U.S. Department of Justice
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CRITICAL INCIDENTS IN POLICING

REVISED

NOTICE

CRITICAL INCIDENTS IN POLICING

Revised

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Editors

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This book is dedicated to

Mr. John E. Otto,

former Acting Director of the Federal Bureau of Investigation and Associate Deputy Director–Investigations (retired), under whose leadership, encouragement, and support the FBI's programs and policies regarding critical incidents grew from ideas into realities.

FOREWORD

Since the turn of the century when Louis Terman first tested police candidates for selection using a modified version of the Stanford-Binet, mental health professionals have been involved in various aspects of law enforcement. Over the years, their interests and research have resulted in their increased knowledge of law enforcement personnel, organizations, and functions. Much as medical doctors began as general practitioners and grew into specialty areas, so too has been the evolution of psychology and the mental health profession in general. Many mental health professionals are specializing in police psychology and are researching virtually all aspects of this unique and stressful occupation.

In 1984, the FBI Academy at Quantico, Virginia, hosted the National Symposium on Police Psychological Services. A major focus of the conference was to determine how psychologists could assist police officers in their personal lives. The World Conference on Police Psychology was held at the FBI Academy in 1985 and concentrated on evaluating how psychologists could assist police officers operationally. We are grateful to the participants of these conferences and proud of the subsequent publications, which have provided a vast amount of new resource literature.

In August 1989 fifty mental health professionals, employee assistance providers, chaplains, and law enforcement officers met for the Critical Incident Conference at the FBI Academy. All gave a week of their time to share thoughts and ideas concerning critical incidents in law enforcement. This publication is a product of their knowledge and their dedication to assist the law enforcement community.

It is only through such efforts by those interested in the well-being of police officers that a body of knowledge will emerge to protect and serve those in law enforcement who are sworn to serve and protect. It is important to note that selection of options with regard to handling critical incident trauma is left to each individual. Presented herein are numerous options and theories, ranging from therapy to spiritual wellness. It is not the intention, nor the right, of the FBI to endorse or suggest any particular coping mechanism as being the most appropriate; nor is the FBI in the evangelical business of promoting religious beliefs. The ideas of the invited authors are herein presented without editing the substance of their messages. These messages provide a range of approaches to meet the needs of those affected by trauma. Each incident is unique, as are the many options suggested. It is impossible, however, to present all of the various options. The choices remain in the control of the readers.

I would like to recognize the members of the Behavioral Science Services Unit, including James M. Horn and James T. Reese, as well as Dr. Christine Dunning, University of Wisconsin, Milwaukee. These individuals conceptualized, organized, and worked tirelessly to bring the Critical Incident Conference together. They have ensured that the knowledge and ideas of those who participated are available through this publication, to assist all in law enforcement.

John Henry Campbell
Chief
Behavioral Science Services Unit

ACKNOWLEDGEMENTS

A special note of thanks is given to the leadership of the Federal Bureau of Investigation: Mr. William S. Sessions, Director; Mr. Floyd I. Clarke, Deputy Director; Mr. Oliver B. Revell, Associate Deputy Director–Investigations; Mr. James W. Greenleaf, Associate Deputy Director–Administration and former Assistant Director of the Training Division under whose leadership this conference was approved and funded; Mr. John E. Otto, Associate Deputy Director–Investigations (retired); Mr. Anthony E. Daniels, Assistant Director of the Training Division; Dr. Roger Depue, Unit Chief (retired), Behavioral Science Instruction and Research Unit (BSIRU) and past Administrator of the National Center for the Analysis of Violent Crime; Mr. John Henry Campbell, Unit Chief, Behavioral Science Services Unit (BSSU), whose early research has served as the seed from which the FBI's critical incident reaction program has grown; and Mr. Robert Schafer, former program manager of the FBI Peer Support Employee Program, BSIRU. Without the support of these men and their dedication to the goals of providing assistance to FBI employees, this conference, and subsequently this book, would not have come to fruition.

We offer our heartfelt thanks to the participants of this conference. They have provided not only the manuscripts that make up this publication, but have richly enhanced the state–of–the–art regarding the psychological and physiological ramifications of critical incidents. All sacrificed a week of their time and unselfishly dedicated themselves to the task at hand, clarifying and enlarging the body of knowledge that concerns law enforcement officers involved in critical incidents.

Busily at work six months prior to this conference, Mrs. Bernadette Cloniger, Secretary to Mr. Campbell; Mrs. Constance Dodd, Training Technician, BSSU, and Ms. Wendy Pledger, summer employee program, ensured that all of the invitees were in possession of the information necessary to make their travel to the FBI Academy comfortable and orderly. We also thank them for their unending mailing, typing, and organizing of files and manuscripts. During the week of the conference, Ms. Tracie Velier, college intern program, spent long hours ensuring that the needs of the conference attendees were met. We express our appreciation to her for her dedication and professionalism.

Dr. Reese wishes to add a personal note of thanks to Mr. Michel Oligny, M.S.S., a Quebec Provincial Police Officer who currently serves as an instructor of Behavioral Sciences at the Quebec Police Institute, Nicolet, Quebec, Canada. Contact with this trusted friend and colleague during a conference sponsored by the Quebec Police Institute served as a reminder that there are many in law enforcement, throughout the world, who are still pioneering efforts within their departments and countries for a more humane way to deal with critical incident reactions and stress. Mr. Oligny's efforts have provided additional incentive to ensure that this book was completed so that it could serve as a useful tool for all who are involved in behavioral sciences in law enforcement. Merci beaucoup.

A special message of appreciation is given to Dr. Christine Dunning, Associate Professor, University of Wisconsin, Milwaukee. She flew to the FBI Academy months before this conference to assist in turning the abstracts submitted into a schedule of presentations. She is an individual of extraordinary talent and her assistance was of inestimable value. Gratitude is also expressed for her reading and editing a portion of the manuscripts in this publication, as well as assisting in designing the format of this book.

Deserving special recognition are Mrs. Cynthia J. Lent, Technical Information Specialist, and Mrs. Susan K. Efimenco, Writer–Editor. For several months they painstakingly read and reread these manuscripts, editing them where needed and, along with Mrs. Cloniger, typing them for inclusion in this book. Additionally, Ms. Lent accepted the ultimate responsibility of ensuring that these manuscripts were in proper form and ready for printing. Her performance was exceptional and because of it, this book is a reality.

Lastly, but most importantly, we wish to thank the many law enforcement officers who not only have suffered trauma during, and following, critical incidents, but who have been courageous enough to share their feelings with others. In that no training scenario can be devised that would approximate the traumatic responses often experienced in actual situations, the information provided by these individuals forms the foundation for our understanding of critical incident reactions in policing.

We believe that this book, Critical Incidents in Policing, will not only serve those familiar with critical incidents but will also educate those who are not. The conference included, and thus this book is designed for, therapists, peer counselors, chaplains, law enforcement officers, and administrators. It will be useful to virtually anyone wishing to gain insight into the topic of critical incidents in policing.

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ASSESSMENT OF PERSONALITY CHARACTERISTICS RELATED TO SUCCESSFUL HOSTAGE NEGOTIATORS AND THEIR RESISTANCE TO POSTTRAUMATIC STRESS DISORDER

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ABSTRACT

Recent research (Getty and Elam, 1988; Hibler, 1984; Strentz, 1984; Gelbart, 1979) attempted to identify those personality variables that are predictive of successful hostage negotiators. These studies basically identified personality characteristics of police officers who were most qualified for selection to a hostage negotiation training program.

