continues to react in a forceful way, then it may be necessary to match the citizen in order to calm him down. Matching the citizen involves mimicking him in terms of voice level, choice of words, breathing rate, tone of voice, and body stance. Matching a person lowers stress because the person, perhaps on an unconscious level, becomes aware of how he appears to the officer. Some officers may be familiar with using this mimicking technique having used it to stop young children from crying. This technique is also taught in many law enforcement crisis intervention courses.

Another effective technique to use when an individual is upset is to completely change the subject. This causes the individual to have a momentary lapse of memory. Parents have successfully used this technique when rearing their young. Every parent can recall experiencing a time when his child was crying over not being able to get his own way. Rather than pursuing the conversation, parents have learned that if they find something of interest to point out to the child, the child's attention is quickly diverted.

Walking down a dark alley is another high stress-producing situation. Officers frequently joke about being spotted because of the loud pounding sounds of their hearts. Taking steps to be an intentional reactor in this situation involves focusing in advance on what one needs to do. It is the same kind of mental preparation an outfielder needs to play baseball. When the batter is up and there are players on first and third, the outfielder needs to review in his mind what he should do if he gets the ball. Going through this mental preparation ahead of time minimizes the chances of error and reduces the stress level.

The officer who prides himself in being an intentional reactor has the proactive skill of self-awareness. He realizes the importance of being flexible. He can adjust from being the police officer at work to being the caring and accepting spouse and parent at home.

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Too frequently officers take themselves and their jobs too seriously. Learning to adjust to a variety of responsibilities is important. Sometimes people adjust by wearing different styles of clothing. They act and react differently when they are dressed up compared to when they have on jeans and a tee shirt. This same type of flexibility is important to bring into one's work.

One officer learned to become more flexible and keep his job in better perspective by doing something nice each day for family members. While driving home at the end of his shift, he reviewed what each member of his family was involved in on that particular day. He developed questions around the day's events to ask each person. At the same time, he came up with ideas on positive things he could say or do. By the time he got home, he was in a good mood. Family members were just as positive in anticipation of his return.

Self-reliance and self-confidence are important to individual development. The question that frequently arises is when to seek professional help. In order to assist a person in making that decision, the following guidelines have been established. One should consider help:

1) When one continues to take steps towards alleviating the problem and yet finds no improvement.
2) When one is unable to come up with any reasonable alternatives or solutions toward eliminating a problem.
3) When one is suffering from a physical ailment.

### "Unwinding" is a Skill

Becoming aware of one's self and developing expertise in the various proactive skills discussed thus far is an outgrowth from "Personal Quiet Time" training.[8] The Personal Quiet Time is defined as a personalized method for enabling a person to become physically, emotionally, and mentally relaxed. The technique is practiced in either a sitting or lying position for 10 to 20 minutes, two times daily. During this time, an individual mentally places himself in a very pleasant scene, accompanied by soft musical and environmental sounds. As he visualizes the pleasant scene, he focuses on relaxing each of the muscle groups in his body. Learning to effectively unwind is a skill.

It is not uncommon for a police officer to feel uncomfortable the first time he experiences a relaxation technique. One reason for feeling uncomfortable is the lack of the body's familiar flow of adrenalin. Another reason is that it is a different way to approach improving performance. When an officer is resistant to practicing Personal Quiet Time, it is sometimes because the person lacks an understanding of relaxation. One of the most effective ways to introduce a person to the values of practicing a relaxation technique is by comparing it to sleep. Sleep is traditionally compared with restfulness.

Studies in sleep and relaxation indicate that relaxation techniques, when practiced, produce different physiological reactions from sleep and that relaxation reactions are related to creating greater feelings of rest. One of the differences noted was in oxygen consumption. Oxygen consumption is defined as the amount of oxygen that is used in combination with the food we eat at the cellular level to produce energy to move muscles and complete tasks.

Another difference is in the production of brain waves, as measured by electroencephalograpy. Sleep is typically characterized with the production of Delta brain waves. When a person practices a scientific method of relaxation, Alpha brain waves predominate. When Alpha waves are emitted, subjective reports reveal that there is an accompanying calm, euphoric feeling. Studies on creativity, conducted at Menninger's Clinic, have shown a connection with Alpha brain wave production intermixed with Theta brain waves and creativity.

Another interesting difference between sleep and relaxation is in relationship to blood lactate levels. Studies have shown that during the first 10 minutes of practicing a scientific method of relaxation that blood lactic acid levels drop significantly. The level lowers during sleep but not as greatly. Significant lowerings in blood lactate levels is important because blood lactate is associated with anxiety. The greater the lactic acid level in the blood stream, the more anxious a person feels.

> "THE OFFICER MUST REALIZE THAT HE IS NOT RESPONSIBLE, NOR IN CONTROL OF WHAT HAPPENS IN HIS EXTERNAL ENVIRONMENT. HE IS, HOWEVER, RESPONSIBLE FOR HIS REACTIONS TO THESE EVENTS"

### Facing Emotional Danger

Much has been written about stress in the world of policing.[9] Unfortunately, much of it tends to have a negative impact on the officers who read it because the writing highlights the hazards of the job; the maladies, and the miseries. Fortunately, there are those who challenge this negativism. They show police officers as perhaps no worse off than the average citizen concerning divorce, suicide, and other problems.[10] A recent study by the National Institute of Occupational Safety and Health (NIOSH) listed the 20 most stressful occupations. Law enforcement was not among them. This is not meant to imply that being a police officer is not stressful. However, it may not be as stressful, physically, as some believe. There is no doubt, however, that it is among the most *emotionally dangerous* jobs in the world. The police officer never knows what he will face next: he witnesses the misery of human beings; investigates fatal automobile accidents, child abuse, rape, murder, and other hideous crimes; receives little or no support from the public he serves; and is forced to make life and death decisions in a matter of seconds. Among his daily emotions are fear, anger, and sadness caused by shock, frustration, conflict and pressure.

Because of these emotional factors, officers, as well as others, suffer from psychosomatic disorders, like ulcers and heart disease. Stress can also result in self-

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inflicted attitudinal injuries such as burn-out, as well as physical maladies. The officer must take charge of his own environment and his own body. He can either *induce* or *reduce* stress; he alone is in control of his reaction to stress. His perception must be altered to a positive attitude. The officer must realize that he is not responsible, nor in control, of what happens in his external environment. He is, however, responsible for his reactions to these events. He must learn to relax.

Learning how to handle the stress one faces in law enforcement is a skill. When an officer practices these skills he is able to perform better on the job, while at the same time derive greater self-satisfaction. Becoming pro-active, and therefore, an intentional reactor, is what makes the difference between an amateur and a pro.

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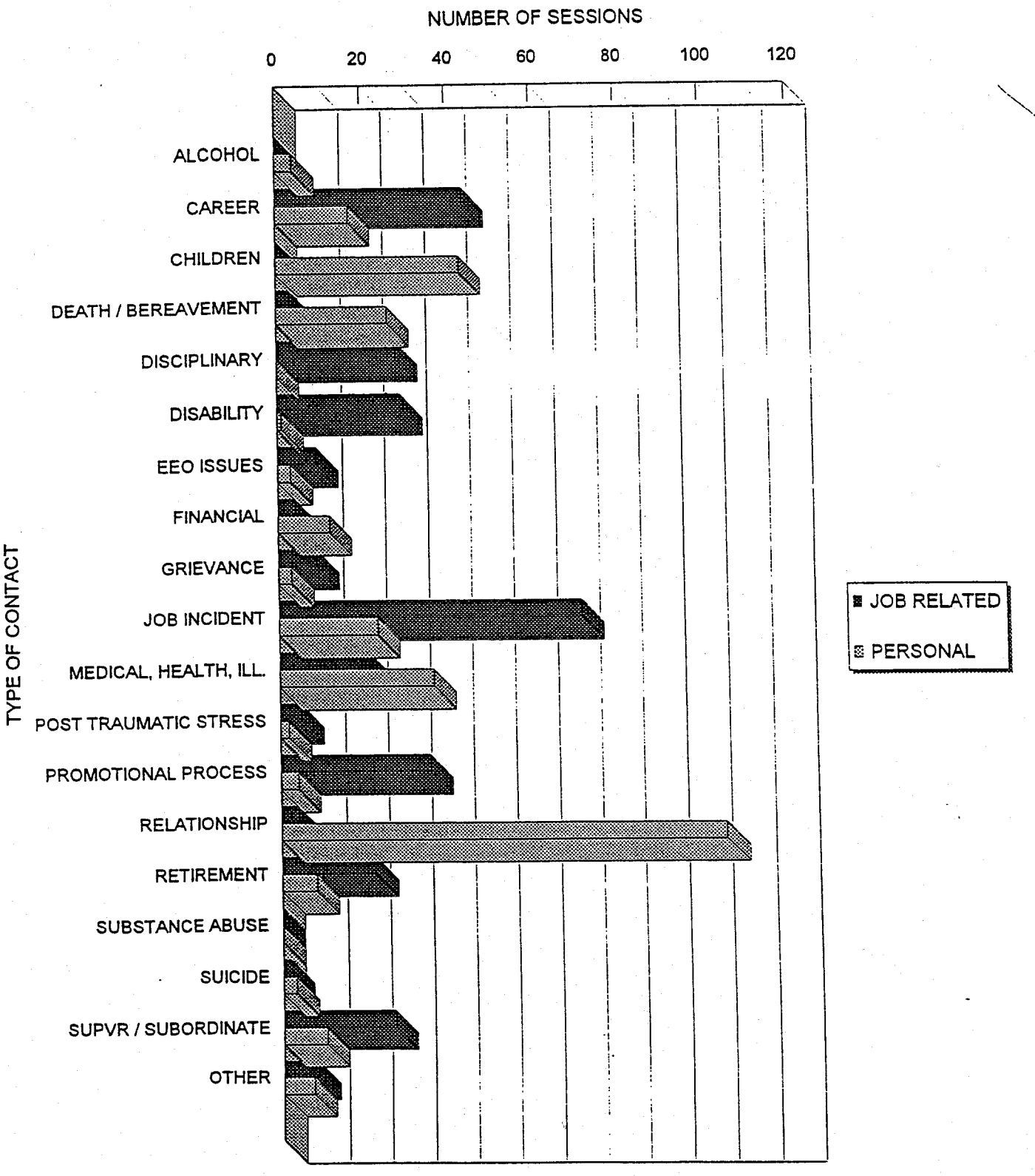
# TUCSON POLICE DEPARTMENT

