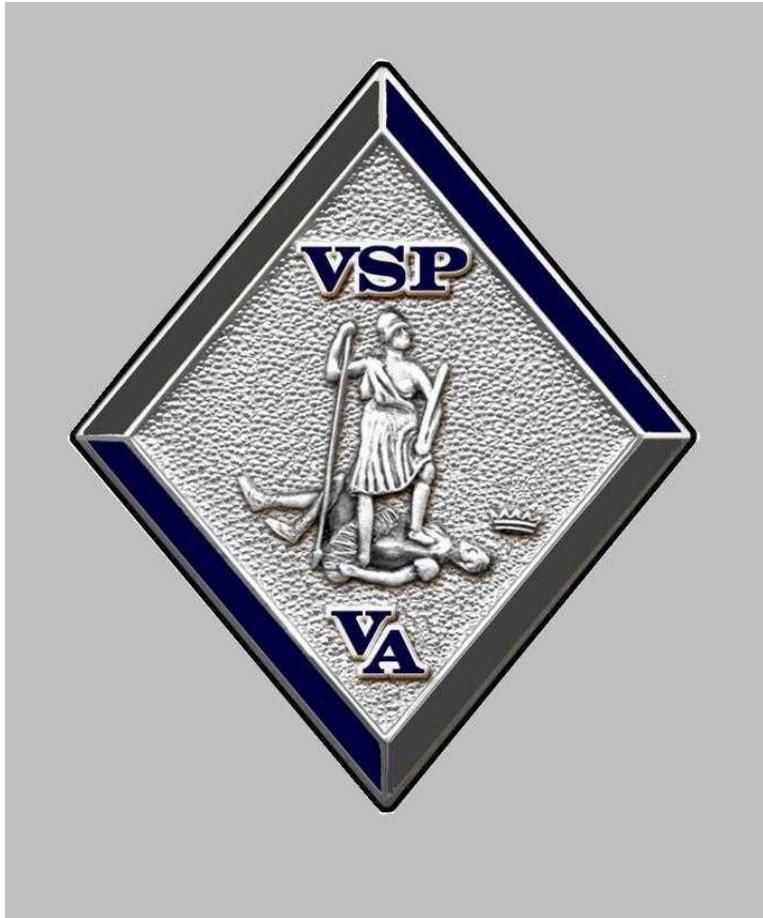


# Virginia State Police



## Critical Incident Stress Management Team

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## **Purpose:**

This manual is written with the intent to help provide stability and continuity to the Virginia State Police Critical Incident Stress Management Team, here after referred to as the CISM Team. This manual is meant as a guide and is not intended in any way to change or supersede Department Policy.

Department personnel and non-Department members of the CISM team should familiarize themselves with ~~General Order 54 of the State Police Manual, and the policies set forth therein.~~ **General Order ADM 14.02 and OPR 7.00 of the State Police Manual, and the policies set forth therein.** **General Order ADM 14.03 and ADM 14.00 also make reference to the CISM Team and policy relating to the activities of the team.**

## **Objective:**

The objective of the CISM Program is to minimize the effects caused by critical incidents and to assist employees and others to cope effectively with reactions to these incidents.

## **Department Management of Critical Incidents:**

Cooperation and support of Department Managers is essential to the success of CISM Team activities. Managers should be familiar with their role and responsibilities as set forth in **General Order ADM 14.02 and OPR 7.00** ~~General Order 54 of the State Police Manual.~~ While supervisors and managers cannot prevent members from experiencing critical incidents and the after effects of those incidents, they can help to facilitate the efforts of the CISM Team in their efforts to provide critical incident services to the affected member. A proactive CISM Program will help to maintain a healthy and effective workforce.

## **Team Mission:**

The mission of the CISM Team is to assist employees in effectively coping with reactions to critical incidents in order to achieve and maintain a healthy and effective workforce.

## **Mission of the CISM Team Members:**

The mission of the CISM Team Member is to provide confidential assistance to employees, their families, and others in coping with the reactions to critical incidents in a healthy and positive manner.

### **Confidentiality:**

Confidentiality is essential to the success of CISM Services. ~~General Order 54~~ **General Order OPR 7.00** of the State Police Manual establishes the standards of confidentiality for CISM Services, and those standards must be strictly adhered to by team members, and honored by supervisors and participants. Notes should not normally be taken during CISM sessions, unless they are in reference to follow up services and contact information. All notes shall be destroyed when they are no longer needed. In the Introduction Phase of all services the rules of confidentiality must be explained.

All CISM Services are confidential and anything that is said during CISM Team Group Services by team members or participants must not be repeated after the conclusion of the services. The information divulged during CISM Group Services may not be used to aid criminal or administrative investigations and must not be used to spread gossip.

The only exception to the confidentiality rule is that if a CISM Team Member or CISM Group Participant reveals information that causes others present to believe that person is a danger to himself, a danger to others, ~~violations of State Police Policy~~, or that the individual is involved in criminal activity.

### **Resources:**

The CISM Team uses a variety of resources including topic materials published for or by **The American Academy of Police Psychology** (Washington D.C.), **Dr. Beverly J. Anderson, B.C.E.T.S.** (D.C. Metro. Police Department), **John Hopkins University**, **The University of Maryland**, **Dr. Jeffrey T. Mitchell, Ph. D., C.T.S.**, **Dr. George S. Everly JR., Ph. D., F.A.P.M.**, and **The International Critical Incident Stress Foundation, Inc.** These professionals and organizations publish updated materials on the topic of stress counseling and peer support on a continuing basis. Up-to-date resources should be consulted frequently.

## **Background:**

The science of CISM is based upon research into the cause of conditions commonly referred to as, “Shell Shock,” or, “Post Traumatic Stress Disorder” (PTSD). PTSD is a serious condition requiring medical treatment, but less serious symptoms and conditions resulting from stress are commonly mislabeled as PTSD. The research has expanded in recent years to non-military professions to include first responders. The prevailing opinion of professionals in the field of stress counseling seems to be that long exposure to traumatic events and even prolonged and/or repeated exposure to non-traumatic, but stressful situations leads to coping difficulty in many people.

Problems arise when we fail to deal with the stress in a healthy way. Symptoms can cause problems in the workplace, at home, and in social settings. CISM is meant to provide intervention, assistance, and education to help those in need to understand the cause, nature, and effect of the symptoms of stressful situations. Some people who do not find healthy methods of dealing with stress following a critical incident, may over time develop serious symptoms to include substance abuse problems, abusive behavior, self destructive behavior, stress-induced illness, and in the most severe of cases, suicide.

According to Doctors Everly and Mitchell, 10% of any group exposed to a traumatic event can be expected to develop PTSD, and 13% of suburban police officers were found to suffer from PTSD. Research has indicated that the old saying, “An ounce of prevention is worth a pound of cure,” is an understatement. Early intervention, which is the goal of CISM, is essential when it comes to serious critical incidents.

## **Types of Critical Incidents:**

The following list is meant to provide a general guide as to the types of incidents that might be considered Critical Incidents, but it is not meant to be all-inclusive or exclusive. A person may experience stress-related symptoms if they respond to, investigate, assist with, experience, or have either a personal or professional relationship with someone who experiences any of the following:

1. Line of Duty Deaths
2. Line of Duty Assaults
3. Serious Line of Duty Injuries
4. Suicide
5. Officer Involved Shootings
6. Mass Casualty Incidents (Manmade or Natural Disasters)
7. Serious Motor Vehicle Crashes
8. Extended Undercover Operations
9. Military Deployments, Combat Operations, and Combat Support Operations
10. Significant Events Involving Children or the Elderly
11. Incidents Involving Known Victims
12. Personal Family Tragedies (Violent Criminal Incidents or Death)
13. Incidents With Negative or Excessive Press Exposure
14. Incidents Involving Civil or Criminal litigation (Against Them)
15. There are countless other types of events that may cause this type of extreme stress.

### **Group Dynamics:**

Society is made of people who tend to bond together with others with similar interests, needs, talents, and experiences. The dynamics of a group are very similar to those of a family. Groups as defined above are called homogenous groups and tend to behave much like a family in that they do not talk about group issues or problems in front of outsiders or those who are not part of their group. This applies to CISM Services and can contribute to the success or failure of CISM Group Services.