The purpose of this research was to identify those personality characteristics--as assessed by the Minnesota Multiphasic Personality Inventory (MMPI) and the California Psychological Inventory (CPI)--that correlate positively with successful police hostage negotiators. The sample included 12 hostage negotiators who have an average of 10 years' experience in negotiation and have responded to approximately 500 crisis scenes. A second purpose of this study was to determine the presence of posttraumatic stress disorder (PTSD)--as assessed by the criteria established by Keane, Malloy, and Fairbank (1984)--in this sample of hostage negotiators.

The study delineated personality characteristics correlated with successful police hostage negotiators. In general, this sample of hostage negotiators can be described as energetic, cognitively conservative with the capacity for abstract and creative problem-solving, less conforming, able to tolerate ambiguity and disorder, and a style of insight to initiate actions that can be utilized to either assist or harm individuals. There were no negotiators scoring in a significant pattern correlated with PTSD. Immediate crisis debriefing at the scene was proposed to be the operative mitigating process.

INTRODUCTION

In most major studies of the assessment of police hostage negotiators, the authors have primarily relied upon subjectively descriptive terms and personality characteristics of police officers selected solely for negotiator training (Hibler, 1984; Strentz, 1984; Fuselier, 1988; Schlossberg, 1980; and Gelbart, 1979). A recent study by Getty and Elam (1988) examined the usefulness of the MMPI and the CPI to develop general selection cutoff rules in the selection of police hostage negotiators. Although the results of this study are compelling, the authors were required to temper the findings since their data could not be correlated with performance scores from a sample of known successful hostage negotiators.

The accurate and appropriate identification of assessed personality characteristics related to the successful police hostage negotiator is crucial to the outcome of hostage incidents. Hence, the present study was undertaken to document personality characteristics as assessed by scales from self-report assessment instruments that can be used as adjunctive screening measures in the selection of hostage negotiators. To this end, the sample for this study included all highly trained and operationally successful veteran police hostage

negotiators. Thus, any scales identified as being predictive for the successful hostage negotiator will be associated with inventory scale data that consistently identify individuals who possess the personality characteristics of the successful police hostage negotiator.

The assessment and diagnosis of PTSD has relied extensively upon the use of the clinical interview (Arnold, 1985; Keane, Fairbank, Caddell, Zimering, and Bender, 1985). Unfortunately, for some traumatized police officers, the diagnosis of PTSD has not been conferred due to a more professional preference toward the more recognizable anxiety and affective disorders (Keane, Wolfe, and Taylor, 1987). Thus, a second objective of this study was to examine the utility of the MMPI in detecting the symptoms of PTSD among this sample of 10-year veteran police hostage negotiators.

METHOD

Subjects. The subjects were 12 veteran hostage negotiators of a large, southeastern metropolitan police department. This sample of subjects has responded an average of 54 times per year to a multitude of complex situations inclusive of air and ship piracy hostage taking, ground hostage taking, barricaded individuals, and suicidal individuals. Demographic characteristics are presented in Table 1. Data were collected during March of 1989.

Procedure. All subjects were administered the 566 items of the MMPI, Form R; all items of the CPI; and completed the Shipley Test, which provided a WAIS-equivalent intelligence score. A rank order of the subjects was then developed by the staff police psychologist (principal investigator) and the negotiator supervisor. A consensus rank order of negotiating competency was established on the first attempt. The rank order of negotiating competency was based upon four factors: skill ability, emotional management, listening ability, and consistency of negotiation performance.

The decision rule for PTSD was determined following the guidelines established by Keane, Malloy, and Fairbank (1984). The diagnostic information available from the standard clinical and validity scales was examined. A decision rule was then devised to identify PTSD subjects. Cutoff scores were calculated: F (66 T), D (78 T), and Sc (79 T). Subjects with scores above these points were classified as PTSD by the decision rule, and those with scores below this point were classified as NPTSD. Next, a special subscale of the MMPI for identifying PTSD was developed. All MMPI items were submitted to chi-square analysis to determine which items were endorsed differentially for PTSD. Forty-nine items produced chi-squares with p values less than .001, and these items were then summed to produce a PTSD scale.[1] The specific MMPI items are provided in Appendix A. Inspection of the frequency distribution of PTSD scale scores indicated that 30 was the optimal cutting score for identifying PTSD.

RESULTS

The means and standard deviations of the negotiator sample on the MMPI and CPI appear in Table 2 and Table 3, respectively. The mean profiles of the negotiator sample appear, respectively, in Figure 1 and Figure 2. The Shipley Test produced a mean IQ of 117 (SD=4.06), which places this sample of negotiators in the intelligence classification of High Average (Wechsler, 1981). It can be seen that the group did not produce clinical elevations (>70 T) on the validity scales or on the clinical scales of the MMPI. The highest elevations of standard scores produced were on scales Ma (M=63.58; SD=10.29), Pd (M=61.08; SD=10.77),

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[1] The MMPI items that discriminated PTSD at the .001 level are as follows (items were endorsed as true by the PTSD group except where designated by an asterisk): 2*, 3*, 8*, 15, 16, 22, 24, 31, 32, 33, 39, 40, 43, 57*, 61, 67, 72, 76, 88*, 94, 97, 104, 106, 107*, 114, 137*, 139, 147, 152*, 156, 182, 217, 241, 286, 303, 314, 323, 326, 336, 338, 339, 349, 350, 358, 359, 366, 372, 376, and 389.

and Mf (M=61.08; SD=9.93). The CPI produced highest elevation of standard scores on scales Py (M=14.67; SD=2.31), Sp (M=40.25; SD=5.48), Do (M=31.92; SD=6.65), and Sa (M=22.58; SD=3.75). As can be seen from Table 2, none of the subjects in this sample were identified as suffering from PTSD (M=8.75; SD=4.85), with the maximum single subject raw score equaling a 20.

The correlational data from this sample are equally interesting. The MMPI, CPI, and Shipley inventories were correlated with rank order using a Pearson product-moment statistic. Higher negotiator proficiency was associated with scales Pt ($p<.05$), Sc ($p<.05$), PTSD ($p<.05$), R ($p<.01$), Es ($p<.01$), O-H ($p<.05$), Py ($p<.05$), Fx ($p<.05$), Fe ($p<.05$), and Shipley ($p<.05$). Neither age nor educational attainment correlated significantly with scores on the MMPI, CPI, or Shipley. These results suggest that scores on negotiator proficiency were, in part, a function of negotiator personality characteristics, a finding that has not been previously reported elsewhere in the literature.

These 10 variables (Pt, Sc, PTSD, R, Es, O-H, Py, Fx, Fe, and Shipley) were standardized into beta weights and summed into a composite score, taking into account the sign of the original correlations. The composite was then correlated with rank order. The beta weights are shown in Table 4. A multiple R of .837 ($p<.001$) was produced for the dependent variable of rank order of negotiator proficiency (Table 5). Neither age nor education produced significant results. Creating a composite of the standardized variables is a more conservative approach than the regression analysis given the small sample size.

A post hoc stepwise multiple regression analysis was conducted with all variables to determine how much practical prediction was actually obtained. The results of this analysis indicated that three variables produced a significant degree of predictability for rank order of negotiator proficiency. The three variables of Fx, Pa, and Mf were able to predict rank order as portrayed in Table 6.