APRIL-JUNE 1994



APA Public Policy Office

TESTIMONY OF

Arthur McDonald, PhD
Chief Executive Officer
Morning Star Memorial Foundation
Lame Deer, Montana

On Behalf of

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

submitted to the

UNITED STATES SENATE

COMMITTEE ON INDIAN AFFAIRS

on the subject of

# A PARTNERSHIP FOR A NEW MILLENNIUM: ADDRESSING THE UNMET HEALTH CARE NEEDS IN INDIAN COUNTRY

May 21, 1998

My name is Arthur McDonald, and I am an enrolled member of the Oglala Sioux tribe. For the past 27 years, I have resided on the Northern Cheyennereservation located in southeastern Montana. As a consumer and psychologist,I am very much aware of the unmet health care needs on reservations like theone where I live.

There are many critical health care issues facing American Indians today, and I would like to address three specific points: 1) The critical need for American Indian psychologists. 2) The need for suicide prevention programs in every American Indian/Alaskan Native (AI/AN) community. 3) The need to develop psychological preventive approaches to combat the critical health problems of diabetes and cardiovascular diseases.

I speak today on behalf of the American Psychological Association (APA). It is the largest scientific and professional organization representing psychology in the world. The membership includes more than 155,000 researchers, educators, clinicians, consultants and students. A total of 18 PhD.s, less than 1% of all new PhD.s in psychology, were awarded to American Indians in 1996, and less than 50 Indians are enrolled in the clinical/counseling field, with only 11 working for the Indian Health Service providing service to Indian people. These numbers are simply inadequate and unforgivable.

The American Psychological Association recognized this inadequacy and in1992 joined with others, including Tribal Colleges, to initiate the 'Indians into Psychology' legislation. The APA has continued to play the leading role in requesting adequate financial resources to properly fund this exemplaryprogram.

In the very limited amount of time available, I cannot begin to discussall the unmet health needs on the Reservation but I can outline a psychological model that has been shown to be effective in reducing the incidence of various health conditions.

The alarmingly high rate of suicide in AI/AN has been well documented and the causes of suicide are multifaceted and include social, economic, and psychological factors. The prevention program developed at the Jicarilla Apache Tribe's community based National Model Adolescent Suicide Prevention Project is cost effective and has reduced the rate of suicide. In 1994, the Congress asked for a report on the costs associated with a suicide prevention program in Indian country. The report outlined an AI/AN national suicide prevention program estimated at $26 million. There is no question that the solution to suicide in Indian country must be addressed from a national perspective. However, if the expertise of psychologists is not recognized, I am afraid that we run the risk of repeating previous failures. It is now 1998, and the recommendations from that report have yet to be implemented, in spite of the fact that reducing the suicide rate of AI/AN is one the of the objectives of the Healthy People 2000. Is it not time for Congress and the Administration to recognize the urgency of this situation?

Let me now move to my third point and discuss the health conditions most people do not usually associate with psychological interventions. What I want to point out is that in 1996, in the Billings Area, four of the top six causes of death were: accidents, substance use and abuse, nutritional (including diabetes), and stress-related cardiovascular disease. These four categories are all behavioral and therefore preventable. However, they are preventable only with the application of appropriate prevention models and psychotherapeutic approaches developed within applicable models. There is a significant amount of evidence in the field of behavioral medicine and health psychology that demonstrates the efficacy of psychological prevention with these disorders. This implies that there is a need for new training of AI/AN psychologists, and new approaches within the service delivery system need to be initiated. We recognize that just as in the case of suicide prevention, the behavioral interventions can not exist without basic social and economic changes. We are all very much aware that change always has costs associated with the change. At the present time, the Indian Health Service (HIS) is not staffed in a way conducive to approaching a behavioral model in prevention, but that should not prohibit them from developing this new direction. The entire health care industry is in a process of change, and it does not matter if we are ready, we will have to change.

That brings us to the theme of this hearing, which is, paraphrased, thedevelopment of new partnerships to address the unmet health care needs inIndian Country. I would propose that the existing successful, but informalPartnership that has produced the funded 'INDIANS IN PSYCHOLOGY' berecognized and formalized so that this new Partnership could be chargedwith developing and initiating behavioral models of preventative healthcare for meeting some of the unmet health care needs in Indian country. Iwould further propose that the 'partners' include at least the AmericanPsychological Association as the lead institution, the Indian HealthService, the Appropriate Tribal Colleges, the Veterans Administrationtraining and outreach components, and various Tribal Health components.

As I suggested earlier, there are always costs associated with implementingchange. It is also true that the planning has costs. It is essential thatadequate new funds be appropriated so that comprehensive planning can takeplace with the goal being the development of a new prevention model that will apply behavioral approaches to life-threatening conditions. Such an approach will not only serve Indian people, but it can be used as a model for all ruralpeople.

I thank you for this opportunity and hope that the discipline of psychology will continue to be included in any discussions of health care delivery in Indian country.

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# HEALTHY WAYS OF COPING



## COPING WITH STRESS:

**"Are you currently under stress at school, home, or work?"**

**Most people, young and old, will answer "yes" to this question. Managing stress frustrates, exhausts, and get in the way of who you want to be, managing stress can be done with some self-assessment, organization, and productive effort:**

- **Work off stress: run, walk quickly, do chores, do something that allows a non-destructive outlet for mental distress.**
- **Talk it off: Ask for time for yourself from a parent, friend, teacher, counselor, anyone who will really listen--you can tell them that you don't need advice or answers, just a chance to work out loud.**
- **Accept yourself: and the things you can't change. Explore alternatives that make good use of talents and traits that you have.**
- **Avoid bigger problems: Pills, alcohol, and all other things that take control out of your hands need to be skillfully avoided.**
- **Get enough sleep: For some people who are actively growing, this can mean as much as ten hours. LISTEN TO YOUR BODY.**
- **Balance work & recreation: Reward yourself with things you like to do (including doing nothing) when you deserve it, and work hard when you work to keep from feeling guilty when you take a break.**
- **Do something for someone else: Find a need and fill it--for friends, neighbors, relatives, parents, siblings, strangers. Reach out instead of turning inward.**
- **Take things one at a time: In small bites, so you don't choke.**
- **Give in: Cry, pound a pillow, stretch, assert yourself, do whatever it's taking so much energy not to do. LET IT OUT!**
- **Make yourself available: or take yourself out of the race for awhile.**

***LET YOUR BODY SERVE YOUR MIND; YOUR MIND SERVE YOUR BODY -- A PEACEFUL COALITION.***

TOP

# DO's AND DON'Ts

## DO's:

- **Do let your genuine concern and caring show.**
- **Do be available . . . to listen, to help with the other children, or whatever else seems needed at the time.**
- **Do say you are sorry about what happened to their child and about their pain.**
- **Do encourage them to be patient with themselves, not to expect too much of themselves and not to impose any "shoulds" on themselves.**
- **Do allow time to talk about the special, endearing qualities of the children they've lost.**
- **Do give special attention to the child's brothers and sisters . . . at the funeral and in the months to come (they too are hurt and confused and in need of attention which their parents may not be able to give at this time).**
- **Do reassure them that they did everything that they could, that the medical care their child received was the best or whatever else you know to be true and positive about the care given their child.**