While people in the same department or profession tend to be a fairly homogenous group, specialty teams and those with specific shared experiences tend to be extremely homogenous. When CISM Group Services are attempted, it is important to keep the groups small and as homogenous as possible. If an incident involves only a small number of people, although they may be of differing professions, they may still benefit from Group Services because of the effect of having been the only people who shared that specific incident. However, when large numbers of people are affected, group dynamics becomes very important to the success of Group Services.

When large amounts of people are affected by an incident, the CISM Team needs to identify the homogenous groups and separate them from others.

Especially for a debriefing, it is important, for example, to have separate debriefings for TACT Teams or Crime Scene Technicians. Those groups will more than likely not open up and allow the Group Services to help them if they are with people who are not in their group. Whenever possible, the peer members in the debriefing should also be members of a similar group.

Another important consideration as CISM applies to groups is the level of exposure to the incident. Members who were on-scene of a critical incident should not be debriefed in a group with members who were not on-scene. First responders should be debriefed with first responders. For the purpose of CISM, dispatchers who are handling the radio traffic for first responders should be considered part of that group and debriefed with them. At a mass casualty incident, crime scene technicians may make up a large group and should not be debriefed with first responders. The larger the scale of the incident, the more groups there are that need to be identified and provided CISM Group Services as a homogenous group. Failing to consider group dynamics can seriously hamper the effectiveness of CISM Services.

The last issue that should be considered as it applies to CISM Group Services and group dynamics is the effect of a successful debriefing on people who do not belong in the group. Often if you fail to filter out people who did not have a similar level of exposure to the incident, the debriefing will fail because the homogenous group will not talk, or will not talk candidly about their experiences in front of the non-members. However, in the event that members do speak candidly about their experiences in spite of the presence of non-members, those non-members who were not previously affected or traumatized by the critical incident may be affected by what they hear or see in the group.

### **Types of CISM Services:**

For most of the services provided by the CISM Team, the Mitchell Model will be used unless another method is recommended by the attending Mental Health Professional. The services of a mental health professional should be obtained for all debriefings, and if available, is encouraged for all CISM Group Services.

#### **1. On-Scene Support:**

In some instances, critical incidents are prolonged and there is an opportunity to provide on-scene services. This may occur

due to at-scene investigations, where the affected member or members are required to remain on-scene or in a nearby location until they can be interviewed regarding the incident. When it is practical to do so, sending a CISM Team member or an individual team member to the scene of a critical incident can be beneficial.

Those performing On-Scene Support must not be involved in the investigation. They should be allowed to enter and leave the area as needed, so that they can attend to the needs and concerns of the affected members. They may choose to just sit with the affected members, to prevent the effects of isolation, they may contact loved ones at the members request, they may provide a sympathetic ear (Allowing the member to tell what happened if they want), or they may take care of basic needs that otherwise would not be tended to. (Facilitating restroom accommodations, obtaining meals or beverages, checking upon status of others or equipment that may be concerning the affected members, or simply obtaining a jacket for members who are cold.)

On-Scene Support members are prohibited from interfering with the investigation in any way. They shall not provide legal advice to the affected member. They are encouraged to give CISM related advice, providing the affected members with information regarding healthy coping techniques.

CISM Team, On-Scene Support personnel operate under the same confidentiality rules discussed previously in this manual, and shall not be subject to interview by investigators or supervisors.

## **2. Demobilizations:**

This is meant to be an area set up near the site of a critical incident where many members were likely to have been affected by the incident or the follow-up events, such as the investigation. This is meant as a decompression or respite area, a safe comfortable environment away from the incident, the press, and the general public, where CISM Team members can

provide refreshments, support, and education regarding symptoms of distress and effective methods of managing stress.

### **3. Crisis Management Briefings:**

This is a structured large group meeting. They are generally used following large-scale critical incidents where large portions of a community are affected by the incident. This is the only group service CISM provides to non-homogenous groups. It is frequently held in a town hall or press conference type of atmosphere. Crisis Management Briefings are very effective following mass casualty incidents. This service is meant to be of three phases.

- A. Provide information about the incident. This helps control rumors and corrects miss-information.
- B. Provide education regarding symptoms of distress and effective methods of managing stress.
- C. Identify resources available for continued support and referral.

### **4. Defusing:**

This is done with a small homogenous group, generally within twelve hours of a critical incident. Defusing is a three-phase group discussion, which may be used repeatedly for on-going events.

#### Phase 1 – Introduction

Brief acknowledgment of incident and explanation of CISM

#### Phase 2 – Teaching Phase

Symptoms, signs, healthy coping skills...

#### Phase 3 – Referral, and Closing Phase

Contact information, and scheduling of services

This is not done in lieu of debriefing, but as a preparatory step to a debriefing in cases where the nature of the incident, due to size, duration, or other factors make it likely that debriefing will be needed, but is not likely to be done as soon as preferred.

Following a line of duty death, debriefings should be held between two and seven days following the funeral. If the funeral is delayed, defusing may be helpful.

Following the Virginia Tech tragedy, the size of the event and the overwhelming number of members affected, made it necessary to conduct multiple debriefings with multiple groups. The process of coordinating with the many agencies to schedule debriefings without interfering with their operations extended the time line for debriefing. Defusing, Crisis Management Briefings, and One-on-One Peer Support were used effectively to bridge the gaps and provide assistance to members while debriefings were being scheduled.

## **5. Debriefing:**

Short for Critical Incident Stress Debriefing, this is a small homogenous group crisis intervention. Debriefings should be done in a seven-phase format, within two to ten days following most types of incidents, but can be done later if necessary.

Phase 1 – Introduction Phase

Phase 2 – Fact Finding Phase

Who, When, Where...

Phase 3 – Thought Phase

What were your thoughts, when...

Phase 4 – Reaction Phase

What was the worst part of this for you?

Phase 5 – Symptom Phase

What signs or symptoms of stress have you seen in yourself?

Phase 6 – Teaching Phase

Symptoms, effects, healthy ways to cope...

Phase 7 – Re-Entry Phase

Questions, referral, contact information...

Whenever possible, debriefings should be done on neutral ground. This means not on Department property or in Department facilities. Church meeting halls and fire department halls are good resources to utilize. It is important to have a good ratio of CISM members to participants. One CISM member to every 5-7 participants is preferred. CISM members should be evenly distributed through the

group. CISM members with similar experiences or expertise should be utilized whenever possible.

In planning for debriefing, it is essential that CISM members be given access to the facts of the incident. Department Managers need to provide as much information to the member as can be done without interfering with on-going investigations. If possible, members not directly affected by the incident, but who have the most knowledge of what happened, should meet with the members to provide the facts of the incident and answer their questions.

## **6. Follow Up / Peer to Peer Support and Counseling**

Peer support and counseling is an essential element of CISM. Team members are encouraged to obtain contact information from those affected by the critical incident and make themselves available for support and counseling. Whether it is done at the scene, at the site of demobilization, or days, weeks, months, or even years after the initial CISM intervention, one-on-one services by team members builds relationships, and can help heal the damage done by serious critical incidents. Department Managers should be encouraged to make every effort to support this type of services by team members.

## **7. Post-Critical Incident Seminars**

The Department of State Police generally has many critical incidents throughout each year. In order to provide effective follow up services, it may be helpful to schedule annual Post Critical Incident Seminars. These seminars typically involve members affected by a variety of incidents, but may be scheduled as follow-up service to a specific large-scale event. The seminar should be set up to provide education and counseling to those members known to be affected by critical incidents. Critical incident seminars also provide a unique opportunity to schedule training for members of the team by involving those affected by recent incidents, and may incorporate a variety of CISM Services to assist participants and train members.

### **Assisting Non-Department Members:**

The Department has offered the services of the CISM Team to other agencies as requested. When a critical incident occurs involving other agencies and our services are requested, at least two members of the CISM

Team should be placed on special assignment to be liaison and planners for the services requested. These members should assess the size of the critical incident and identify the groups affected, as well as, the types of services needed. They should assist the requesting agency in planning the services and provide information to agency management about the needs of the team for effective service. For example, they need to be aware of the need to separate groups by level of exposure and group characteristics. These members should also provide peer-to- peer services as the opportunity arises.

The Department may also provide CISM Team services to the family of affected members. Family members should never be debriefed with non-family members, and should not be invited to Department member debriefings.

### **Large-Scale Incidents:**

Large-scale incidents involving multiple agencies and multiple groups within specific agencies are a unique challenge. The Incident Command System as set forth in ~~General Order 30~~, **General Order OPR 10.00** of the State Police Manual, shall be utilized for management of CISM Services following large-scale events. These incidents require a great deal of planning. One team member should be assigned to manage the overall effort (CISM Incident Commander).