DISCUSSION

The findings of the present study that scales of the MMPI, CPI, and the Shipley Test were robust when applied to a sample of veteran police hostage negotiators appear to strengthen the rationale for using these scales as an aid in screening for police officers applying for placement on hostage negotiator teams. These findings are of increased specificity when compared with the earlier conclusions of Schlossberg (1980) who concluded that a profile of a hostage negotiator could not be developed.

According to the literature, there appears to be a general personality profile of a hostage negotiator (Getty and Elam, 1988; Ebert, 1986; Hibler, 1984; Strentz, 1984; Fuselier, 1988; and Gelbart, 1979) of those police officers selected for training in hostage negotiations or who are presently hostage negotiators, but there has not been any documented performance data associated with competency. The results of the present study support the use of the MMPI, CPI, and Shipley scales as one component in a broadly based screening package for police hostage negotiators. Findings from the rank order stepwise multiple regression analysis strongly suggest that the function was efficient in discriminating specific and predictable psychological characteristics of effective police hostage negotiators. The factors Fx, Pa, and Mf were found to be predictive of the successful and competent negotiator. Correspondingly, Pt, Sc, PTSD, R, Es, O-H, Py, Fx, Fe, and Shipley can be predictable factors in police hostage negotiator selection.

Behaviorally, our findings are descriptive of a successful and competent police negotiator possessing numerous characteristics. Relevant behavioral concomitants predictive of the successful hostage negotiator include descriptors of: insightful, intelligent, relational, logical, clear-thinking, self-controlled, decisive, able to make concessions, assertive, determined, values success, self-confident, persistent, trustful, expresses frustration appropriately, abstract and creative/imaginative problem solving, tolerant of ambiguity and disorder, ability to determine how others think and feel, and the use of insight to either help or hurt others.

A final issue that is of clinical relevance is the finding that this sample of long-term, often utilized, and successful hostage negotiators were significantly symptom-free (as determined by the PTSD scale of

Keane, Malloy, and Fairbank) of PTSD. Lack of significant levels of PTSD within this sample may be suggestive of the proactive insulating processes against stress inherent in the personality characteristics identified earlier in this study. A second alternative is this may be the result of immediate debriefing at the scene following profound negotiation scenes. It appears that direct therapeutic exposure to the traumatic event has been identified as the single most important treatment factor in PTSD (Keane, Zimering, and Caddell, 1985; Boudewyns and Shipley, 1983). Whether exposure to the trauma is a requisite component to the treatment of PTSD in hostage negotiation remains empirically debatable. Horowitz, Marmar, Weiss, Dewitt, and Rosenbaum (1984) have posited that exploratory actions by others that uncover debilitating affective interpretations and responses are effective for individuals who are stable and focused toward healthy response. As a logical extension, it appears that on-the-scene debriefings provide exploratory investigation of actions and emotions, social support as an adaptive coping strategy (Sarason, Sarason, Potter, and Antoni, 1985), and systematic desensitization and imagery that focus on the reduction of arousal to cues of traumatic conditioning experience (Keane and Kaloupek, 1982).

In summary, the present study is the first to utilize a sample of successful police hostage negotiators. This sample produced empirically derived criteria from the MMPI, CPI, and the Shipley Test that are predictive of prospective hostage negotiators. A special subscale of the MMPI was utilized to rule out significant PTSD among these highly successful veteran hostage negotiators. Several divergent alternatives were suggested to explain this finding. It is evident that further replication of these exploratory findings is necessary due to the small sample size. Also, due to the significant amount of incomplete data for the Inwald Personalty Inventory (IPI), it was regrettably unavoidable that no statistical analysis could be derived. Therefore, it is evident that further comparative research is warranted as other inventories--most notably the IPI--may offer comparable, if not superior, predictive accuracy than that of the MMPI, CPI, and Shipley when used with police hostage negotiators. A third area of investigation could be directed at determining if the identified predictor variables may also militate against hostage negotiators developing PTSD.

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Table 1

DEMOGRAPHIC CHARACTERISTICS

Race			
	White	6	
	Black	2	
	Latin	4	
Sex			
	Male	10	
	Female	2	
Mean Age		41.9	Range: 32–45
Mean Education (years)		14.8	Range: 12–24
Mean Experience (years)		10.2	Range: 4–15

Table 2

MEAN AND STANDARD DEVIATIONS
OF THE MMPI

Scale	Mean	Standard Deviation
L	47.00	5.74
F	51.00	6.34
K	57.67	7.69
Hs	53.67	12.98
D	53.58	13.21
Hy	57.08	12.33
Pd	61.08	10.77
Mf	61.08	9.93
Pa	56.42	10.62
Pt	55.58	13.27
Sc	57.50	10.72
Ma	63.58	10.29
Si	55.75	7.03
A	49.67	5.02
R	53.00	6.83
MAS	46.83	11.97
Es	57.25	6.88
Re	51.67	6.05
Pr	47.08	8.78
Cn	55.75	10.49
O–H	50.42	10.42
RAWMAC	23.58	1.78
PTSD	8.75	4.85

Table 3

MEAN AND STANDARD DEVIATIONS
OF THE CPI

Scale	Mean	Standard Deviation
Do	31.92	6.65
Cs	21.75	3.39
Sy	28.25	5.12
Sp	40.25	5.48
Sa	22.58	3.75
Wb	37.33	4.34
Re	30.08	3.58
So	35.92	3.12
Sc	29.67	5.38
To	23.50	4.80
Gi	18.25	6.68
Cm	27.00	1.71
Ac	31.17	3.38
Ai	21.67	4.40
Ie	42.58	4.76
Py	14.67	2.31
Fx	10.33	4.79
Fe	16.75	3.28
Shipley	117.08	4.06
Age	41.90	4.23
Ed	14.80	2.17
Rank	6.50	3.61

Table 4

COMPOSITE SCORES BETA WEIGHTS OF VARIABLES
CORRELATED WITH RANK ORDER

ZPT	ZSC	ZPTSD	ZR	ZES	ZOH
.0314	- .0466	1.2899	- .2926	-1.6359	.1519
- .1947	- .0466	-1.1867	- .2926	.9815	.2477
- .3454	- .6061	.4644	-1.3166	.5453	.2477
-1.0236	-1.2589	- .9803	.5852	.5453	- .7116
2.9704	2.6576	2.3218	1.9018	-1.3450	1.3033
- .2700	.3264	- .1548	.2926	-1.3450	1.9749
.1821	- .6061	- .7739	- .2926	.9815	- .4238
- .8729	- .6994	- .5676	- .5852	.6907	- .4238
- .2700	.5129	.2850	.5852	- .4726	- .4238
- .1193	- .0466	.0516	1.4629	- .4726	.4326
- .1193	.5129	- .1548	-1.1703	.5453	-1.9589
.0314	- .6994	- .5676	- .8774	- .9815	- .4238

ZPY	ZFX	ZFE	ZSHIP
-1.5877	-1.1128	.6862	- .0206
1.0104	.5564	- .8387	- .2671
.5774	1.5996	.9912	- .5137
- .2887	1.1824	-1.1437	.9658
.1443	.1391	.6862	-1.2535
- .2887	-1.1128	.9912	-1.7466
-1.5877	- .2782	- .5337	.9658
1.0104	- .4869	- .8387	.4726
.1443	- .4869	- .8387	- .5137
-1.1547	-1.3215	1.9062	- .5137
1.0103	1.3910	- .8387	.7192
1.0103	- .0696	- .2288	1.7055

Table 5

MULTIPLE REGRESSION ANALYSIS AS A FUNCTION OF RANK ORDER

Entry Order	R	R^2	Beta	F	df
Rank Order	.8367	.7001	.8367	23.34**	1, 10

** $p<.001$

Table 6

STEPWISE MULTIPLE REGRESSION ANALYSIS

Entry Order	R	R^2	Beta	F	df
Fx	.6313	.3986	−1.0960	6.63**	1, 10
Pa	.8077	.6524	.5633	8.44*	2, 9
Mf	.9257	.8568	− .5552	15.96*	3, 8

* $p<.01$

**$p<.001$

APPENDIX 1

MMPI PTSD SUBSCALE[1]

All items are endorsed as true except where designated by an asterisk, which indicates the item as being answered as false.