## DON'Ts:

- **Don't let your own sense of helplessness keep you from reaching out to a bereaved parent.**
- **Don't avoid them because you are uncomfortable (being avoided by friends adds pain to an already intolerable experience).**
- **Don't say that you know how they feel (unless you've lost a child yourself, you probably don't know how they feel).**
- **Don't say "You ought to be feeling better by now" or anything else which implies judgement about their feelings."**
- **Don't tell them what they should feel or do.**
- **Don't change the subject when they mention their loss.**
- **Don't avoid mentioning the child's name out of fear of reminding them of their pain (they haven't forgotten it).**
- **Don't try to find something positive (e.g., a moral lesson, closer family ties, etc.) about the child's death.**
- **Don't point out that at least they have their other children (children are not interchangeable; they cannot replace each other).**
- **Don't say that they can always have another child (even if they wanted to, and could, another children would not replace the child they've lost).**
- **Don't make any comments which in any way suggest that the care at home, in the emergency room, hospital, or wherever was inadequate (parents are plagued by feelings of doubt and guilt without any help from their family and friends)**

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*American Journal of Community Psychology, Vol. 16, No. 3, 1988*

# An Indigenous Community Mental Health Service On the Tohono O'odham (Papago) Indian Reservation: Seventeen Years Later[1]

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*Tohono O'odham, Psychology Service, Sells, Arizona*

*The status of a fully indigenous mental health program serviced and controlled by the Tohono O'odham (Papago) Indian tribe is reviewed from the perspective of its 17-year history. The program functions in large measure in a crisis intervention model, with suicidal or acutely disturbed cases being most frequent. However, a whole range of disorders and ages are seen. Traditional Medicine Men and Women are often used as consultants, as are some professionals. In recent years child sex abuse and abuse of drugs among youth are prominent problems. The program experienced problems of obtaining services off reservations for patients in need, and in establishing credibility of the Indian Mental Health workers with the outside service providers.*

One of many innovative ideas of the "third mental health revolution" was that services should be provided, directed, and controlled by the people of the indigenous community that was being served. The number of programs that were fully implemented according to this indigenous principal is unknown. They have not fared well at least as suggested by reviews of the paraprofessional-new careers program by Perl (1981) and by Arnhoff (1981).

The Tohono O'odham Psychology Service is one that was fully implemented. This program is controlled and run by the O'odham tribe and

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is serviced by O'odham people who are indigenous to the reservation. From its very tentative beginnings in 1969, it has developed a mental health staff of six, a secretary, and two part-time professional consultants. The program is not only alive and well but undergoing a phase of renewed vitality. It has not compromised its indigenous stance nor its sensitivity to the culture of the people it serves.

The staff is a stable, experienced one that continues to take training opportunities and has become increasingly sophisticated in dealing with the mental health problems of their people. The initial selection and training of the indigenous staff is described by Kahn, Henry, and Lejero (1981). Selection was based on factors of identity with their own group, being responsive, sensitive, and wanting to help, free of severe personal problems, being selected and accepted by their own people. Training was tutorial with the professionals at first and then with their own experienced staff. Referrals to traditional healers are still frequent. Along with the ever-present problems of depression, suicide, family disturbance, delinquency, and school dropout (most of which are associated with alcohol abuse), newer problems involving marijuana and hard drug use, spousal and child abuse are now more evident.

The early development of this program has been reported previously (Kahn & Delk, 1973, Kahn et al., 1974). This report is an update and a status report on the program 17 years after it beginning.

## AN OVERVIEW OF THE PROGRAM

### *The Setting and the People*

The Tohono O'odham reservation is located in a vast desert area southwest of Tucson, Arizona. It borders Mexico to the south and covers an area the size of the state of Connecticut. Distances to outlying villages from the location of the psychology service in the central and largest village can be up to 100 miles, sometimes still unpaved roads. Patients are seen from all areas of the reservation. The numbers are more or less proportional to the size of the villages. The overall Tohono O'odham population served is about 12,000.

### *Changes in the Setting Over the Years of the Clinic*

During the period of the clinic's existence, there have been a number of developments that are of significance for mental health and other aspects of the reservation community. During that period, a stronger, more integrated



tribal government has developed. The residents recently approved a new constitution which includes the name change for the tribe. The former name, Papago, apparently was given by the early Spanish explores. Their own designation for themselves has traditionally been *Desert People* or in their language, *Tohono O'odham*. This name change is symbolic of the developing pride, assertion, and control that is gaining on the reservation.

Paving and improving the roads to the larger villages and increasing availability of water and electricity have had their influence. Television, for instance, is available almost everywhere on the reservation, for better and for worse. There has been a growing shift away from sending children to distant boarding schools run by the Bureau of Indian Affairs, toward local schools with O'odham school boards. The population is growing and housing is scarce and often crowded, but many new Western style homes have replaced the dirt-floor adobe ones that were more dominant when the program started. These changes have not been sudden nor dramatic but do represent a steady movement in the direction of developing facilities similar to the standards of the dominant culture.

The impact of this in our impressionistic view has been a strengthening of both identify and pride in being Tohono O'odham, along with some improvement in material aspects of living, at least for some.

However, along with these changes, many of the social, psychological, and economic problems that were there when the clinic started now seem accentuated and perhaps more pervasive. Both the social change and the increased impact of the dominant culture on traditional ways have increased stress. The influence of the mental health service has made people sensitive to and brought into the open many problems that were neither recognized nor dealt with in the earlier period.

Alcohol and more recently other drug abuses have played a direct or indirect role in almost all of the cases seen. This is of course but a symptom of deeper and more complicated factors. Economic factors continue to cause stresses. Indeed, the unemployment rate on the reservation still stands near 50%. The glittering television portrayal of the dominant culture provides a demoralizing contrast to life on the reservation and intensifies a conflict of cultural values and beliefs. The suicide rate is unacceptably high. Depressions and suicidal ideation and attempts are factors in almost one half of the case load of about 200 persons per year. In a similar proportion of the case load, the nuclear family of husband and wife is often unstable in association with alcohol abuse. Children are reared by various relatives or single parents. School achievement is too frequently low and dropping out of school before completing high school is all too frequent, although no exact figures are available. Only recently, probably largely because of the national television coverage, child and spousal abuse as well as incest has come to the attention of the service.

The predominant mode of functioning of the psychology service has been crisis intervention, but the service provides other services as well. The mental health technicians are on 24-hour call, 7 days a week, and do this on rotational basis. Because of the great distances and very few telephones, communication depends on a two-way radio. The approach is to contact the individual in crisis as soon as possible. In some instances, such individuals can be brought in by the police or health workers in the village but often mental health workers drive out to them. Most crisis situations involve suicide threats or attempts. Frequently, alcohol is involved. Even at noncrisis proportions, depression is a frequent symptom, particularly since there has been a recent lowering of funds for various jobs on the reservation. Family therapy is used although the male often will not attend the family sessions. In noncrisis cases, alcohol abuse is also present and more often than not is a major contributing factor to the difficulty.

Also among the noncrisis-oriented functions is service to the schools and courts, providing evaluations and counseling. The service has also provided parenting skills classes.

Two types of consultants are used. Western professional consultants include a psychiatrist and a clinical psychologist who function to provide backup case conference reviews, training, and some direct patient contact. The general rule of the service is that when all else fails, use a Western consultant.

The other type of consultant is the O'odham Mahkai or medicine person. They have been part of the program from the beginning. When the indigenous workers conclude that the problem is experienced by the patient in traditional cultural terms and when the patient agrees to a traditional approach, the service arranges for a *Mahkai* and pays them a consultant fee. The frequency of such referrals is not great, perhaps one or two a month. The low frequency is probably due to the fact that many people with traditional beliefs seek out a medicine person on their own and probably would not consider this service at all.

Problems that are likely to be referred to a medicine person are varied. An example would be of an individual who experiences fears but cannot identify the source. Such an individual may experience hearing the voice of a dead relative or experiencing an omen that may suggest the dead person is trying to contact them. Traditional beliefs are such that it is not unusual for dead relatives to try to contact the living. Only a medicine person can communicate with the spirits and is able to put them to rest.

Of the many problems that the service continues to confront is that mental illness still carries a very strong stigma and is viewed generally very negatively by the people. Generally, people do not want to admit to that kind of problem in themselves or in family members. The program works to provide education but the progress is slow. Another enduring problem has to do with obtaining services for patients from agencies other than the ones available through the tribe.



## PROBLEM TOPICS

### *Alcohol–Drugs*

Overriding most of the difficulties that come to the attention of the service is the long-standing problem of alcohol and recently the growing problem of abuse of other drugs. The widespread overuse of such substances is symptomatic of the cultural disruption and exploitation that the people have suffered for many generations (Kahn, 1982). The tribe does maintain a separate alcoholism program, but the mental health program has a focus on drug usage in the schools. Over the past 10 years, the use of heroin and "speed" has been found, especially among those in junior and senior high school. The more common drug abuse is with marijuana and the sniffing of inhalants such as glue and gasoline. The latter is common with younger school-age individuals. Perhaps half of the teenage population on the reservation is involved in some level of drug abuse.