A second member should be assigned as logistics officer. The logistics officer does not need to be a team member but does need to be familiar with the area of operation, and be able to coordinate lodging, meals, and facilities for team members.

Frequent meetings must be planned to get all of the responding members up to date with efforts and needs. On extremely large events like the Virginia Tech tragedy, meetings may be required as often as twice per day. These meetings also allow the CISM Incident Commander to re-allocate personnel as needed.

Each affected agency should be assigned one, and if possible, two liaison officers to help coordinate and plan services. Liaison officers need to be sure to emphasize the importance of putting affected members into homogenous groups.

In the case of mass casualties, the Incident Command Staff and the Chaplains should also be assigned a liaison officer. As many members as can be spared, should be assigned to the reception area where victim's families respond for notification or identification. They will function in the role of on-scene support, providing for the needs of and offering peer support to officials and family members as needed.

Services should be offered first to those most affected, but support staff and command staff should not be forgotten. It is especially important to provide debriefing for the CISM Team members who provide CISM Services for large-scale incidents.

### **Conducting a CISM Debriefing:**

A mental health professional is critically important to a seven-phase debriefing. The mental health professional's role is that of an observer and advisor. They may interrupt the debriefing or interject information at any point they deem appropriate. They should aid in determining the need for specialized follow-up services and may assist with the teaching phase.

The ratio of team members to participants is important. One team member for every five to seven participants is preferred. The debriefing should be held on neutral ground, and away from Department facilities. Team members should be in business casual attire unless otherwise determined by the planning group.

A facility should be located and utilized that allows the debriefing area to set up with a circle of chairs, so that everyone has an equal position, and everyone can see and hear everyone else without barriers or obstacles, such as tables or desks. The team members should be evenly distributed throughout the group. During the planning phase one team member will be designated to lead the debriefing. That member will call the group to order. The debriefing may follow a period of refreshments to allow everyone to arrive prior to starting the debriefing, and light refreshments should be made available immediately following the debriefing.

No one will be required to speak in the debriefing. Supervisors are usually not debriefed with subordinates. If anyone leaves during the debriefing, they will be accompanied by a team member to ensure that they are provided assistance if needed. Confidentiality is essential.

The following is a list of the phases of a seven step debriefing with some possible discussion questions. The phases and questions are designed to bring the group from the cognitive areas of the brain into the emotional, and back.

**Phase 1 – Introduction Phase**

The debriefing leader will introduce him or herself, provide a short statement as to the reason for the debriefing, set the rules for the debriefing, and then invite the other members of the team to introduce themselves. Each member should provide a brief statement to identify him or herself and to state where they are from, and how they are related to this specific group or event if possible.

**Phase 2 – Fact Finding Phase**

Each participant will be asked to introduce themselves. “Please tell me who you are, what your role in the organization is, how you were involved in this event, and what happened from your perspective.”

**Phase 3 – Thought Phase**

Invite each participant to tell what they were thinking during any specific point in the event.

**Phase 4 – Reaction Phase**

Invite each participant to speak about what the worst part of the event was for them, personally.

**Phase 5 – Symptom Phase**

Invite each participant to tell about any signs or symptoms of distress they have experienced as a result of the incident.

**Phase 6 – Teaching Phase**

Provide handouts on symptoms of stress and healthy ways to deal with stress. Discuss healthy coping skills. Teach on each incident discussed in the group. The teaching phase is usually led by another member of the team, as determined prior to starting the debriefing.

**Phase 7- Re-Entry Phase**

Tie up loose ends. Answer any questions. Summarize the incidents discussed in the debriefing. Discuss referral and follow-up services. Provide contact information.

**Attachments:**

The attachments may be used as training aids and handouts. Each handout has been added to this manual with permission of the source. Sources are identified on each handout.

## CRITICAL INCIDENT STRESS INFORMATION SHEETS

You have experienced a traumatic event or a critical incident (any event that causes unusually strong emotional reactions that have the potential to interfere with the ability to function normally). Even though the event may be over, you may now be experiencing or may experience later, some strong emotional or physical reactions. It is very common, in fact quite *normal*, for people to experience emotional aftershocks when they have passed through a horrible event.

Sometimes the emotional aftershocks (or stress reactions) appear immediately after the traumatic event. Sometimes they may appear a few hours or a few days later. And, in some cases, weeks or months may pass before the stress reactions appear.

The signs and symptoms of a stress reaction may last a few days, a few weeks, a few months, or longer, depending on the severity of the traumatic event. The understanding and the support of loved ones usually cause the stress reactions to pass more quickly. Occasionally, the traumatic event is so painful that professional assistance may be necessary. This does not imply craziness or weakness. It simply indicates that the particular event was just too powerful for the person to manage by himself.

Here are some common signs and signals of a stress reaction:

<i>Physical*</i>	<i>Cognitive</i>	<i>Emotional</i>	<i>Behavioral</i>
chills	confusion	fear	withdrawal
thirst	nightmares	guilt	antisocial acts
fatigue	uncertainty	grief	inability to rest
nausea	hypervigilance	panic	intensified pacing
fainting	suspiciousness	denial	erratic movements
twitches	intrusive images	anxiety	change in social activity
vomiting	blaming someone	agitation	change in speech patterns
dizziness	poor problem solving	irritability	loss or increase of appetite
weakness	poor abstract thinking	depression	hyperalert to environment
chest pain	poor attention/ decisions	intense anger	increased alcohol consumption
headaches	poor concentration/memory	apprehension	change in usual communications
elevated BP	disorientation of time, place or person	emotional shock	etc...
rapid heart rate	difficulty identifying objects or people	emotional outbursts	
muscle tremors	heightened or lowered alertness	feeling overwhelmed	
shock symptoms	increased or decreased awareness of surroundings	loss of emotional control	
grinding of teeth		inappropriate emotional response	
visual difficulties		etc...	
profuse sweating			
difficulty breathing			
etc...			

**\* Any of these symptoms may indicate the need for medical evaluation.  
When in doubt, contact a physician.**

## THINGS TO TRY:

- WITHIN THE FIRST 24 - 48 HOURS periods of appropriate physical exercise, alternated with relaxation will alleviate some of the physical reactions.
- Structure your time; keep busy.
- You're normal and having normal reactions; don't label yourself crazy.
- Talk to people; talk is the most healing medicine.
- Be aware of *numbing* the pain with overuse of drugs or alcohol, you don't need to complicate this with a substance abuse problem.
- Reach out; people do care.
- Maintain as normal a schedule as possible.
- Spend time with others.
- Help your co-workers as much as possible by sharing feelings and checking out how they are doing.
- Give yourself permission to feel rotten and share your feelings with others.
- Keep a journal; write your way through those sleepless hours.
- Do things that feel good to you.
- Realize those around you are under stress.
- Don't make any big life changes.
- Do make as many daily decisions as possible that will give you a feeling of control over your life, i.e., if someone asks you what you want to eat, answer him even if you're not sure.
- Get plenty of rest.
- Don't try to fight reoccurring thoughts, dreams or flashbacks - they are normal and will decrease over time and become less painful.
- Eat well-balanced and regular meals (even if you don't feel like it).

## FOR FAMILY MEMBERS & FRIENDS

- Listen carefully.
- Spend time with the traumatized person.
- Offer your assistance and a listening ear if (s)he has not asked for help.
- Reassure him that he is safe.
- Help him with everyday tasks like cleaning, cooking, caring for the family, minding children.
- Give him some private time.
- Don't take his anger or other feelings personally.
- Don't tell him that he is "lucky it wasn't worse;" a traumatized person is not consoled by those statements. Instead, tell him that you are sorry such an event has occurred and you want to understand and assist him.

# 'I lost my humanity'

Why police officers pay a high cost for keeping others in line

Fairfax Journal November 3, 1987

"The things I don't talk about are my real inner emotional feelings. I stuffed all my fear. I stuffed all my sadness. Then I began to stuff all my happiness and I became unemotional completely unemotional. By not showing emotions I think that eventually I got where I didn't have them either."

"I lost my family. I lost my old friends. And I lost who I was. I lost my humanity."

Many of the officers saw themselves as victims—of the system, of the public's sometimes contradictory expectations, but mostly of their routine exposure to badness, unhappiness, ugliness, and loss.