2*	–	I have a good appetite.
3*	–	I wake up fresh and rested most mornings.
8*	–	My daily life is full of things that keep me interested.
15	–	Once in a while I think of things too bad to talk about.
16	–	I am sure I get a raw deal from life.
22	–	At times I have fits of laughing and crying that I cannot control.
24	–	No one seems to understand me.
31	–	I have nightmares every few nights.
32	–	I find it hard to keep my mind on a task or job.
33	–	I have had very peculiar and strange experiences.
39	–	At times I feel like smashing things.
40	–	Most any time I would rather sit and daydream than to do anything else.
43	–	My sleep is fitful and disturbed.
57*	–	I am a good mixer.
61	–	I have not lived the right kind of life.
67	–	I wish I could be as happy as others seem to be.
72	–	I am troubled by discomfort in the pit of my stomach every few days or oftener.
76	–	Most of the time I feel blue.
88*	–	I usually feel that life is worthwhile.
94	–	I do many things I regret afterwards (I regret things more or more often than others seem to).
97	–	At times I have a strong urge to do something harmful or shocking.
104	–	I don't seem to care what happens to me.
106	–	Much of the time I feel as if I have done something wrong or evil.
107*	–	I am happy most of the time.
114	–	Often I feel as if there were a tight band about my head.
137*	–	I believe that my home life is as pleasant as that of most people I know.
139	–	Sometimes I feel as if I must injure either myself or others.
147	–	I have often lost out on things because I couldn't make up my mind soon enough.
152*	–	Most nights I go to sleep without thoughts or ideas bothering me.
156	–	I have had periods in which I carried on activities without knowing later what I had been doing.
182	–	I am afraid of losing my mind.
217	–	I frequently find myself worrying about something.
241	–	I dream frequently about things that are best kept to myself.
286	–	I am never happier than when alone.
303	–	I am so touchy on some subjects that I can't talk about them.
314	–	Once in a while I think of things too bad to talk about.
323	–	I have had peculiar and strange experiences.
326	–	At times I have had fits of laughing and crying that I cannot control.
336	–	I easily become impatient with people.
338	–	I have certainly had more than my share of things to worry about.

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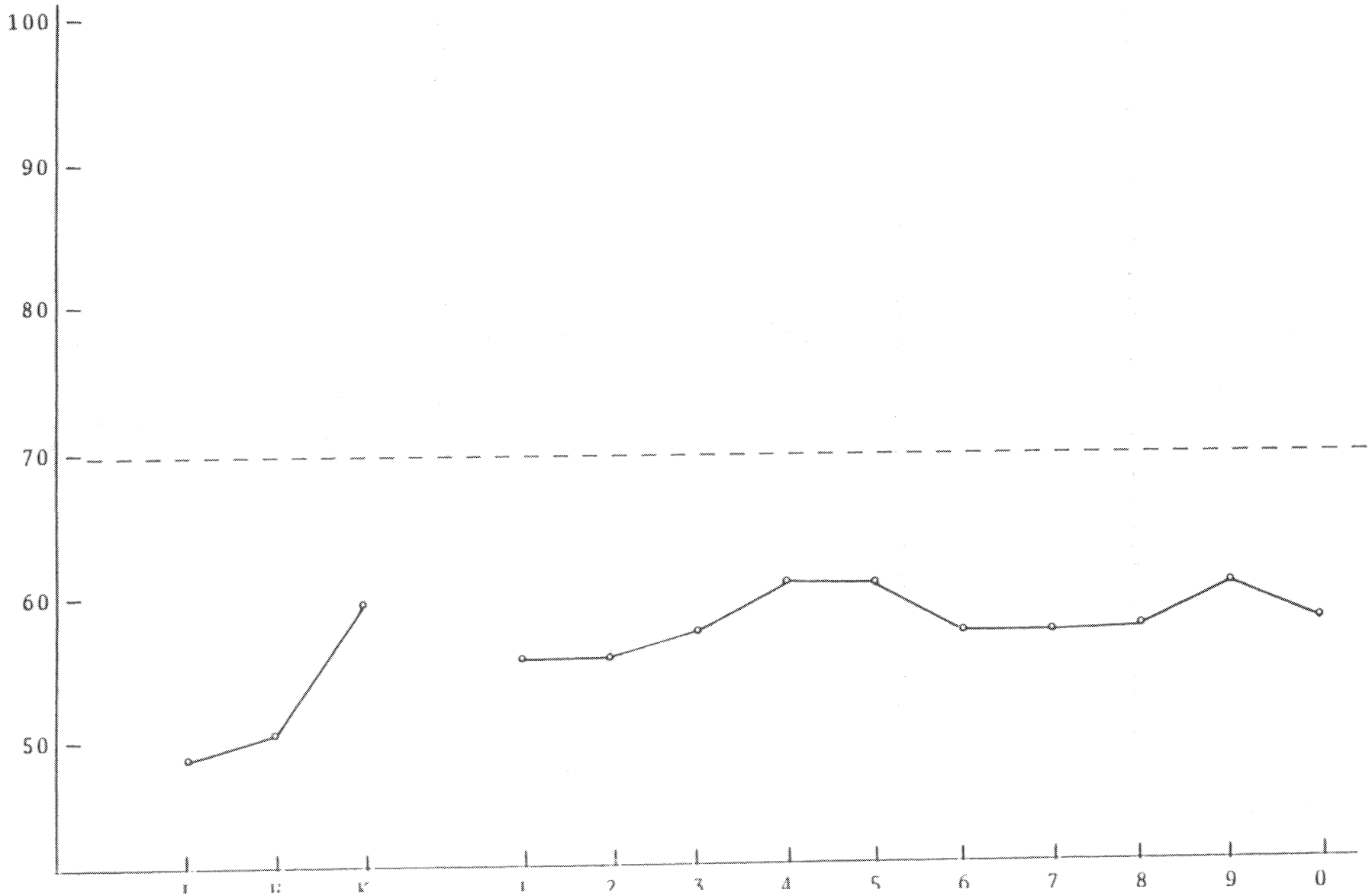
[1] Keane, T. M., P. F. Malloy, and J. A. Fairbank. (1984). Empirical development of an MMPI subscale for the assessment of combat-related post-traumatic stress disorder. Journal of Consulting and Clinical Psychology, 52, 888-891.