The behavior problems that bring these individuals to the program are school truancy and various delinquency patterns. The increase in crime and delinquency on the reservations appears very much related to the drug problem, as stealing and other forms of delinquency have become a way of obtaining money for the drugs. Drug abuse is much greater problem with the males than females, by about 3 to 1, and has been seen in individuals as young as 7 years old. But alcohol abuse is still the most prominent drug in the school age group. Most of the individuals that are seen for drug–alcohol problems come from broken homes, where there is an alcoholism problem with the adults. The approach to these problems is twofold: to provide education with regard to drugs, to try to help reduce drug intake; and to work with emotional problems. The pressure from the courts to avoid a legal penalty by going to treatment is often the main motivational factor for treatment.

### *Suicide*

Depression, suicidal thoughts, and suicide attempts are found in almost half of the 200 cases that are seen. Much of the crisis work centers around acute suicidal situations, often occurring when an individual is drunk.

None of the patients seen by the service in recent years have completed suicide but many have been seen who have suicidal ideation. Clinic records

for the past 2 years indicate 85 individuals, or about a quarter of the case load, referred or came in specifically because of a suicide attempt or preoccupation. An average of 3½ cases a month are seen who have serious suicidal symptoms.

Unfortunately, completed suicide occurs on the reservation at a rate several times that of the national average. An early suvey of the suicide on the reservation by Conrad and Kahn (1974) found the rate was over three times that of the national average and was most likely to occur in individuals who lived closest to the urban areas. Recent suicide rate may actually be somewhat higher than that found by Conrad and Kahn and suicide appears to be occurring more frequently further out on the main reservation. Perhaps the cultural conflict is moving deeper into the reservation as traditional ways are more and more eroded.

In recent years, only one of the completed suicides have been known to the psychology service. That seems indicative of the considerable stigma regarding suicide among the people. The act often is considered as sinful, evil, or the result of someone being possessed by bad spirits, or some kind of a taint on the family. This seems to be a major factor in the lack of referral for help for those individuals who later committed suicide.

A major prevention effort is underway in cooperation with a range of other service programs. It is aimed at informing the public about early warning signs of suicide, where and how to seek help, and particularly to emphasize that it is often due to depression and is a treatable, preventable disorder and not a sign of some bad doing.

Patients recently seen for suicide attempts are young and it is rare to have one in an individual above the age of 30. The reasons vary. Some have had to do with juveniles in detention who seemed unable to tolerate such restriction. Others have to do with individuals who felt their home situation was intolerable, or have a problem with intimate relationships where the attempter felt abandoned, unloved, or rejected. Attempt methods are varied too, although ingestion of pills and drug overdose are most common. One individual attempted to hang himself by the use of a braid of his long hair. Many attempts occur after heavy drinking or drug use. They are initially seen in a crisis intervention approach and then followed up when they are sober. Unfortunately, when sober, many such individuals, perhaps partly out of embarrassment, do not respond to efforts to contact them and to work with them.

### *Sex Abuse and Incest*

In recent years about one case of child sex abuse has come to our attention every few months. That is a marked change from the early years when no cases were reported.





Child sex abuse is considered by the people to be a most terrible act, so much so that people try to avoid recognizing it. They talk about it only in the O'odham language, in hushed tones, as it is considered so bad that it should not be said. Sexual abuse has been there, but until recently it was unreported and no services were available. That has changed. Perhaps because almost all villages now have electricity and there has been much on the subject on television, and because children have learned about sexual abuse from the schools, sex abuse has become a more open topic. People are now learning about the effects and symptoms, and they do not want that to happen.

In the cases seen, the victims are usually girls although there were a few boys as well. The abuser is not necessarily a step-father but often the natural father. In many situations children have been molested in the family home. Incest cases that come directly to the service are few, but from adult patients we hear that, as children, they were sexually abused; sisters by brothers, women by first cousins.

On the other hand, child beating cases are very rare. That probably has to do with the fact that O'odham are very loving and giving to their children and do not try to control them by physical means.

In most cases the goals are to get family members, mainly the daughter and mother, to feel basically good about themselves, to help them see that they have a strong secure place and end the power struggle between daughter and mother. Such cases are also referred to the Children's Court and/or Federal Law Enforcement, and sometimes to Parents United Program.

Wives have been reluctant to file criminal charges against the offending husbands and fathers. Children, too, do not want to formally bring accusations against the offending parent. Thus, when working with such cases, the effort is to change the situation within the home and to support the victim's efforts to have a place in the home without the sexual abuse.

## MEDICINE PERSONS AND TRADITIONAL HEALERS

The medicine persons or Mahkai of the tribe are held in great respect by most O'ohdam. They usually acquire that position through heredity; that is, their father or mother were traditional healers and they inherit the powers. But it is possible for individuals to learn the necessary knowledge through training with a skilled medicine person as well. In past times, Mahkai were very much leaders and were held in great respect. In fact, they were sometimes feared because medicine persons can do evil things as well as good medicine. Some people still fear that the Mahkai may be able to read a person's mind or sense their feelings. If one were to offend a Mahkai, that individual might be very afraid of the medicine person's revenge.

When the clinic has been involved in problems that seem to have a supernatural cause, referral to a Mahkai is made. The traditional healer, by his or her various procedures, can blow away evil spirits or such out whatever the offending causal object might be, such as a feather, a rattle, or a stone. Medicine persons deal with things that ordinary people cannot, such as strange noises, or frightening communication with the spirits by dreams of dead people. For instance, it is believed that people who commit suicide think they are still alive. Only the Mahkai can contact the spirit and inform that person that he or she is no longer alive. If something has been requested by the spirit and has not been done, then the spirit will come back. The Mahkai can determine what the spirit wants and how to set the situation right.

While there were separate diagnosticians who can determine the nature of the offending problem, healers generally, but sometimes even diagnosticians, perform healing ceremonies. A diagnostician can tell which bad spirits, devils, or ghosts are around, and also can help with the healing by doing the various rituals and songs.

There are many types of sicknesses associated with different spirits. Some have to do with how one has offended an animal, and one must be very careful how they kill an animal for food and not to use too many of them (see Kahn *et al.*, 1974).

If a person knows a Mahkai in their village, the referral is to that one. Older people tend to know medicine men. For the younger patients, it is the parent's request. We know of no problem with children complying. In one village for instance there are two or three. They have acquired their status through heredity. They recommended ways for getting away from ghosts or devils or animal spirits and they also recommend prayers and Hail Marys as part of the procedure. A person may go to a Mahkai for a curing by himself or herself or often with other family members.

When patients are referred, the Mahkai are paid for the service. They are asked what they want for their service, but mostly they say whatever somebody can give or afford. In the past, people would give what they could. If they could not pay at the time, they could pay later on, even 20–30 years later, but it did not matter if they paid or not.

Many O'odham people have beliefs in the spirits and problems that medicine men deal with. "When you do believe, you will be cured. I feel that how well the medicine man's treatment works depends on how much belief you have."

## WHEN NONTRIBAL RESOURCES ARE NEEDED

A long-standing difficulty in providing service for the people on the reservation often has occurred when a reservation resident is in need of



specialized services, such as psychiatric hospitalization, or special training schools provided by the state, county, and city. In the past, reservation residents have been considered ineligible for such services since they reside on federal non-state-taxable land.

Although this seems to have been modified in recent years, difficulties in getting reservation residents into the non-federal public facilities persist. One county takes a clear stand that a reservation resident who knows disturbed behavior on the reservation would not be eligible. However, if the disturbed behavior occurs off the reservation, the individual then could be eligible.

The other problems have to do with the status and credibility of the O'odham Mental Health workers when they deal with outside agencies. Personnel of these agencies lack the familiarity and understanding of O'odham behavior, especially when interviewed by non-O'odham.

The O'odham Psychology Service on the average has hospitalized about 10 patients a year off the reservation. Until recently, the program had all but given up trying to get admission to the public facilities. In situations where a patient is very disturbed and needs psychiatric hospitalization, as when their behavior is very unmanageable or there is a very serious suicide threat, it seldom has been possible to get such patients admitted to county hospitals. Fortunately, there are some funds available with which to hospitalize privately, but such money is limited.

A major problem is that the nonreservation public hospitals do their own screening evaluation and refuse to accept our evaluation, since they did not observe the same behavior. There needs to be an understanding of O'odham culture. Some of our patients do not understand English and their aggressive loud behaviors change when they are screened by a stranger. They then appear shy and quiet. They act differently toward an Anglo than toward an O'odham.

When we learn of the abnormal behavior of an individual, we go out to the village and evaluate the patient. If we feel he or she needs to be hospitalized, we transport him to the hospital. The drive usually is 2 hours. Once there, we have had to wait up to 3 to 5 hours in the emergency room for a social worker to do the screening. We give them information on the patient, but are given little credibility and the patient may not be admitted. We must then bring the patient back. The patient continues to roam around the village and we get called on him or her again.