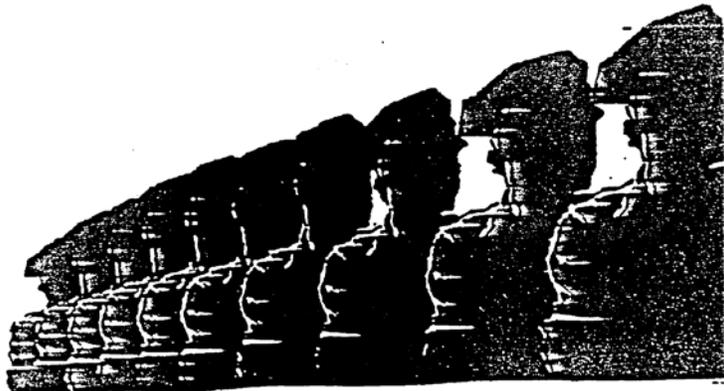
"Police work is personally destructive and this personal hurt results in a personality change which may be permanent."

"I began to examine my own world and realized that I was becoming cynical, withdrawn and frustrated, perhaps a victim myself."

"Confronting the bad everyday, I began to doubt such things as truth, honesty, and goodness really existed. Eventually, there was nothing positive that I really believed in, and that was the time I felt most empty."

**"THE HEALTHIER MENTALLY THAT POLICE OFFICERS ARE, THE BETTER THEY CAN DEAL WITH THE PUBLIC'S PROBLEMS. THERE WILL BE FEWER INTERNAL COMPLAINTS, FEWER BRUTALITY COMPLAINTS. THE PEOPLE WILL GET MORE OF WHAT THEY'RE PAYING FOR."**

By Chuck Haga, St. Paul, Minn.



# **The Echoes of Violence in The Police Family**

**Dr. Beverly Anderson**

*The credit goes to the person who's actually in the arena; whose face is marred with the dirt, sweat and blood; who knows great enthusiasm and joys. Who spends himself in a worthy cause, and whose place shall never be with those timid souls who knew never victory nor defeat."*

*Teddy Roosevelt*

With the terrorist attacks of September 11, 2001, the bombing of Pearl Harbor was no longer the deadliest day in American history. Over 3000 innocent people lost their lives. The world watched in horror as the twin towers collapsed entombing hundreds of police and firefighters who had rushed into harm's way to rescue the victims. These "first responders" would soon emerge as the real American heroes. The selfless acts of bravery witnessed by a stunned nation was not a new phenomenon. These unsung heroes who have been virtually unnoticed have captured the hearts of Americans if only for a brief moment. Unfortunately, the public's interest in the effects of traumatic exposure has waxed and waned throughout history. It seems to peak immediately following catastrophes like those of September 11<sup>th</sup>. Nevertheless, it is with this recent tragedy in mind, that the effects of traumatic exposure among law enforcement officers will be examined within the context of their twenty-plus years of public service.

There are over three-quarters of a million police officers in the United States today. Law enforcement is a highly stressful job wherein officers continually face the effects of murders, violent assaults, accidents and serious personal injury. Over 70,000 officers are assaulted each year on the job – more than 200 officers per day. (These are "reported" assaults to the Department of Justice. Many, if not most, actual assaults against police officers go "unreported.")

Unlike any other occupation, police officers are expected to die for the community they serve. It's an occupational hazard. They are expected to risk their lives every day to protect the citizens who, most often, do not appreciate them. Assaults against police officers are often not prosecuted even though a similar offense against a citizen would almost certainly result in an arrest and prosecution. Law enforcement, the media, and the public foster the myth that police officers can experience trauma and violence without suffering any ill effects. In fact, research has shown that when stressors are prolonged and overwhelming, individuals lose their ability to cope.

The traumatization of this profession uniquely and profoundly impacts not only the officers themselves, but their families as well. "Police Trauma Syndrome" (PTS) is a major public health problem among police officers worldwide. The symptoms of this syndrome can develop over time or acutely after a single catastrophic event.

The results can be seen physically, emotionally, mentally and behaviorally. The statistics are alarming: high divorce rates, suicide, domestic violence, heart attacks, stroke, cancer, depression, alcoholism and morale problems. All police veterans suffer in varying degrees from the syndrome. However, with education, intervention and support, the devastating effects of police trauma syndrome can be mitigated.

Law enforcement organizations and the therapeutic community should be aware of the complex type of posttraumatic stress reactions that occur consistently after prolonged, repeated exposure to violent assaults, murders, rapes, child abuse, natural and manmade disasters as well as on-going personal physical assaults.

The current definition of PTSD (posttraumatic stress disorder) is directed primarily to survivors of relatively circumscribed traumatic events such as combat, disasters or rape. This diagnostic category fails to encapsulate the symptoms manifested as a result of prolonged, repeated trauma in an occupation that refuses to validate that these events are catastrophic for those who are exposed to them. Hence, we devised the term, "Police Trauma Syndrome" to describe the condition that afflicts countless law enforcement officers as a direct result of their jobs.

In 1984, the Fraternal Order of Police Labor Committee representing police officers of the Metropolitan Police Department in Washington, D.C. began to address an alarming problem within the police department--- serious problems with overly aggressive police officers. The Labor committee's legal bills were escalating due to recurring problems of officers who were repeatedly in trouble for "overreacting." Paradoxically, these same officers had been productive and responsible but were now experiencing serious symptoms of stress and burnout. Simply providing legal representation for the officers was not addressing the root cause of the problem.

Apparently, the Union's dilemma was substantiated by the 432 police brutality suits brought against the District for the years 1984, 1985 and 1986. The District government was forced to pay out \$5.4 million dollars for these suits against the police department. Similar problems existed in other urban areas in the 1980's. In the Los Angeles Police Department, applications for disability pensions increased by 82%. Sixty-three percent (63%) of disability claims were stress-related.

In November of 1988, under Article 45 of the collective bargaining agreement between the District of Columbia Government and the F.O.P. Labor Committee, a jointly sponsored Union/Management Program was instituted. The only program of its kind, the Metropolitan Police Employee Assistance Program was chosen as a model for all law enforcement agencies in 1991 by the United States House of Representatives Select Committee on Children, Youth and Families in the hearing "On the Front Lines - Police Stress and Family Well Being."

This unique, comprehensive psychological services program has provided counseling and critical incident debriefing for over 5,000 police officers and their families. It has provided training to over 10,000 officers, supervisors, recruits and family members. It has provided post-shooting debriefing to over 800 police officers who have used their weapons in the line of duty.

More than ever, the increase in violence in our society echoes throughout the law enforcement community with more use of "deadly force" and unprovoked assaults against police officers. Unlike combat veterans, who are often compared to the police, the traumatic experiences suffered by police officers are encountered day after day over a period of twenty-plus years. The traumas do not take place in foreign lands far away from family and home. In fact, police officers work in or adjacent to the neighborhoods where they live.

Each officer represents an investment of thousands of tax dollars. The effects of stress and trauma exact a high toll in lost dollars and inferior services rendered to the department and to the community. Let us now examine how trauma plays a role in the police experience.

*"Nothing fixes a thing so in memory as the wish to forget it."*

*Montaigne*

The word "trauma" is derived from a Greek word, which means "to wound" or "to pierce." It is most often used to describe any sudden physical injury. The intensity or violence of the wound is such that the consequences are long-lasting. Just as the body can sustain a physical trauma that can devastate its defenses, so too, can psychological trauma overwhelm one's normal coping mechanisms. Long term exposure to traumatic events or "critical incidents" can and do have a negative impact upon police officers and their families. While the human response to trauma is consistent among all people, the job of policing separates law enforcement officers from the rest of society.

### **JOB STRESS AND THE LAW ENFORCEMENT OFFICER**

Police work is highly stressful and is one of the few occupations where an employee continually faces the inherent danger of physical violence and the potential of sudden death. The police officer is continuously subjected to cruelty and aggression and is often called upon to make critical life and death decisions within seconds. Situational crises and traumatic experiences often wreak havoc with an officer's emotions. Being shot at, almost killed, viewing and handling dead, mangled bodies, dealing with abused and battered children or sexually molested children all exact a high toll on the police officer.

No other occupation so completely affects, not just the officer, but his or her family as well. All too often the police officer's life becomes chaotic and unmanageable. While it is easier to quantify the number of physical injuries and deaths as a result of police work, it's not so easy to enumerate the number of broken homes, broken hearts, and broken lives that are the direct result of the emotional toll on officers and their families.