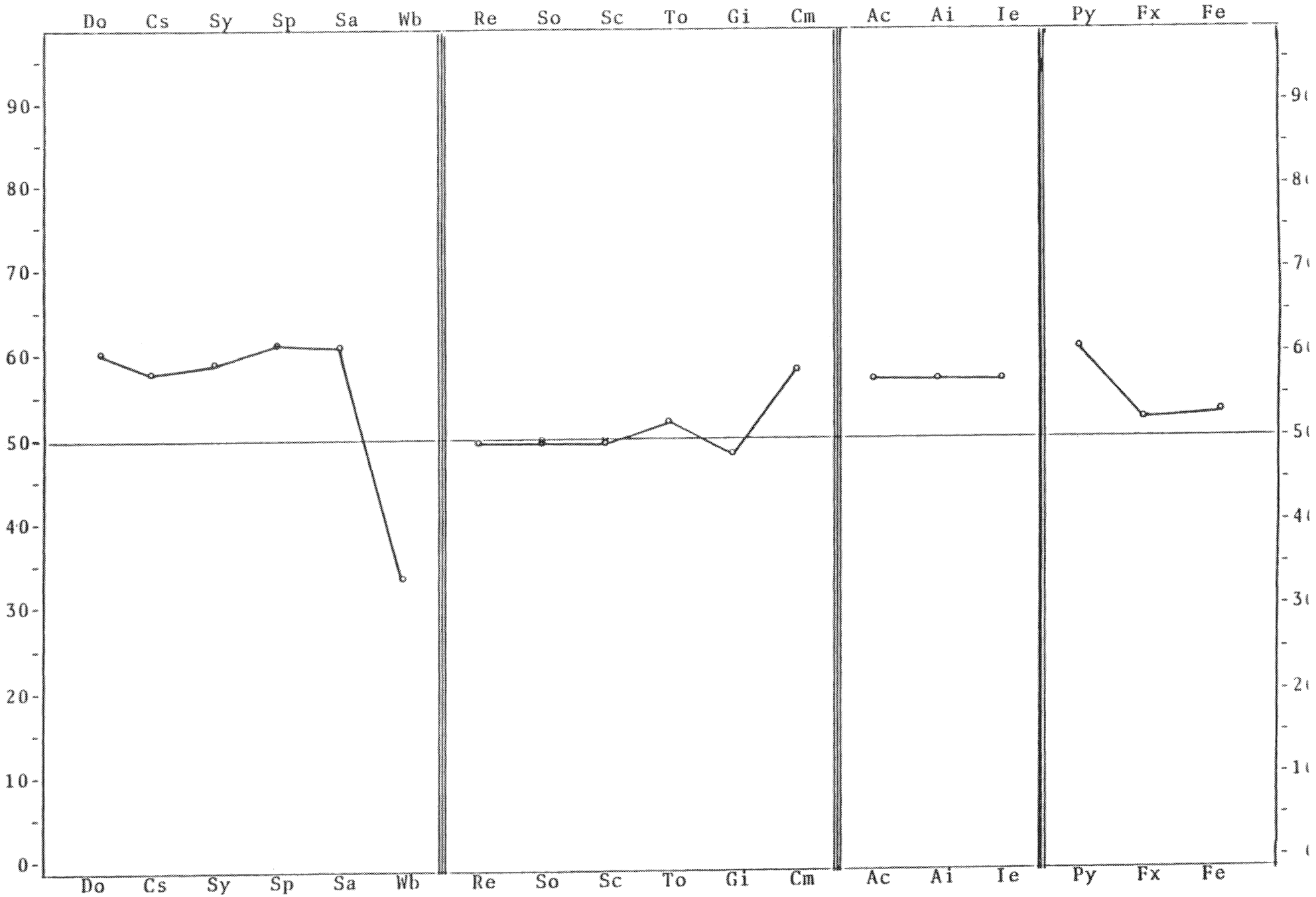
339 – Most of the time I wish I were dead.
349 – I have strange and peculiar thoughts.
350 – I hear strange things when I am alone.
358 – Bad words, often terrible words, come into my mind and I cannot get rid of them.
359 – Sometimes some unimportant thought will run through my mind and bother me for days.
366 – Even when I am with people I feel lonely much of the time.
372 – I have sometimes felt that difficulties were piling up so high that I could not overcome them.
376 – It makes me feel like a failure when I hear of the success of someone I know myself.
389 – Whenever possible I avoid being in a crowd.

FIGURE 1

T-SCORES
MMPI



T-SCORES
CPI


Do Cs Sy Sp Sa Wb Re So Sc To Gi Cm Ac Ai Ie Py Fx Fe
90
80
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50
40
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20
10
0
Do Cs Sy Sp Sa Wb Re So Sc To Gi Cm Ac Ai Ie Py Fx Fe

THE CHAPLAIN'S ROLE IN CRITICAL INCIDENT RESPONSE: AN OVERVIEW

Gary L. Benjestorf

ABSTRACT

The police chaplain of the past held a ceremonial role in the agency served. Agencies have discovered a far greater use for chaplaincy service and thus the role of chaplain has expanded. This paper presents an overview of this evolutionary process to the involvement of chaplains in critical incident response.

Historically, law enforcement administrators have called upon area ministers to help out in those occasions where protocol would seem to demand an appropriate prayer. The opening of new facilities, a retirement dinner, an awards banquet and the annual Police Officers Memorial Day would be chosen as times to feature a chaplain.

There has been reluctance on the part of law enforcement administrators to go further in the use of the chaplaincy. Part of the difficulty would certainly lie in the lack of awareness on the part of the department as to what a chaplain could do. Administrators would be more apt to worry about a chaplain becoming involved in labor relations or that the chaplain would disturb the routine of the department. Concerns about officers' reactions and fears of the chaplain collaring officers and forcing scriptures down their throats and the ideas that perhaps the chaplain would be out of touch with the real world have probably been thoughts of many department heads.

Gradually, however, departments have seen the chaplaincy as a much more valuable resource than a formal events guest. Chaplaincies have expanded to offer marriage and family counseling and academy instruction in the areas of ethics, stress, and the police family. Chaplains enlist the help of other professionals to host seminars on issues ranging from family communications to financial planning. They are frequently called upon to perform weddings and conduct funerals and memorials.

This evolutionary growth was not accidental. Agencies have begun to see that their worst fears about chaplains have gone unrealized, and positive benefit has taken its place. They have received substantial positive feedback from officers in the field through exposure as chaplains frequently ride–along and become part of agency events. They observe the chaplain and conclude that he is a real person, and the word "God" that they had imagined to be stenciled on the chaplain's forehead begins to fade.

The care of the chaplain and his corps of volunteers extends beyond the perfunctory to traumatic events and helps in practical ways. Perhaps it is the maid service provided to a family while the officer's dad had a prolonged illness, perhaps the meals organized with help from the wives' clubs when a police officer was killed. There is the case of the records clerk who had a stroke on the job and later died. The chaplain worked with the family through a decision to terminate life support, the grieving process, and the funeral. He then held a debriefing in the division where she had worked.

Consider the case of Officer J.R. His 13–year–old son fell off his skateboard, hit his head on a curb, and lapsed into a coma. The coma lasted for many months. On first contact with Officer J.R., the chaplain received the "thanks for your concern and maybe I'll call" kind of response. Respecting J.R.'s feelings, the chaplain quietly and gently followed up. First, the chaplain contacted J.R.'s wife, who was most receptive of

the support. Some meals were arranged from throughout the department and specifically J.R.'s division. Another low-key response to J.R. by the chaplain was made, and J.R. began to talk and share his feelings and fears about the incident. His son was moved to another city for care. The chaplain assisted the Widows and Orphans Fund in a fund raiser to help cover the medical expenses not covered by the family's health insurance. Upon learning of the boy's move to yet another facility and a need for a place to park a trailer on visits, arrangements were made for parking at the county sheriff's department parking lot just a block away from the hospital.