Agency personnel often make us feel as though we do not have the qualifications and that our diagnoses of our patients are not correct. We feel humiliated and then we have to return the patient back home and be their "shadow" so they do not harm themselves. However, when funds are available to hospitalize in a private facility, they listen to our information, and work with us. Recently, the Public Health Service hired a psychiatric con-

sultant who works closely with our program and has helped arrange a better working relationship with the nonreservation hospitals. The situation has improved.

There have also been similar difficulties getting people into drug abuse centers. Again, it is a complicated picture of who is going to pay. For whatever reason, our patients do not get into behavioral halfway houses and it seems that nobody wants to take responsibility for the payment.

What is needed on the reservation is a crisis center and halfway house facility to deal with emergency situations, in order to get people properly medicated and stabilized. This would avoid the lengthy trip to town only to be misunderstood and sent back with no help for the patient.

## EVALUATION

How effective has the Tohono O'odham Psychology Service been over its 17 years of history? The answer to that can only be approached impressionistically. As with most mental health services there are few hard data. The program was developed as a clinical service with no provision for research as such. Research as Western academics define it is regarded suspiciously and as an unneeded drain on the overwhelming clinical needs.

What can be documented by data is that prior to the service, almost no O'odham individuals were receiving psychological help, as we have defined it, while such services have in recent years been provided to over 200 new cases per year. From this treated prevalence can be estimated in a gross way types and rates of mental health problems on the reservation.

We believe the service has helped bring into focus the pervasive and destructive influence of the widespread overuse of drugs and alcohol. The program has coped with, and we believe prevented, many suicides, and has counseled with and supported many teen-agers with school problems, delinquents, and individuals caught up in family problems and family disruptions.

The fact that the case loads, self- and agency referrals continue to grow demonstrates that some inroads into the strong stigma with regard to mental health among the people is being reduced, and also demonstrates increasing acceptance by the people.

A unique contribution of this program is the demonstration that a technical-professional service field can be administered by the indigenous people it serves, and operate successfully with basic technical services provided by indigenous mental health workers.

We believe services are rendered with cultural understanding and sensitivity and have reached many people in need. Further, the program has demonstrated the skill and ability of the indigenous persons in such helping





roles. The O'odham mental health workers are also role models for other O'odham people. They demonstrate that O'odhams can perform relevant technical services for their people and demonstrate a meaningful way of gaining economic self-sufficiency.

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W.M.A.T. Police Dept.

2/4/99

Support sources: Death of Police Officer

1) WMAT Guidance Center (Victims Comp.) Traumatic Incident
2) " Police Dept. Div.,
3) " Hospital - Social Services - E.M.S., Mental Dept.,
4) Dr. Gilmartin - & Assoc.
5) Church - Pastors Mixed Churches ⇒ Bapt. Lut., Mormon, Assembly of God.
6) Suicide Prevention Team
* 7) Medicine men - Bert, Larold, Harris, Eunice,
8) W.M.A.T. Chairman - (CAW)
9) " Tribal Council
10) Other agencies ⇒ G&F; Fire Dept; APACHE & NAVASO Cty's., DPS
~~Rangers~~,
11) TRIBAL Social SERVICES: SHELTER: ⇒ SAFE HOUSE.
12) A.A. RAINBOW TREATMENT CENTER:
13.) M.A.D.D. & A.P.A.G.:
14.) DARE & GREAT
15.) School Counselors
16) Prosecutor (Victim-Witness)

1. G.C.
2. Hosp.
3. Church
4. Dr. Gilmartin

Network of Support System =
i How Communities function?
obligations of commitment to assist in helping.
appropriate Kind of intervention
i How problems & Social problems get Solved?
Peer Support ⇒ in Resource to another's Dept.

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MAJOR ISSUES - REFERRALS

FAMILY
TPD / PCSO PSYCHOLOGICAL SERVICES
PIMA COUNTY V/W
TOPS
MEDECINE PERSON
PRIEST
EMTS
VICTIM WITNESS / LOCAL + FEDERAL
DPS
FOP / ALC
RED CROSS
FIRE DEPT.
SOCIAL SERVICES
CONCERNS OF POLICE SURVIVORS
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(Support Sources)

Chaplain - ICPC
Dr. STORM
EMPLOYEE ASSISTANCE
College counseling
- PEER SUPPORT GROUP

(Community Resources)
Brewster Center MAC Team
VICTIM / WITNESS

PIMA College DPS

UAPD - PEER Support group
GILMARTIN & ASSOCIATES
C.O.P.S - Concerns of Police Survivors

F.O.P

* ICPC -> INTERNATIONAL CONFERENCE OF POLICE Chaplains

(Support Sources)

- Chaplain - ICPC
  - Dr. STORM
  - Employee Assistance
  - College counseling
  - Peer Support group

(Community Resources)

- Brewster Center
- MAC Team
- Victim / Witness

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UNIVERSITY of AZ POLICE

EMPLOYEE WELLNESS CENTER

DR. MORGAN

CENTER SAMHEIL

STUDENT HEALTH

UMC

Mobile Acute CRISIS Team

Employee Relations

VICTIM WITNESS

B S U. from TPD

PEER COUNSELORS

PCC chaplain

ST. PETER & PAUL

OASIS center

HMO COUNSELORS

RED CROSS

SALVATION ARMY

Brewster center

RAPE CRISIS center

Dean of STUDENTS

RESIDENCE LIFE.

COPE

Legal AIDE through UA

UNIVERSITY FINANCIAL Services

ARIZONA LABOR COUNCIL

FOP lodge #51

CENTER for ENGLISH Second Language

AFRICAN AMERICAN Center

NATIVE AMERICAN Center

HISPANIC Center

ETHNIC Centers

ISLAMIC Center

BAPTIST STUDENT Center

NEWMANN Center

MORMON Center

AFFIRMATIVE ACTION Office

CONCERNS of POLICE SURVIVOR

[redacted]

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ISLAMIC Center

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NEWMAN Center

MORMON Center

AFFIRMATIVE ACTION OFFICE

CONCERNS of POLICE SURVEY

[redacted]

# stages of grief

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A brief quote adapted from: Joseph Bayly, The Last Thing We Talk About (revised), (David C. Cook Publ. Co.)

***Swiss-born psychiatrist*** Dr. Elisabeth Kubler-Ross has counseled hundreds of patients and their families through her research into death and dying. She described the classic pattern of the coping strategies of patients who know their diagnosis is terminal.

The first stage is *denial.* Upon hearing the diagnosis, the patient reacts with a shocked, "No, not me." According to Dr. Kubler-Ross, this is a healthy stage, and permits the patient and the family to develop other defenses.

Next comes *anger or resentment.* "Why me?" is the question asked now. "Why my child?" *Blame,* directed against the doctor, nurses and God often is a part of this stage. This outcry should be accepted, unjudged.

The third stage is *bargaining.* "Yes me, but-" "If you'll just give me five years, God, I'll . . ." This Dr. Kubler-Ross calls a period of temporary truce.

The fourth stage is *depression.* Now the person says, "Yes, me," with the courage to admit that it is happening; this acknowledgment brings depression. (Note: The family often goes through all the stages, along with the patient.)

Finally comes *acceptance,* a time of facing death calmly. This is often a difficult time for the family, since the patient tends to withdraw, to be silent.

To understand that these stages are normal is to be freed from alarm when they occur. We need not fear that a person is losing his or her faith because of anger or depression.

Amy Carmichael once said, "In acceptance lieth peace." And it is most true when the acceptance is of impending death.

What can we do during the unfolding of these successive stages? Dr. Kubler-Ross suggests that the best response is to listen, not to try to "prove" anything to the patient, but to listen.

And at times there will be nothing to listen to; we can only sit with the grieving one, lending support by our simple presence.

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*--Joseph Bayly in The Last Thing We Talk About (Revised),*

# The Growth and Development of Tribal Police

## Challenges and Issues for Tribal Sovereignty

Eileen Luna

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*The Growth and Development of Tribal Police*

Challenges and Issues for Tribal Sovereignty

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American Indian tribal governments have the opportunity to expand tribal sovereignty subsequent to the passage of the Indian Self-Determination and Education Assistance Act, and the Indian Self-Governance Act. The legal window created by these acts, coupled with cutbacks in Bureau of Indian Affairs Law Enforcement Services, has created an environment in which tribal governments are developing and expanding tribal law enforcement services. The legal minefield in which tribal governments and law enforcement personnel operate is a complicated one, but one which must be successfully negotiated if tribal sovereignty is to be advanced through the assertion of police authority.

Law enforcement, in the way that it has been practiced in Indian Country during the 20th century, is a foreign concept to most Native American communities. Policing has been imposed on Indian peoples by the United States government through the use of the Plenary Power Doctrine. This doctrine, invented by the U.S. Supreme Court in the early 1800s with the rulings in the Marshall Trilogy (*Cherokee Nation v. Georgia*, 1831; *Johnson v. McIntosh*, 1823; *Worcester v. Georgia*, 1832) and cemented into place with

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*Self-Governance*

Under the Indian Self-Determination Act of 1994 (H.R. 4842), 25 tribes have now taken over direction of their own law enforcement activities. This act empowers the Secretary of the Interior, on the request of a tribe, to grant funds for the purpose of "the strengthening or improvement of tribal government" including the provision of law enforcement services, the nature of which is determined by the tribe. Although a reporting requirement exists within the act, the nature and contents of the report are not delineated.