Stress is naturally inherent to a police officer's job. During parts of any given shift he or she may simply be in a state of low-level readiness or "hypervigilance" patrolling a sector while monitoring assigned radio frequencies. Suddenly, an emergency call comes in and the officer responds totally with adrenaline racing, heart pounding, blood pressure rising, body tensing for action – ready for the challenge of what may follow. When the emergency is over, he can turn off his vehicle's emergency equipment but he cannot turn his body off. The "fight or flight" response, nature's way of dealing with stressful situations, continues to thunder. There may be no time to recover from this state of "alarm" before a second and third emergency occurs. This leads to exhaustion since the body cannot continuously be in a state of readiness. All too often, the police officer remains in a state of exhaustion for long periods of time. This physical and mental exhaustion leads to a less effective officer.

Unrelieved stress can result in high blood pressure, cardiovascular disease, chronic headaches, gastric ulcers, depression, aggression, irritability and burn-out. Burn-out is a progressive process of fatigue, lethargy and depleted personal resources marked by physical and emotional exhaustion, negative job attitude, and a loss of concern for the people you are supposed to be helping. It is caused by excessive and continued demands on one's energy and resources.

The police profession is plagued with "burn-out." Job-related stressors such as shiftwork, hypervigilance, poor nutrition, work overload, unpredictability, responsibility for people, and ongoing contact with stress carriers all lend themselves to high "burn-out."

Police officers respond on a "routine" basis to situations which are "emergencies" to those outside law enforcement. On the job, Police officers must suppress the natural human emotions such as fear, anger, horror, or sadness. This "image armor" that the officer wears "on duty" is very difficult to shed at the end of a shift.

A "burned-out" officer is not only a non-productive member of the department but also a human being in pain – perhaps a father and husband and mother and wife who becomes incapable of filling these roles effectively. "Burn-out" is a very counter-productive way of coping with occupational stress. The officer's coping mechanisms are no longer healthy and soon may include projection (blaming others), withdrawal, and detachment.

Officers are at high risk for developing negative coping behaviors such as gambling, overeating, smoking, spending sprees and excessive drinking. Instead of coping directly and internally with feelings of alienation by talking about them, emotions are hidden away. This psychological withdrawal from work and personal life is in response to excessive stress – moving from an attitude of empathy to apathy. All of these symptoms are a cry for help. It is encouraging to note that "burn-out" is treatable through intervention, education, and prevention.

Traits that make for a good police officer aren't necessarily conducive to being a good family man or woman. Paranoid traits are healthy on the job – crucial even. However, the same behavior at home drives spouses and children away. So often wives recount how their husbands have changed: "We never talk anymore. He's always so angry. He won't talk to me about his

feelings.” Recently, one officer told me that after 15 years on the Department and two marriages, he doesn’t feel anything – no pain, no happiness, no sadness. He asked, “What do you do when you just feel numb?” Let us now turn to several specific stressors encountered by law enforcement personnel. The stressors that seem to effect the greatest psychological damage are unique and segregate the officer from the rest of society.

### **WORK OVERLOAD VERSUS WORK STAGNATION**

It has often been said that policing is “hours of boredom interrupted by moments of terror.” While that may have been true at one time, it is not true today in cities like Washington, DC. Officers are called upon to respond to one emergency call after another with few breaks to rest. This requires that the officer be in a state of constant readiness or “hypervigilance.” The need for police officers to be hypervigilant is well illustrated by the statement, “There’s no such thing as a routine traffic stop until the citizen is gone and the police officer drives off.” The first thing that a police officer does when he/she enters a new surrounding, no matter how benign it may seem, is to scan the scene, looking for “what’s wrong in this picture.”

When an officer is called upon to respond to a potentially life-threatening situation, his autonomic nervous system sets in motion the old “fight or flight” arousal- the body’s immediate response to extraordinary demands made upon it.

The normal human response is the “fight or flight” reaction, which enables the individual to strike out against the stress agent or flee from the scene. Police officers responses must be measured; running away is not an option. However, “fighting back” must be a controlled response. Officers must control the natural “attack” response that is instinctual.

### **THE GENERAL ADAPTION SYNDROME**

***No living organism can exist continually in a stage of alarm – an agent so damaging that continuous exposure to it is incompatible with life. After prolonged exposure to any noxious agent, the body loses its acquired ability to resist, and enters into a stage of exhaustion. This third stage always occurs as long as the stress is severe enough and is applied long enough, because the adaptation energy or adaptability of a living being is always finite.***

***Dr. Hans Selye***

Defined by Hans Selye in 1936, this is the body’s way of mobilizing its defenses against a perceived threat. It is a “whole body” response and involves all the resources the body can garner. Consider the following example: Officer Thomas is working the 3:00 p.m.- 11:00 p.m. shift. It is Saturday at 10:00 p.m. and he has responded to one run after another without a break. He has responded to everything from a “domestic” to a “breaking and entering” to a drug- related murder. Officer Thomas is standing in the Seven-Eleven store devouring two chili dogs, then washes them down with a 12-ounce can of Pepsi. He receives a radio call for a stolen vehicle. The driver has struck and killed two pedestrians, a mother and her toddler, and is now proceeding at a high rate of speed in Officer Thomas’ direction. He answers the call and jumps

into his vehicle with lights flashing and siren screaming. What is going on in his body is even more dramatic. Within seconds of the call, the General Adaptation Syndrome is in full swing.

### ALARM REACTION STAGE

A small portion of the brain called the hypothalamus, a control center of the brain, has triggered the pituitary gland, located near the base of the brain, and the hormone ACTH (adrenocorticotropin) is released into the bloodstream. ACTH goes directly to the adrenal glands, intimately involved in the body's response to emotions, which then steps up secretion of three hormones that travel to different organs and control blood flow. They are adrenaline, epinephrine and corticoids. These hormones bring the body up to its arousal state. Within the first eight seconds, the bloodstream has carried these stress organizers into every cell of the body. At the same time, commands are traveling through the nerve communication system to alert heart, lungs, and muscles for action. The muscles are now more richly supplied with blood, as the thin vessels constrict and blood pressure increases. However, blood has been diverted away from Officer Thomas' extremities (if he sustains a wound, he would be less likely to bleed to death). His liver is working harder than ever to convert its stored glycogen into glucose which his brain and muscles will need in greater supply. Meanwhile, his breathing is more rapid and shallow, increasing the amount of oxygen in his blood thus enabling his muscles and brain to burn that glucose more efficiently.

His heart is pumping, sending an abundant supply of blood to the priority portions of the body. Epinephrine is released, causing his heart to speed up and increasing formation of platelets that induce clotting. His kidneys have increased their production of renin, an enzyme that restricts blood flow and plays a role in hypertension. His skeletal muscles brace, and, with the blood he needs in his stomach reduced in favor of these high priority areas elsewhere, he's going to have indigestion-payment for the chilidogs and Pepsi. Over long periods of time, Officer Thomas stands a greater chance of developing stomach ulcers and chronic digestive problems.

Officer Thomas' brain is busy with preparations for violent physical action-one reason why he is *unable* to think very effectively on an abstract level during this alarm stage.

He is joined in the high-speed chase by several other police cruisers. They stop the vehicle and apprehend the suspect. Based on our knowledge of the "fight or flight" response, Officer Thomas' natural response would be to "fight." However, because he is a law enforcement officer, he must exert considerable energy to restrain himself from using excessive force.

Following the "Alarm Stage" comes the critical stage called the "Resistance Stage." It is during this time that the body attempts to adapt to the situation. If the stressor has disappeared or been overcome, the body tries to reverse the alarm reaction. If the exposure to the stressor or similar stressors continue, the body attempts to replace emergency bodily changes with adaptive changes. In other words, certain bodily reactions become fixed. Chronic muscle tension is a good example of this kind of adaptation. The problem is that it requires a great deal of energy for this kind of resistance. Hence, the final stage, *exhaustion*, results if the stressor continues or if other stressors follow at close intervals.

Even before this extreme stage has been reached, excessive hormonal secretions may result in severe physiological damage that Hans Selye termed "diseases of adaptation," in the form of, ulcers, high blood pressure, and coronary artery disease.

Officer Thomas no sooner leaves the scene after the suspect is arrested than yet another call comes in, activating the alarm stage cycles all over again. How will Officer Thomas cope? Will he adapt?