Perhaps the most dramatic development in chaplaincy service has been the involvement of chaplains as team members in critical incident response teams. When we deal with a critical incident response, we recognize that the incident could be an officer involved in a fatal accident or a homicide scene that is particularly disturbing. It could be that he has been shot at or has dealt with the death of a child. A plane crash or other community disaster would certainly qualify as a critical incident.

The important thing to remember is that what is shocking to one might not be shocking to another. The critical event is the one that challenges the officer's ability to cope with its effects. His normal coping mechanisms are not prepared or equipped to deal with what he sees or feels.

The chaplain addresses a number of needs that officers face at a time of critical incident. While, admittedly, there have been a number of advances made into the understanding of the physiological and psychological happenings involved in a critical incident response, chaplains have been dealing with many of its symptoms and, thus, its causes for some time. Grief, guilt, anger, and depression have been around for a long time. Having additional training in law enforcement needs is certainly required. There would seem to be few clergymen truly equipped to deal with law enforcement problems without an understanding of the law enforcement profession and the people who choose that profession as a life's work.

Effectively addressing the needs of an officer in a time of crisis takes, I believe, a whole-body approach to healing. Using the trichotomous model, I would suggest that support be addressed to the body, soul, and spirit. There are physical needs to be met and certainly needs that involve the psyche and the spirit. Thus, a team effort is needed. The chaplain helps with some peripheral issues as well as spiritual concerns. He further can coordinate the efforts of other helpers. The peer supporter follows up as a trained observer, and the psychologist makes evaluations and suggestions for follow-up.

The chaplain's role begins far before the emergency call. As stated, relationships with all department personnel already established through ride-alongs, through meetings for coffee, briefings, and visibility at special events.

To illustrate a chaplain's role in critical incident response, let us select a model that would put an officer involved in a shooting when the suspect has been killed. When the call comes, the immediate response for the on-call chaplain is go to the station. The scene is a far too cluttered and traumatic place for meaningful work to be done. A predesigned office is used as an interview room. The traditional place of suspect interviews in the detective division is NEVER, EVER USED.

The "shooting team," comprised of a homicide detective, internal affairs investigator, district attorney investigator, the officer and his designated union representative, has been called. While this team is being assembled and the stream of supervisors and other officers arrive, the homicide supervisors are notified that the chaplain is available and that he is doing an initial interview. In this interview, the chaplain is careful not to contaminate the investigation in any way by talking about the event or prompting responses or making judgments, etc. The purpose of the interview is to reacquaint the officer with the process that is taking place. He is usually not ready to talk about his needs yet anyway, as many things are going through his mind concerning the statement that he is about to make. The numbing shock is still there, but he is generally worried about remembering all of the facts of the incident and can feel some of the pressure of being confused

on some issues that were incidental to the shooting. He might not even remember how many shots were fired and may feel fearful about not being considered professional or capable enough of an officer.

The issues are many in number and cannot be listed completely here. The chaplain reassures the officer by letting him know the purpose of his interview that is ahead, and also what the expectations are and what they are not. He is reassured that here is support and that folks around him care about him and are concerned about his welfare. Often, with the officer's approval, a prayer is offered.

His union representative is then called in and reaffirms that he is there to support the officer and his rights, and that this part of the investigation is not an internal affairs investigation into his conduct but rather a completion of the statement of facts to be presented in court in the criminal proceedings against the suspect.

After the interview with the shooting team, the officer is then advised by his supervisor that he has five days off with pay and that he is not being punished. Another service weapon is issued to him as a reassurance that he is okay and part of the family.

The chaplain then briefly asks the officer to discuss how he feels about the incident. We have come to believe that an officer is unable to have a clear feeling about what is going on in his own life for 24 hours or so. This is often the case; however, many times I have observed officers clearly being able to articulate their feelings as soon as one hour after the event. In the safety of the nonjudgmental environment of the interview room with the chaplain, one officer said to me, "I know what you said at the academy about the moral implications of the shooting, but I feel shaky inside. I do not know if it's my faith or not. Will you tell me that part again?" This leads me to believe that even though what might be considered the most meaningful therapy comes later, good work can be done very shortly after the event.

The interview continues by advising the officer of some of the things that can happen after a shooting has taken place. He is advised of the various symptoms that have been developed and that have been experienced by other people, and he is reassured that this is part of the process of his body and mind trying to deal with the events at hand. He is given a brochure outlining the effects of posttraumatic stress for later review. The department psychologist is given a warm and firm recommendation in order to reassure the officer that this unknown psychologist is not going to give him a fitness-for-duty evaluation or possibly damage his career in some way, but will merely try to make sure that he is okay with the shooting itself.

The department psychologist has a most difficult job. Without knowing the officer, he is required, sometimes in only one visit, to determine what follow-up is needed. Most law enforcement budgets do not allow for nearly enough time to follow up in a comprehensive treatment plan.

It is extremely helpful to the officer and therapist if there is some knowledge of each other prior to the incident. That is why it is recommended that the psychologist volunteer his time for ride-alongs. During a ride-along, walls are broken down and a trust is established as the officer sees a real person capable of dealing with his problems.

Since effective and consistent follow-up are tantamount to a good treatment plan, the psychologist, chaplain, and peer support team must work together, with the clear support of administration, with a well-organized treatment plan.

Very soon after the incident, the chaplain visits the officer's family. The family is advised of some of the things that the officer might be feeling and that they might see and experience. If the family is a strong one, the support the officer receives is irreplaceable, and chances are they have been practicing good family support skills to begin with.

All too often, however, an event like this happens in a family that is not as strong as it could be and it seems to pull the family together for a brief time in order to help the officer. But if the family is

dysfunctional for other reasons, the shooting can complicate matters, and family therapy is very much recommended. Whatever the case, the family can provide valuable insight as to how everyone is doing with the event.

The chaplain, through this process, provides support for issues of personal faith. The officer usually has one kind of faith, whether active or not. The officer will deal with the ethical and moral implications of the shooting. He can deal with guilt, anger, or fear. If he has a chaplaincy-trained clergyman available he can deal with the possibility that he doesn't feel bad and thinks that he should.

The chaplain addresses the needs of the spirit when, at a time of crisis, the officer is brought into confrontation with his own mortality. The officer often has questions about his own destiny or his dwelling on eternal issues. As one officer wrote recently, "...a stress avalanche occurs because of the guilt the shooter carries around with him. Believe me when I say there is guilt. As misplaced as you may think it is, guilt rides heavily with the officer involved with a shooting. 'Thou shalt not kill' is a maxim taught from the crib. Regardless of the legal definition of justifiable homicide, there is always 'well, maybe I did screw up,' in the background" (Call Box, 1989).

Then there are those who have strong-to-mild religious convictions who would be afraid to discuss those issues with the psychologist for fear of being thought foolish or in other ways discounted. Fortunately, there is beginning to be a change in the minds of many psychologists as it pertains to a person's personal faith.

The need for support in these cases is well documented, and helpers who respond and demonstrate a truly caring spirit are providing something called "ministry of presence." Through all of this process, the clergy stand as a symbol of caring. The chaplain is more than a person offering a heartfelt prayer. He is also someone sensitive to the person's needs and provides practical humanitarian concern and interest.