*State Law Enforcement Pursuant to PL 280*

A number of reservations (39) and 106 *rancherias* (small, rural, Indian areas, many of which are not federally recognized) are situated within those states that were delegated law enforcement authority pursuant to PL 280. The BIA has no authority to act in these areas. The state and local governments provide law enforcement services to these Indian reservations and rancherias, although a number of the tribes also employ their own law enforcement or security. Often, whether due to the relatively remote locations of the Indian areas or due to negligence or unwillingness, the local sheriff does not provide adequate law enforcement services to the tribes. This has forced a number of tribes to try to fend for themselves or to do without.[5]

## SPECIAL POLICING ISSUES IN INDIAN COUNTRY

State, federal, local, and tribal law enforcement agencies face many different issues and special problems when considering working in and with Indian Country.[6] Sovereignty, hot pursuit, cross-deputization, the requirements of federal funding, the development of culturally compatible models of policing, and the operation of PL 280, all create hurdles that must be overcome if accountable and effective policing is to take place in Indian Country. In some places, states and tribes are trying to solve these issues.[7] However, the resolution of cross-jurisdiction and other issues remains of particular concern when tribal law enforcement departments are being newly created and face, from the start, the high incidence of criminal conduct that exists on many reservations.

*Sovereignty*

The idea that the various Indian nations and reservations are sovereign,[8] have the right to govern themselves, and must be dealt with by U.S. and local governmental agencies as equals is one that is surprising to many in the non-Indian community, even those in law enforcement. Setting aside that it is a concept that is even deeply resented by some, it can often be a stumbling block in negotiations between tribal councils and the state. Unfortunately, this remains the case even with the government-to-government mandated relationship ordered by President Clinton (Executive Memorandum, April 29, 1995) and subsequently reasserted by U.S. Attorney General Janet Reno (1995a).



*Hot Pursuit*

Shared geographic boundaries complicate the interrelationship between Indians and state governments. Criminal perpetrators do not necessarily stay within jurisdictions. They may commit crimes in Indian Country and flee into state jurisdiction or the reverse. Very often, this flight can result in a hot pursuit, where law enforcement chases a suspect from one jurisdiction into another.

These pursuits are usually not a problem between state jurisdictions where mutual aid agreements, negotiated between the jurisdictions, exist. In those instances, the law enforcement officers are free to pursue into the neighboring jurisdiction and can even receive assistance by local law enforcement in handling the pursuit, detention, and arrest. Mutual aid agreements are rare, however, between Indian Country and state jurisdictions.

The issue of sovereignty is one that has impeded the creation of mutual aid compacts. Many states and local governments have been unwilling to recognize that tribes have the ability to constrain state action to any extent. On the other hand, Indian communities have expressed concern regarding state or local police having authority to enter into or act in Indian Country without constraint.

*Cross-Deputization*

Cross-deputization of law enforcement personnel is one solution to the problems that exist where state and tribal lands are contiguous and intermingled. Under this procedure, tribal police are given deputy status by state authorities and state police are given deputy status by tribal officials. With this, both the tribal police and state law enforcement have the power to arrest wrongdoers, whether or not Indian and whether or not on the reservation.

Although cross-deputization may seem like a good idea, cooperation between the tribal, state, and local agencies has not been good. One stumbling block is that sometimes only one agency wants to cross-deputize. Another is that, often, state agencies refuse to recognize the training received by tribal

**TABLE 1**
*State-by-State Overview of the Status of PL 280*

| | Indian Country Affected |
|---|---|
| **Mandatory states** | |
| Alaska | All Indian Country within the state except the Annette Islands with regard to the Metlakatla Indians |
| California | All Indian Country within the state |
| Minnesota | All Indian Country within the state except Red Lake Reservation (retrocession accepted for Nett Lake Reservation) |
| Nebraska | All Indian Country within the state (retrocession accepted for Omaha Reservation) |
| Oregon | All Indian Country within the state except the Warm Springs Reservation (retrocession accepted for Umatilla Reservation) |
| Wisconsin | All Indian Country within the state (retrocession accepted for Menominee Reservation and Winnebago Indian Reservation) |
| **Option states** | |
| Arizona | Air and water pollution |
| Florida | All Indian Country within the state |
| Idaho | Seven areas of subject matter jurisdiction; full state jurisdiction if tribes consent: compulsory school attendance; juvenile delinquency and youth rehabilitation; dependent, neglected, and abused children; insanities and mental illness; public assistance; domestic relations; and motor vehicle operation |
| Iowa | Civil jurisdiction over Sac and Fox Reservation |
| Montana | Criminal jurisdiction over Flathead Reservation: full state jurisdiction where tribes request, counties consent, and governor proclaims (retrocession accepted for Salish and Kootenai tribes) |
| Nevada | Full state jurisdiction, but counties may opt out; later amendment required tribal consent (retrocession accepted for all covered reservations) |
| North Dakota | Civil state jurisdiction only, subject to tribal consent |
| South Dakota | Criminal and civil matters arising on highways: full state jurisdiction if United States reimburses costs of enforcement |
| Utah | Full state jurisdiction if tribes consent |
| Washington | Eight subject areas of jurisdiction on Indian trust land; full state jurisdiction as to non-Indians and Indians on nontrust land, although the state has allowed full retrocession fairly liberally (retrocession accepted for Confederated tribes of the Chehalis Reservation, Quileute Reservation, Swinomish tribal community, Colville Indian Reservation, Port Madison Reservation, and Quinault Reservation) |

consent requirement, which required a tribal referendum before states could assume jurisdiction. Since that date, no tribe has so consented.

In those states that have assumed jurisdiction (see Table 1), PL 280 established state jurisdiction without abolishing tribal jurisdiction. Thus, the powers are concurrent, even though some states, particularly California, have denied that such tribal jurisdiction exists (Goldberg-Ambrose, 1995). A



number of states have supported retrocession of part or all of the powers that they asserted as well as to specific reservations within their states (Cohen, 1982). This has resulted in a jurisdictional maze, characterized by overlapping laws and geographical areas. Specifically, PL 280 gives the named states the same power to enforce their regular criminal laws inside Indian Country that they had always exercised outside of it. With PL 280, the Federal Enclaves Act and the Major Crimes Act were wholly supplanted by the states.

## CONCLUSION

The burgeoning growth of tribally funded police departments raises a significant challenge to tribal governments. The taking over of fundamental services brings with it the responsibility to ensure that the services are carried out in an effective and accountable manner.[10] Growth of institutions and assertion of authority, although an expansion of tribal sovereignty and compelling for many reasons, can create more problems than previously existed if they occur without thoughtfulness, planning, and careful design. To truly meet the needs of Indian people, tribal police departments should be carefully planned and crafted to fit the particular communities and the challenges each faces. The departments must be designed to effectively address the problems that are likely to arise while containing components that are appropriate to the community they serve. Finally, they must be accountable to the tribal government, to ensure that any defects in the original design, staffing, or operations can be corrected as they become apparent.

The following suggestions could be useful when considering the creation or implementation of tribal police departments. First, tribal governments should consider a community policing approach. This approach is supported by the U.S. Department of Justice, Office of COPS, and funding provided by them is conditioned on the development of community policing components. This approach to policing is based on the concepts of restorative justice, tribal cohesion, and community action.[11]

Various components of community policing are particularly well suited to the conditions existing in Indian Country. Proactive peacekeeping, rather than arrests and crime control after an incident, fits well, as does an emphasis on responsibility and accountability of law enforcement to the community, rather than only to the department's chain of command. The devolution of power to, and community consultation with, a broad-based circle of responsible leaders is a common approach to decision making in many Indian communities. This element alone could greatly enhance the work of police in Indian communities.