Another difference among police officers is that they remain in a state of hypervigilance—a constant readiness for whatever may happen. They become so accustomed to this low-level alarm reaction, that it becomes a part of their personalities, causing them to remain jittery, irritable, impatient and incapable of relaxing. However, the hypervigilance becomes an important defense because people are able to influence the nature of stress through their ability to control and anticipate events in the environment. Hence, to always be ready, decreases the chance of "*shock*." The unanticipated event often has the greatest deleterious impact on an officer and leaves the most persistent aftereffects. This was especially true in the case of the Air Florida Tragedy.

Wednesday January 13, 1982 was a bleak, snowy day, in Washington, DC. An Air Florida jet crashed after take-off into the Fourteenth Street Bridge with 79 passengers on board. Within minutes it sunk into the icy waters of the Potomac River taking all but 5 passengers. Four people on the bridge were also killed as the jumbo jet careened over cars, crushing them on its tragic descent. Traffic had been at a standstill in the snowstorm and officers who were ordered to the scene were completely unprepared for the carnage. Many officers have relived in nightmares the scenes of mangled bodies and crushed vehicles with blood dripping from the wreckage. The scene has remained an undigested image impossible for the officers to weave into the fabric of their lives. So many learned the danger of being emotionally unprepared for that experience.

Even now, twenty years later, talk of "Air Florida" triggers strong emotional reactions for the officers who were on the scene. The following is one officer's account of the Air Florida disaster.

*Wednesday, January 13, 1982*

*I was assigned to the Third District's Drug Enforcement Unit and was gathering intelligence for a narcotic search warrant on Sixth Street, N.W. It was late afternoon by the time I had worked my way into the vacant rowhouse that had served as my observation post for the past several days. I usually had my partner as company on these forays, but he was in court on this frigid winters day. Instead, I carried an extra revolver as my companion. Over the years I had learned that there is no such thing as backup when you venture into abandoned buildings in inhospitable territory.*

*After about an hour of observing and note - taking of tag numbers and various people's descriptions, my police radio came to life. The dispatcher was calling for all detective and vice units to respond to the 14<sup>th</sup> Street Bridge to assist with a plane crash. I was a bit taken aback, thinking there must be some mistake but she kept repeating her request. Figuring, what the hell, (I could do this observation anytime since these drug boys weren't*

going to close shop and I had never seen a plane crash), I packed my gear and worked my way out a rear first floor window into the snow - covered trash strewn backyard.

I walked over to Seventh Street and flagged down a cab. The cabbie was an elderly black preacher who said he was glad to give a policeman a lift. He dropped me off on the north side of the Bridge. It was dusk. The streetlights were on and a light snow was falling. It was quiet. The bridge and river were white, the Virginia horizon a dark foreboding grey. There were cars parked on the far end of the northbound span. Disdainfully musing to myself that this must be a typical MPD clusterfuck, I set off on that long fateful walk to advise these drivers to move on and clear the Bridge of traffic.

As the cars drew nearer I sensed something not normal. There was no movement whatsoever and no plane or person was in sight. The cars and truck were in disarray, turned and twisted. Everything was distorted. Something was terribly amiss, it was as if I was engulfed in a surreal twilight zone. As I walked up to what resembled a car, my eyes focused on a purple red stream which had poured from beneath the door onto the snow in a frozen waterfall of blood. The car's roof was missing and so were the heads of the people inside.

Reeling and staggering my mind went blank. I tried to regroup. Looking over the railing there was a huge black hole in the ice. Jagged shards of ice floated on top. There was bright colored clothing and debris in the water and hanging in the trees on the Virginia shoreline. Countless police and firemen lined the shore and southbound span staring at the void waters. No one was on the Bridge. I was alone with the dead. My mind screamed, "Where are the people to be saved? Let me see them, I can jump in the river and at least save one. I've done it before, I've never let them drown." I looked for someone in charge, looking for direction, for something to do to occupy my mind. There was no one who was not as dazed as I.

I don't remember leaving the Bridge or how long I was there. I don't know how I got back to 3D. The next memory I have of the day was sitting at my friend's bar in Georgetown. Normally a beer drinker, I had the bartender pour me a water glass full of bourbon. I knew this was my worst day on the police force but I couldn't explain why. I stayed until closing and since I had court the next day and the roads were treacherous I decided to stay in D.C. that night. With a case of beer I sat in my truck on the vacant lot at 13<sup>th</sup> & W Street, N.W. and bullshitted with the midnight crew until dawn. Court was canceled due to the weather and I staggered home. Phoning the two women in my life, I tried to tell them what had happened. I must have then gone to sleep.

Officer T.J.M.  
MPD, Washington, DC

### HUMAN PHYSIOLOGY

We are growing in our understanding of the physical and emotional impact of traumatic exposure. Reactions to the trauma, memory distortions, and increased vulnerability are a whole "mind/body" phenomenon.

The human body is a fine-tuned and complex system of pathways. Each of its 100 billion nerve cells has 200,000 synapses. The brain interacts with the endocrine system (pituitary, thyroid, adrenal) activating them to secrete hormones which are in turn carried by the bloodstream throughout the body. When hormones reach a certain level, they turn off the brain's

activating brain cells. This is called a negative feedback loop. In order to understand the psychobiology of trauma, one must learn about the body's metabolism. Psychobiology is the study of chemical/structural changes in the brain that relate to changes in behavior and emotions.

Bessel van der Kolk, M.D. a noted researcher, trauma psychiatrist, and theorist describes the impact of trauma on the mind and body with the phrase "the body keeps the score" (1996). Studies have consistently shown a positive correlation between the severity of a stressor and the level of cortisol in the bloodstream. A severe stressor increases cortisol levels. Traumatic exposure that is chronic and cumulative produces chemical and biological changes that may be permanent.

While we do not understand fully the complexities of trauma-related changes, it is clear that a major mind and body pathway for reactions to stress becomes disordered. The result is a lowered tolerance to stress. Elevated levels of epinephrine and norepinephrine (stress hormones) in the bloodstream may cause anxiety, panic, and agitation in the aftermath of traumatic exposure. Also prevalent in individuals post-trauma is a form of adrenal hyperactivity that appears to be associated with hyperarousal, hypervigilance, anxiety, panic, irritability, and rage.

Stress-induced analgesia (numbing) can occur when there is an increased release of endorphins in response to stimuli resembling previous traumas. In persons suffering posttraumatic reactions, studies have also shown increased thyroid activity. Some researchers believe that sensitization of areas in the brain by traumatic stress can eventually lead to "kindling" or autonomous electrical activity in these areas which then causes intrusive thoughts and flashbacks. MRI studies have also revealed structural changes in the hippocampus which may be permanent. The hippocampus is involved in learning and memory, particularly explicit memory for events. (There are two types of memory: explicit memory and implicit memory. Explicit memory refers to recollections of facts and events. Implicit memory refers to memories of skills, habits, reflex actions and emotional responses. Knowledge expressed in performance like riding a bike is an example of implicit memory.)

Difficulties in learning and memory are also prominent features in individuals suffering from traumatic exposure. Researchers have also discovered proof of changes in cerebral blood flow and brain activity due to trauma. Neuro-imaging techniques such as PET scans (positron emission tomography) show increased activity which provokes traumatic stress reactions by "telling the story." Conversely, Broca's area, which is involved in speech, is deactivated. This may explain the difficulty some officers have in verbal expressions of the trauma in addition to distortions of memory.

Individuals suffering from traumatic exposure also experience medical problems to include: migraine headaches, irritable bowel, early adult-onset diabetes, immune system problems, arthritis, and coronary artery disease. It is not surprising that traumatic exposure can have an impact on the body's immune system. In fact, police officers suffer many stress-related illnesses that are often left untreated. Police officers are very good at taking care of others. They aren't so good at taking care of themselves. Education is the key for understanding the mind/body connection in traumatic exposure among law enforcement officers. What an officer doesn't know can hurt.

## ROLE CONFLICT & THE POLICE FAMILY

*"In street police work, where you're exposed to a certain amount of violence and inhumanity on a daily basis, you come to realize that there are two different worlds. One world is the world where you work and the other world where you have your family and friends. But the worlds are a couple of light-years apart and you find yourself, especially in homicide, unable to tell family and friends about the other world because they can't comprehend it. I worked a lot of hours and had trouble differentiating between the two worlds."*

*-Homicide Detective Joe Quantrille Washington Post, December 5, 1988*

The "image armor" that police officers develop is a defense mechanism that works well for the officer's survival. Unfortunately, it does not come without a price to be paid in terms of failed marriages, poor relationships with children, and family violence. The traits that make for an effective police officer do not necessarily make for a good spouse or parent.