Finally, in a shooting situation, the chaplain contacts, and follows up with, officers on the perimeter of the incident. The ones who didn't shoot need care as well as the officer who did. In my own personal experience as a deputy sheriff with San Joaquin County, California, I can recall very vividly an event of not shooting when my partner did. For years I always felt compelled to answer questions that weren't being asked. Questions like, "Why not? Were you going to? Was it righteous?"

In a recent shooting where one of our officers was killed in a barricaded subject situation, follow-up was made with some 45 officers, some of whom were patrolling on the other side of the county. This just amplifies the need for a chaplaincy service with a corps of volunteers able to extend themselves in emotional and spiritual debriefings during a problem of this magnitude.

Whatever the critical incident may be, it is clear to this observer that a team effort is badly needed. It is clear that the officer needs an administrator who is sensitive to his needs and clearly understands the officer's situation and is able to communicate that concern to him. The officer needs peers who are educated to defeat the "suck it up and go syndrome" and support one another. He needs chaplains and psychologists who understand the dynamics of police work as well as critical incident response; then maybe we can see officers healed and productive once again.

Unfortunately, police departments do not have the resources necessary to follow up on officers as much as is needed. Since many chaplaincies operate at no cost or little cost to the agencies involved, chaplaincies become an integral part of the law enforcement family. But whatever the case, law enforcement administrators have agreed that a department that operates without a departmental chaplain and psychologist is one that is not adequately equipped to deal with a critical incident.

REFERENCE

Officer Involved Shootings, Call Box, Vol. 8, Number 6, p. 1., 1989.

CRITICAL INCIDENT DEBRIEFING FOR LAW ENFORCEMENT PERSONNEL: A MODEL

Richard A. Blak, Ph.D.

ABSTRACT

Law enforcement professionals have become increasingly aware of the disabilitating effects on officers' lives following traumatic or acutely stressful events. Experience has taught us that the psychological, spiritual, and physical damage that follow often is cumulative in nature and may take years to manifest in frank symptomatology. In an attempt at secondary intervention, many of us have taken our clinical skills to those touched and injured by the trauma soon after that trauma. The appropriate approach is psychoeducational in nature and has evolved from the early work of Reiser, Roberts, Stratton, and others on the Postshooting Syndrome. "Critical incidents" now include a range of human trauma from shootings to plane crashes, infant deaths, search and rescue operations, SWAT actions, mass homicides, etc. This paper will present a model for Critical Incident Debriefing. It is a working dynamic model based upon 15 years' experience during which 2,000 individuals involved in 265 separate critical events have been "treated." The model will offer rationale, theoretical underpinnings, and pragmatic recommendations for the elements and processing of such debriefings.

The study of psychological stress and its psychological effects on human functioning has been ever expanding since the pioneering work of Hans Selye. The relationships between stress and emotional disorders, disease entities, medical syndromes, work performance, family dynamics, organizational effectiveness, and quality of life have been explored by social and medical scientists in a multitude of ways. This research has been invaluable to those of us who provide clinical services to those men and women who have chosen careers with a high exposure to the risks of stress reactions.

It is generally accepted that law enforcement personnel, fire fighters, paramedics, and the like expose themselves to stressful events to a higher degree than most other professions. The negative effects of stress are well known to most of us, if not on a cognitive level, certainly on an experiential level. Intense or acute stress reactions often follow a critical incident. In defining critical incident, Mitchell (Mitchell & Resnick, 1981) has focused on the response side of human functioning: "A Critical Incident is any situation faced by emergency personnel that causes them to experience strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later."

It would appear that certain tragic events are so dramatic, shocking, or disturbing to our collective psyches that we agree that they are stressful and therefore critical incidents. Those, of course, include natural disasters, multiple fatalities and/or injuries, shootings or near shootings, prolonged search and rescue operations, and death or serious injury to a fellow officer. Much of the early work in this area evolved out of the work of Dr. Martin Reiser, Los Angeles Police Department; Dr. John Stratton, Los Angeles Sheriff's Department; and Dr. Michael Roberts, San Jose Police Department, who were among the first to identify the Postshooting Syndrome.

A significant powerful contribution to this area of investigation came from our colleagues who have worked with Vietnam era veterans who suffered from what became known as Posttraumatic Stress Disorder (PTSD). Not only did we as a nation learn how we had scarred ourselves physically and emotionally, we learned more about the dramatic cumulative effects of stress. In general, we learned that the more frequently

an individual experienced threat to his physical and psychological integrity, the more likely he would be injured and damaged psychologically. And while it is estimated that only 4% to 10% of those who experience a critical incident develop a full-fledged PTSD, it has been my experience over 15 years of clinical practice specializing in the law enforcement area, that 90% of personnel exposed to critical incidents experience some emotional, physical, or psychological reaction to that exposure.

I believe that critical incident stress debriefing (CISD) in its many forms and variations came out of the experience of clinicians and healers who typically "caught the bodies downstream." In an attempt at secondary intervention (I believe education and training are primary interventions), CISD was developed by a number of professionals who were acutely aware of the painful toll stressful events exact from the professional helpers of our world. We came from various disciplines: Police psychologists, emergency health service professionals, other public safety support personnel, and chaplains. Our common goal was to take care of our brothers and sisters who had been injured by their exposure to stressful events.

In a pragmatic way, CISDs are conducted as a prophylactic; i.e., we wish to minimize the damaging effect of the stressful event upon our officers. We want the participants in such stressful events to see their reactions as normal responses to abnormal situations. That is to say, when an officer engages in a shooting, or works feverishly to save an injured victim, or pulls bodies out of wrecked automobiles or planes, or retrieves the body of a child, or witnesses a colleague's death, he is going to experience some major disruptions in his biology, his cognitions, his belief systems, and his emotionality. These disruptions may result in an acute transient stress reaction or they may accumulate to accelerate the wear and tear on the body and psyche of the officer. Traditionally, officers have been taught to stuff their feelings and deny their hurt. The CISD allows the affected officers to recognize and cope more effectively with their reactions.

WHEN TO CONDUCT A CISD

It has been my experience that CISDs should be conducted within 72 hours of the incident in question. The rationale is based upon two issues. First, if the CI required mobilization of many personnel from different areas and sectors, it becomes increasingly difficult to get them all together again. Second, the immediate effects of stress reactions will already have been experienced by participants in the CI, and it is critical that they be educated as to the nature and implication of those reactions. A related issue has to do with the reinforcement of individual coping skills and the collective power of the group in terms of the healing process. The CISDs promote the reaffirmation of the "family" and the unity of the group.

THE CRITICAL INCIDENT

Various agencies define the need for CISDs according to their need and experience. The following is a suggested set of criteria that has been established at Yosemite National Park under the direction of myself and J.R. Tomasavic, EMS Coordinator. Please note that the National Park Service commissioned Rangers are peace officers, and fire fighters, and many are certified EMTs.

I would urge each agency or jurisdiction to set policy as to the parameters and criteria for establishing CISDs. In some instances the cogent motivation is the avoidance of vicarious liability issues; i.e., sending an officer back to work after experiencing a critical incident when he/she is not psychologically fit to perform safely and effectively as a peace officer.