Second, tribal governments and police departments should develop codes, ordinances, and police protocols that clearly spell out proper conduct in given

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# THIS JOURNAL IS ABOUT:

# BORN:

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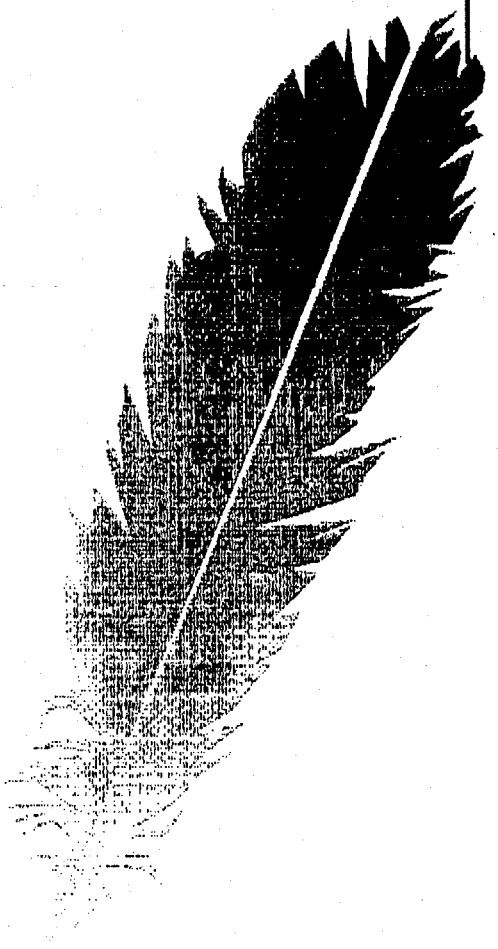
# JOURNAL KEEPER:



# A VERY SPECIAL PERSON HAS DIED

Nobody will ever realize exactly how much you meant to me, it was just between you and me.

Amy, 15

I want to begin the journal describing who you were and what you meant to me:

Our relationship was special. Here I'll describe things we did together, what we enjoyed, and some of our favorite things.

Our Funniest time together was...

The last time we talked or saw each other was...

Some things that I remember you saying that I don't ever want to forget are...

## YOUR DEATH

When I first found out that you died I was in shock, but I had to know the whole truth, every detail.

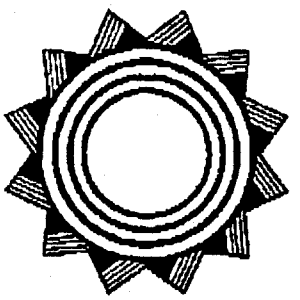
Brad, 17

This is what I know about when, where and how you died, and who was with you at the time:

My own thoughts and feelings of how and why you died:

What I did and felt right after I found out about your death:

What it felt like going back to school after you died:



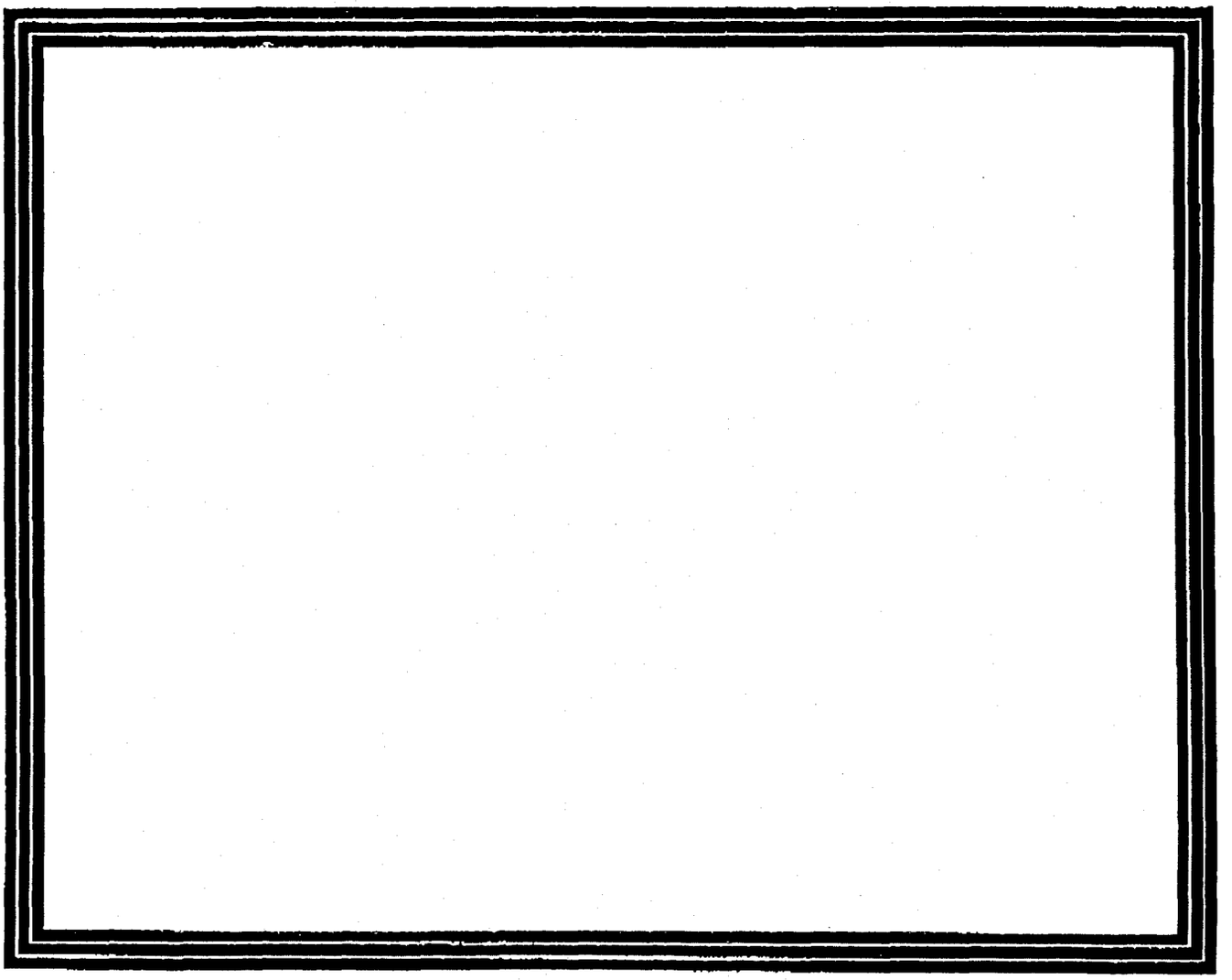
When I search for some meaning or try to make sense of your death this is what I've come up with:

Sometimes I find myself imagining that if these things were different your death might not have happened:

I wish you could tell me what your death was like, what really happened. I think you'd say:

I can physically feel the pain of your death, and this is where and how I feel it in my body:

Here is a drawing of what my pain looks like:



# FUNERAL MEMORIAL SERVICE

The funeral felt so unreal, like I was watching a movie, it wasn't really us, just actors who looked like us.

Alex 18

On this page I will describe the funeral service, the people who spoke and the personal touches that reflected you life and personality:

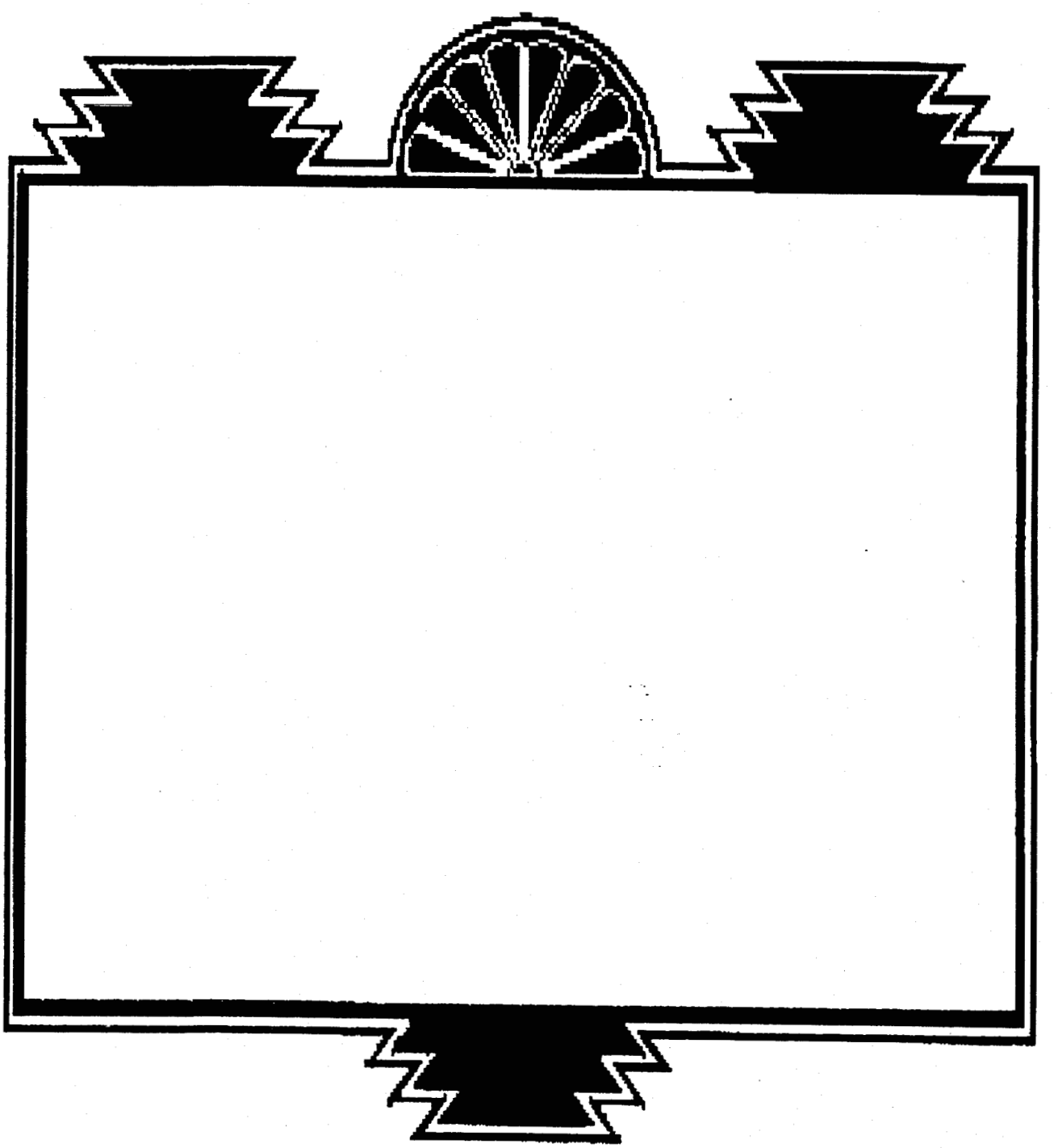
This is how I felt being there(or if I didn't go..Why I didn't go):