Let us consider the role of the average police officer "on the street." Police officers have tremendous power. They have the authority to take away one's freedom. They are viewed, by the public, as protector and problem-solver. They must be "in control" at all times. An officer can never show that he is afraid or uncertain. He must control his own emotions when the normal person might falter. Sometimes, especially in cases involving children, an officer's "image armor" can shatter.

The following is an illustration of such an event:

*Detective B was a member of the Department's elite homicide squad. His closure rate was among the best and he was among the best and he was respected by his peers as a hard-driving, hard-working, hard-drinking cop who was "tough as they come."*

*He was ready to call it quits at 7:00 a.m. after working 16 hours straight. It was one of those steamy mornings where the previous night's heat had given no reprieve from the scorching day that had preceded it.*

*The Captain walked in with an ashen look on his face and announced that there had been a mass murder in the upper northwest in a large rowhouse. Detective B was never known to say "no" to the Captain no matter how fatigued he was.*

*When he arrived on the scene the reporters and news cameras blocked the entrance. They clamored for his attention but he made his way through without speaking.*

*The gruesome scene inside assaulted every cell of his already worn body. Blood and brain matter dripped from the walls. Bodies of men, women and children riddled with bullets lay in unnatural poses around the house. Already numbed out he went to work.*

*Several hours later, the last of the bodies was being removed and Detective B opened the cellar door to escape to the cool dampness that struck his face.*

*As he walked down the steps he felt the tenseness leave his body escaping the silent clamor of activity. The basement was barely lit from one small window and his eyes had not yet adjusted to the dark when he spotted a deep basin sink before him. He would wash his hands and face.*

*As he turned on the water and felt its coolness, he reached for a string that dangled from a dirty light bulb and pulled it down. (It was already 2:00 p.m. and his wife, Pam,*

would be leaving for work at the hospital. He hadn't seen her in two days. He pictured her teasing him about her cycle and that the time was right for them to "make a little jimmy." After five years, still no children; but Pam wouldn't give up).

As he looked down into his hands reaching for some soap he froze. Lying in the deep tub was the blood-spattered body of a baby no more than three months old. A wave of nausea came over him and he began heaving the contents of his stomach until all he could get up was bile and acid, burning his throat as they passed through his mouth.

One might think that Detective B would share this experience with his wife or another person close to him. More often, however, officers are reluctant to talk about the horrors they see. As one officer put it: "I'd find myself sitting at the dinner table with nothing to talk about that didn't frighten my wife." There are several theories as to why this is so. I shall offer the following for the reader's consideration:

1. Police officers take their roles as "protectors" very seriously. Losing one's innocence through traumatizing events is bad enough without exposing one's family, those dearest to the officers, to the trauma.
2. It is easier, in the short run, for officers to "stuff" their pain. Why talk about it? Talking about it brings back images and pictures that arouse pain and hurt feelings about the traumatic incident. The officer may feel guilt that he was unable to save a victim. "If I had only gotten there sooner," is an often-heard phrase.

Because spouses do not understand this aspect of policing, so often they misperceive the officer's sullen moodiness for other things. "Maybe he/she doesn't love me anymore. Maybe he/she is having an affair and doesn't know how to tell me." Remaining aloof, unfortunately, is one of the few responses that becomes tenable for an officer. In order to remain unaffected by the suffering and pain an officer confronts on the street, it becomes necessary to keep feelings and emotions under rigid control. So often officers who enter therapy express their long-held fear that once they let their emotions flow, they will be unable to control the deluge that would follow. The "wall" that officers build around themselves soon becomes impenetrable. Even the officers themselves are unable to get past it. One release is in the use of the grotesque humor that becomes so much a part of the police mentality.

"You make cruel jokes. You make light of the fact that people are dead. But you wouldn't last six months if you didn't do something like that," says Detective Joe Quantrille.

Police officers become more comfortable with anger and humor, less comfortable with tenderness and displays of affection. Often they may replace "requests" with "demands." For instance, an officer might order his child to "buckle up your seat belt or we're not going anywhere." What motivates this show of anger? The officer cannot relate to his/her child stories of dead children pulled from car wrecks. He cannot communicate to his child how frightened he is at the thought that this could happen to his child. Police officers know that horrible things happen to good people-not just to strangers one reads about in the newspapers. Officers are more apt to command, order, and direct and less apt to discuss and request with their spouses and children. Wives complain that their husbands sometime speak to them as though they were criminals. Children relate how their police officer parent is unapproachable and distant. To separate

the role of "cop" from that of "parent or spouse" is a monumental task at best. Far too many officers succumb to this role conflict.

It is little wonder that police marriages suffer as they do. Healthy human development requires balance-so do human relationships. Virginia Satir, experiential family therapist, stated that, "Communication is to relationships what breathing is to life." Unfortunately, the quality of interactions with spouses in police marriages is sorely lacking. They are of short duration, sporadic and with faulty or poor communication. The couple grows apart leaving the spouse of the police officer feeling unimportant and rejected. How can an officer switch roles after eight hours of being a cop, especially if he/she has just watched someone die."

In 1991, I testified before a House Select Committee on Children, Youth and Families regarding stress and police families. Among the many professionals who testified was Lenore B. Johnson, Ph.D., associate professor of family studies at Arizona State University, who reported the results of her study "Work-Family Stress among Police Officers." The study was conducted in the early 1990's and is the only empirical study regarding police families in recent years. In the study, Johnson surveyed and interviewed 728 officers in two East Coast police departments and 479 of their spouses. Seventy-seven percent of the spouses were above the scale mean in reporting stress from their mates' jobs. Coping problems included alcohol abuse, divorce, family violence and suicide. Alcoholism rates for police officers exceeded the mean by 17%. Forty percent of the police officers surveyed reported that within the six months before the survey, they had behaved violently toward their spouses or children.

Johnson offered the following factors as contributing to family strain:

**ROTATING SCHEDULES:** "Not surprisingly, 71 percent of the spouses believed that the police administration does not take family life into consideration when making policies which may affect families and 51 percent agreed that a police officer's career could be hurt if his family voices any special needs or frustrations.

**HOME LEADERSHIP STYLE:** The spouses complained that officers were unable to leave the job at work. Instead, they expected the last word in family discussions and were seen as overly critical.

**EMOTIONAL AVAILABILITY:** Many spouses reported that the officer did not communicate his/her feelings.

**IMAGE ARMOR COPING STRATEGIES:** The rugged individualism, being tough, was seen as a typical coping strategy that often leads to depersonalization of citizens. It's equally detrimental to marriage and family life.

**LACK OF SOCIAL SUPPORT:** The absence of social support from all sources (squad supervisor, spouse, and friends) has an influence on police stress. Dr. Johnson's data suggested that those officers who did share work problems with their spouses or non-police friends had lower burnout. While this was true for male officers, it did not hold true for female officers who were married to non-police officers. They claimed that their husbands did not want to hear about their wives' jobs.

In reporting individual and family pathology, Johnson stressed the seriousness of the problem whereby nearly 90 percent of the police spouses felt that the police department should provide for the officers and their families both marital and psychological counseling, while 75-82 percent felt that alcohol rehabilitation and stress reduction programs should also be provided.

All available data continues to support the belief that what happens to police officers on the job very much affects their families. Dr. Johnson's study did not include interviewing the children of police officers. However, in 1992, the Metropolitan Police Employee Assistance Program joined with the National Institute of Mental Health's Laboratory of Developmental Psychology, funded by the MacArthur Foundation Research Network on Early Childhood Transitions, to study the effects of parental post-traumatic stress disorder (PTSD) on the children of police officers.

The phenomenon of "secondary post-traumatic stress disorder" wherein family members, including children, develop symptoms consistent with PTSD, was found in families of combat veterans who were themselves suffering from PTSD (Rosenheck & Nathan, 1985; Scaturro & Hayman, 1992). Children of holocaust survivors have also fallen victim to this "secondary" traumatization as reported by Fryberg, 1980; Kar-Venaki, Nadler & Gershoni, 1985; Perskin, 1981. Similar findings have also been reported by White in 1991 in treating parents of children who were severely traumatized.

In our work with police families, we are finding high rates of this secondary traumatization in children of police officers with PTSD. Many of these children are manifesting serious conduct disorders and high rates of attention deficit hyperactivity disorder (ADHD). This project investigated the possible contributions of parental PTSD to various behavioral and adjustment problems in the children of police officers. The first empirical study of its kind, the results of this project has helped us understand the effects of severe occupational stress that exists in law enforcement. Trauma is contagious and not easily forgotten no matter how hard we try to defend against the aftershocks.