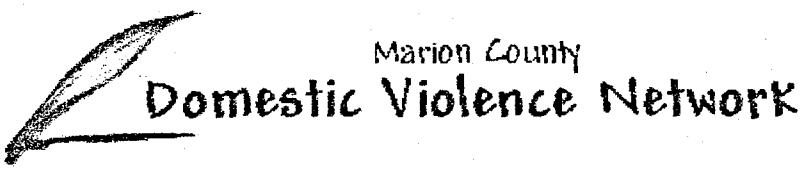
If I planned the service for you it would have been like this:

Sometimes I wonder what it would have been like if it was my funeral(how would it be different):

The Funeral service handout can be attached to this page as well as pictures and newspaper clippings.

This is what I would write on your tombstone so that anyone who would read it would have an idea of the person you were:






## Child Safety Plan When Experiencing Domestic Violence in the Home.

1. **Don't try to get in the middle of a fight.** Talk about where children may try to intervene to protect the victimized parent. Explain why this is not a safe thing to do, even though they may want to help the victimized parent very badly. Explain that there are ways to help without getting physically involved.
2. **If you can get to a phone safely, call 911 for help and stay on the phone.** Talk about finding a phone out of sight of the batterer. Discuss options such as going to a neighbor's house to ask to use the phone. Talk about what the children should tell the dispatcher who answers the call and why it's important to stay on the phone (unless it becomes too dangerous to do so) until they have been able to give the dispatcher their address and information about what is happening in their home.
3. **Try not to get trapped in a small room or closet or the kitchen.** Talk about places in the home where the children might be trapped or cornered. Explain why it's important to stay away from places in the house, like the kitchen, where there are sharp objects that can be used as weapons.
4. **Get to a "safe place." Find a safe relative or neighbor and ask for their help.** Talk about which grownups a child can feel safe turning to. Talk about other people the child might turn to if a relative or neighbor is unable or refuses to help right away. Emphasize how important it is to keep trying, even if the first people they turn to are not receptive. A violent parent may tell a child that he will hurt the child or the victimized parent if the child seeks help. Explain to children that family violence almost never goes away by itself, so that even if it is scary, they should try to get help from a safe adult who won't tell the abuser.

**Be sure to convey to the children in these discussions that it is not their fault and that they shouldn't feel ashamed about asking for help.**

From American Bar Association Commission on Domestic Violence "It's OK: Let's Talk About Domestic Violence" presenter guide. For information regarding video and other materials available call 1-800-285-2221.

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The National Center for Victims of Crime

# *INFOLINK*: DOMESTIC VIOLENCE-- SAFETY PLAN GUIDELINES

These safety suggestions have been compiled from safety plans distributed by state domestic violence coalitions from around the country. Following these suggestions is **not a guarantee** of safety, but could help to improve your safety situation.

**Personal Safety with an Abuser**

- Identify your partner's use and level of force so that you can assess danger to you and your children before it occurs.
- Try to avoid an abusive situation by leaving.
- Identify safe areas of the house where there are no weapons and where there are always ways to escape. If arguments occur, try to move to those areas.
- Don't run to where the children are as your partner may hurt them as well.
- If violence is unavoidable, make yourself a small target; dive into a corner and curl up into a ball with your face protected and arms around each side of your head, fingers entwined.
- If possible, have a phone accessible at all times and know the numbers to call for help. Know where the nearest pay phone is located. Know your local battered women's shelter number. Don't be afraid to call the police.
- Let trusted friends and neighbors know of your situation and develop a plan and visual signal for when you need help.
- Teach your children how to get help. Instruct them not to get involved in the violence between you and your partner. Plan a code word to signal to them that they should get help or leave the house.
- Tell your children that violence is never right, even when someone they love is being violent. Tell them that neither you nor they are at fault or cause the violence, and that when anyone is being violent, it is important to keep safe.
- Practice how to get out safely. Practice with your children.
- Plan for what you will do if your children tell your partner of your plan or if your partner otherwise finds out about your plan.
- Keep weapons like guns and knives locked up and as inaccessible as possible.
- Make a habit of backing the car into the driveway and keeping it fueled. Keep the driver's door unlocked and others locked -- for a quick escape.
- Try not to wear scarves or long jewelry that could be used to strangle you.
- Create several plausible reasons for leaving the house at different times of the day or night.
- Call a domestic violence hotline periodically to assess your options and get a supportive understanding ear.

**Getting Ready to Leave**

- Keep any evidence of physical abuse, such as pictures, etc.
- Know where you can go to get help; tell someone what is happening to you.
- If you are injured, go to a doctor or an emergency room and report what happened to you. Ask that they document your visit.
- Plan with your children and identify a safe place for them (for example, a room with a lock or a friend's house where they can go for help). Reassure them that their job is to stay safe, not to protect you.
- Contact your local battered women's shelter and find out about laws and other resources available to you before you have to use them during a crisis.
- Keep a journal of all violent incidences, noting dates, events and threats made if possible.
- Acquire job skills as you can, such as learning to type or taking courses at a community college.
- Try to set money aside or ask friends or family members to hold money for you.

**General Guidelines for Leaving an Abusive Relationship**

- You may request a police stand-by or escort while you leave;
- If you need to sneak away, be prepared;
- Make a plan for how and where you will escape;
- Plan for a quick escape;
- Put aside emergency money as you can;
- Hide an extra set of car keys;
- Pack an extra set of clothes for yourself and your children and store them at a trusted friend or neighbor's house. Try to avoid using next-door neighbors, close family members and mutual friends;
- Take with you important phone numbers of friends, relatives, doctors, schools, etc., as well as other important items, including:

    - Driver's license; Regularly needed medication;
    - List of credit cards held by self or jointly, or the credit cards themselves if you have access to them;
    - Pay stubs; and checkbooks and information about bank accounts and other assets.

**If time is available, also take:**

- Citizenship documents (such as your passport, greencard, etc.);
- Titles, deeds and other property information;
- Medical records;
- Children's school records and immunization records;
- Insurance Information;
- Copy of marriage license, birth certificates, will and other legal documents;
- Verification of social security numbers;
- Welfare identification; and
- Valued pictures, jewelry, or personal possessions.

- Create a false trail. Call motels, real estate agencies, schools in a town at least six hours away from where you plan to relocate. Ask questions that require a call back to your house in order to leave phone numbers on record.

**After Leaving the Abusive Relationship**

**If getting a restraining order and the offender is leaving:**

- Change locks and phone number;
- Change work hours and route taken to work;
- Change route taken to transport children to school;
- Keep a certified copy of your restraining order with you at all times;
- Inform friends, neighbors and employers that you have a restraining order in effect;
- Give copies of restraining order to employers, neighbors, and schools along with a picture of the offender.
- Call law enforcement to enforce the order.

**If you leave:**

- Consider renting a post office box for your mail or using the address of a friend;
- Be aware that addresses are on restraining orders and police reports;
- Be careful to whom you give your new address and phone number;
- Change your work hours if possible;
- Alert school authorities of situation;
- Consider changing your children's schools;
- Reschedule appointments that offender is aware of when you leave;
- Use different stores and frequent different social spots;
- Alert neighbors and request that they call the police if they feel you may be in danger;
- Talk to trusted people about the violence;
- Replace wooden doors with steel or metal doors. Install security systems if possible;
- Install a lighting system that lights up when a person is coming close to the house (motion sensitive lights);
- Tell people you work with about the situation and have your calls screened by one receptionist if possible;
- Tell people who take care of your children which individuals are allowed to pick up your children. Explain your situation to them and provide them with a copy of the restraining order;
- Call the telephone company to request caller ID. Ask that your phone be blocked so that if you call, neither your partner or anyone else will be able to get your new, unlisted phone number.