Let us now turn to other factors that contribute to create "overload" for police officers. They are shiftwork, midnight work, and the responsibility for people.

## **SHIFTWORK/MIDNIGHTS**

***"...the human adult is an animal whose body is tuned by evolution and training to go about its business during the hours of daylight and sleep during those of darkness. Ask it to work at night and sleep during the day and it does both rather badly." (Wilkinson, 1970)***

In order for an officer to meet the demands we have discussed thus far, he/she is expected to be in the best physical condition. Unfortunately, officers do not always eat the right food and, more often than not, do not get proper rest and relaxation.

Working the midnight shift exacts a heavy toll on police officers. Since human beings are not nocturnal, staying awake through the night requires suppressing nature's cycles. This requires energy. It should also be noted that daytime sleep in controlled laboratory testing has been found to be qualitatively different from nighttime sleep and less satisfying (Kroes, 1976). Shiftwork, especially rotating shifts, though a necessary part of any law enforcement organization often wreaks havoc on the officer's body including adjustments in circadian rhythms. As much as shiftwork is difficult for the officer's biological and social adjustment, it also infringes in drastic ways on the lives of his/her family members.

Let us turn to the complicated problem of shiftwork and the difficulty officers have adapting their physiological and psychological rhythms to a new sleep wakefulness cycle.

The 24-hour cyclical rhythm has been given the name "circadian rhythm." If the cycle follows the 24-day/night pattern, it may also be called the diurnal pattern (Kroes).

Circadian rhythms are seen in fluctuations of body temperature; urine flow; renal excretion of sodium, potassium, and phosphates; metabolism; heart rate; skill conductance; cortical and medullary production of adrenal hormones; sleep cycle; and overall mental and physical functioning. Research has shown that practically all physiological functions show circadian rhythm cycles. As one can imagine, shift work conflicts with these circadian rhythms. How negatively this will affect the individual will depend on several factors:

1. The work environment
2. The individual's support system
3. The individual's overall health
4. The individual's coping style
5. The individual's attitude toward the shiftwork

In our society, almost all communal activities take place during the day-working, eating, shopping and socializing. When an individual deviates from this societal norm, he/she is cut off from the normal avenues of social interaction. For the young officer who works midnights, there are special problems. It's not easy to pick up his date after he gets off work at 7:00 a.m. When the officer has a family, children are cautioned not to make too much noise; the phone must be answered on the first ring or taken off the receiver. And, of course, the spouse and children are left alone at night. When the officer works 3:00 p.m. to midnight, he/she will only see the children on weekends during the school year.

With changing or rotating shiftwork, the problems associated with physiological adaptation increase. It takes approximately two weeks for the average individual to re-adjust his eating and sleeping patterns. For the officer on a two-week rotating shift, no sooner does he/she adjust, than he/she is forced to change gears to a new shift. William H. Kroes, Ph.D., reported the following results of research conducted with police officers: 93 out of 100 police officers surveyed mentioned disruption of eating habits as a problem resulting from changing shift routines. Over 30 percent reported sleep problems.

There are some officers who enjoy the permanent midnight shift. However, very few of officers are not adversely affected physiologically and psychologically by the midnight shift.

While there are those who would argue that many people work midnights or evenings and that these individuals lead productive, healthy lives, it must be remembered that for police officers, work schedule is only one of the major stressors. In fact, these occupational stressors taken one-by-one may not be so overwhelming; but taken collectively, in addition to typical life stresses, they can be very harmful to officers and their families.

## RESPONSIBILITY FOR PEOPLE

Responsibility for the welfare of others, for making “life or death” decisions within seconds, takes a heavy toll on police officers. For an officer who is the first to arrive on the scene of a serious accident or fire, the actions he/she takes may drastically affect the lives of others. To watch human pain and suffering on a daily basis is tremendously draining- although you probably will not hear an officer say these words. More often you may hear an officer assert that it’s all part of the job- no big deal. In fact, you may even hear him joke about the atrocities that he must witness on the job. This “emotional numbing” is a defense mechanism that prevents officers from going to pieces.

While officers may seem hard and cold, I have found them to be deeply concerned and caring individuals who internalize the human misery and tragedy they face in their jobs. There are situations for police officers that are emotionally overwhelming.

One patrolman saw a three-year-old child who had been catapulted through the windshield of a car and decapitated. He went on a three-day drinking binge as a result of the experience, and when he returned, he was disciplined. He would not explain why he had been absent for three days because it would have required acknowledging that he had been deeply moved by the experience. And the department didn’t know why he had behaved that way. (Kroes, Society’s Victim-The Policeman, Pg. 64).

Here is the reaction of a young officer just out of the police academy:

*My first radio run that day was to investigate a sick child emergency. Upon arrival at the residence, several people met me in the front yard and, in a frantic state, said that an infant had just stopped breathing. Upon entering the residence and first observing the blue-cast skin on the three-month-old infant, I immediately called for the life squad and initiated mouth-to-mouth and nose resuscitation. After arrival of the life squad and their attempt to mechanically resuscitate the infant to no avail, it was my duty to inform the parents the child was deceased and take their child from them to the morgue and handle all necessary paperwork.*

*To make matters worse (mentally for myself) five months previously, I had become the proud father of a baby girl. And for weeks after this incident, besides not being able to eat or sleep, I tried to rationalize why this had to happen and not being able to help. I believe my religious belief was the biggest help in helping me pull myself together and face the real world. (Kroes, Society’s Victim-The Policeman).*

While over a period of time most police officers learn to deal with many of life’s tragedies, the exception to this is the anguish that an officer feels whenever he must deal with a child tragedy. Among these are situations like telling a mother of her child’s death, having to take a dead child to the morgue, being called in on a child abuse case, or having to clean up a body after an accident.

How does the officer make sense of all this? How does one go on living in a world when so many terrible things happen? In the words of one young officer, "What's the point?" Emotional reactions to life's atrocities are normal. The following is a list of coping techniques that don't work as well as those that do:

### **TECHNIQUES THAT DON'T WORK**

1. Suppressing your normal reactions and emotions.
2. Holding back affection from your loved ones.
3. Denying stress for fear of appearing weak.
4. Excessive use of humor.
5. Commanding, ordering and directing family members.

### **CRITICAL FACTORS IN COPING**

1. Learn to talk out your concerns and feelings.
2. Take responsibility for your personal health. Diet, exercise, and rest are important.
3. Separate your family and your job. Leave the job at work.
4. Learn stress reduction techniques.
5. Respect the enormity of the job's impact on your life.
6. Look for the "red flags" that indicate the job is affecting you personally.
7. When you recognize that you're feeling emotionally numb, reach out to your family. Do the opposite of what you feel. For instance, when talking to family members, close the physical distance between you and them. When speaking with your spouse touch him/her on the shoulder. Look into their eyes when you're talking. This behavior is not one you practice on the street. When a citizen gets into your personal space, your response is usually, "Step back, man." When you decrease the physical space between you and a family member, your reactions will tend to be less "cop - like" and more like "family."
8. Learn to say "no."
9. Understand that people at home don't "see" what you "see" and "know" what you "know."
10. Take pride in your badge and your profession.
11. Learn to laugh at yourself.
12. Use your support network. Ask for what you need from loved ones. Don't expect them to read your mind.
13. Tell the people you love that you love them - at least once a day.
14. Learn to live in the moment and appreciate it. Remember, "yesterday" is a canceled check and "tomorrow" is promised to no one.
15. Always keep your promises - to yourself and others.
16. Use your annual leave - don't save it to "cash in" at retirement.
17. Keep "current" in your profession. Develop new skills

## *Understanding the Police Culture*

“Police officers are inherently distrustful of mental health services. Although job-related stress increases in proportion to levels of violence and traumatic exposure, officers are still less likely to seek help than the average person. While many occupations give rise to a variety of stressors, most do not constitute the closed and guarded culture of law enforcement. No matter how “numbed out” police officers appear (and they are champions at the art of emotional cover-up), they suffer terribly from the psychological assaults of their work. Therapists cannot be of real help until they come to understand the danger and face the evil that accompany the police on every tour of duty.”

Dr. Beverly Anderson

The American Academy of Police Psychology

*“Confidentiality in Counseling: What Police Officers Need to Know”*

Calibre Press, 1988