CISD CRITERIA

*1. Violent death of a fellow worker in the line of duty.
*2. Taking a life in the line of duty.
3. Shooting someone in the line of duty.
*4. Suicide of a fellow worker.
5. Violent or traumatic injury to a fellow worker.
6. Responding to and/or handling of infant mortality.
7. Responding to and/or handling multiple fatalities.
8. Responding to and/or handling a prolonged rescue operation in which victims expire.
9. Responding to and/or handling a barricaded suspect.
10. Responding to and/or handling a hostage taking and negotiation.
11. A SET Team (aka SWAT, Tactical Units, etc.) operation where dangers present.
12. Observing an act of corruption, bribery, or other illegal activity by a fellow worker.
13. Suspension and/or threat of dismissal.
14. Structural flashover and shelter deployment.

*Indicates high priority for removing personnel from the scene.

WHO PARTICIPATES

Drawing again from the family system model, we believe that virtually all involved personnel should be a part of a CISD, particularly if the magnitude of the CI dictates a major event for the agency. Our first attention often goes to those in the thick of the action, but peripheral and support personnel are often deeply affected by the CI.

I typically insist that dispatchers particularly are part of the process, for they are the link that ensures cohesion of the operation in the first instance. Other support personnel such as officers on the perimeter of the scene are certainly part of the team and may have as serious a stress reaction as those at center stage. In fact, at times observers who cannot react directly to the threat to others experience significant anxieties and frustration.

Representatives from the command level demonstrate their sensitivities to the pain and anguish of their troops by their presence at a CISD. It is an opportunity to focus on the human side of enterprise and recognize the psychological and spiritual parts of their family. When one member of a family hurts, the whole family hurts.

THE PROCESS

Although CISDs flow through stages, it has been my experience with 265 separate critical incidents in which more than 2,000 individuals have been "treated," that the demarcation of these stages is flexible and elastic. Dr. Jeffrey Mitchell has formulated these stages.

Initial defusing – performed shortly after the CI, a spontaneous sharing of feelings, support, and ventilation; not a part of the formal CISD.

Introductory phase – mental health professional explains his role and sets the ground rules, issue of confidentiality is addressed; prohibition of critiquing the incident from a functional point of view (that's another forum).

Fact phase – elicitation of content and facts about the personnel involved and the nature of the call.

Feeling phase – elicitation of feelings associated with the CI and related experience.

Symptom phase – description, education, and elaboration of participants' emotional, physical, and cognitive reactions.

Teaching phase – discussion of stress response syndrome.

Reentry phase – wrapping up loose ends and returning to duty when fit.

Follow–up phase – may be conducted several weeks or months after the original CI.

Dr. Mitchell's model identifies the important components of a CISD. My approach is to facilitate the telling of one's story; i.e., the participants all have a story to tell of how the CI was experienced by them. There is no right version or one way to tell the story. At times, misperceptions or events perceived out of chronological or temporal order will be more accurately placed within the cognitive framework of the personnel involved. Ideally the assembled participants as a group should have the answers to most factual questions. As we know, under stress incoming data are typically subjected to partial or distracted attention and therefore are prone to distortion. In addition, those who experience strong emotions during the CI will have experienced the CI through a particular set of filters.

Once the atmosphere of trust and support is set, it has been my experience that participants tell their story and in so doing ventilate feelings that may include: frustration and anger, grief, depression, guilt, vulnerability, general anxiety, existentialist anxiety, and feelings of inadequacy.

Often the CI will provide a catalyst for previously repressed or suppressed feelings or conflicts that may be related or unrelated to the job. It is not unusual that the sights, smells, and sounds of a current CI will take individuals back to earlier memories of violence, death, and destruction. For example, the sound of a helicopter often resensitizes an officer to his experience in Vietnam; having to use deadly force will certainly remind an officer of any previous similar episodes; and investigating violent injuries to a child most undoubtedly impacts the officer who has children of his own. It is important that participants of the CISD come to know the authenticity of their emotional reactions. The group dynamics allow for the granting of permission for one to the other to put into words their inner experience without embarrassment or fear of ridicule.

CISD FACILITATORS

It is very important to conduct a CISD with a sense of cohesion and professionalism and with a leader or facilitator who has specific training as a mental health practitioner. Ideally he/she would have first–hand knowledge of the specific agency in need or at least a working knowledge of what that agency does. It is also my opinion that the facilitator should go to the scene of the incident or some close proximity. From the point of view of putting oneself in that environment, I have empathized more accurately with others' reactions to CIs.

Beyond relying on personal charisma, the facilitator should be well–schooled and grounded in the symptomatology and presenting complaints of those psychologically injured by CIs. This suggests that the facilitator have some basic clinical experience treating stress reactions, particularly PTSD, and emotional illness in general. The appropriateness of a referral to a tertiary intervention such as intense psychotherapy is best addressed by a professional in the mental health field.

THERAPEUTIC CHARACTERISTICS OF CISDs

* physical and psychological "security"
* attachment to others who are perceived to be concerned with the individual's growth, development, and survival
* affiliation with a normative group, which provides clear definitions of rules, reinforcements, and status
* opportunities for intimacy with others
* opportunities for experiencing mastery in an environment of support and acceptance regarding relatively complex issues
* reinforcement of coherent meaning structures, which relate to the developing self, the social group, and the physical environment

(Adapted from Leonard S. Zegan, 1982)

COMMON THEMES AND CONCERNS

During the process of CISDs, there are a number of common issues that emerge as the affected officers tell their stories:

* distress regarding vulnerability and relative powerlessness
* distress regarding threatened loss of control (leads to isolation)
* distress regarding feelings of responsibility (leads to guilt)
* fear of repetitions (leads to hypervigilance)
* depressions and reactions to loss (leads to numbness)
* distress regarding aggressive impulses (particularly in shootings)
* emotional lability (may include startle response)
* anger or even rage toward victims, onlookers, media, administration, etc.
* questioning of career choice and professional identification
* reaffirmation of one's professional and individual efficacy and competence

FOLLOW-UP

During the debriefing, certain individuals will be identified who may require follow-up care from a mental health professional. Every effort should be made to transition those individuals from the CISD mode to a more classic treatment mode. If the facilitator has an ongoing professional relationship with the agency, this transition can be processed relatively easily. If this is not the case, the access to treatment should be provided through EAPs or other organizational mental health programs. Risk managers or other personnel responsible for Workmans' Compensation programs will be the people to contact and authorize treatment. The former approach appears to have the advantage in regards to confidentiality issues.

For mental health professionals who provide services to the organization or agency involved in the CI, it is important to provide a presence at CISDs even though they may not be actual facilitators or group leaders. Again the link between the CISD and follow-up care ideally should be clear and manageable.

In the case of individual or small group CISD's (e.g., one to three officers involved in a shooting, single officer major injury, etc.). I typically follow up with a telephone call to the officer's home and speak to the spouse or significant other. These support people often are very solid sources of data and in addition they are provided with reinforcement in regards to their involvement in the recovery of the injured officer.

Either during the CISD session or the follow-up session, I recommend to the affected officer that upon returning to duty, he physically place himself at the scene of the CI. The rationale for this is twofold. First, it allows the officer to reinforce his mastery of the emotional reaction to the CI. Contraindicators include an intense phobic reaction as part of the clinical picture. In almost every case of a posttraumatic reaction, the affected officer has feared that "it would happen again" in some form. I advise the officer to place himself at the scene and allow whatever emotions and cognitions to bubble up and experience them. Second, it has been my clinical experience that some officers unconsciously avoid the CI scene, which creates a potential interference in safely and effectively performing their duties. I recall very clearly one officer making a car stop immediately in front of a residence where he shot a suspect a mere three nights before. Based upon state-dependent learning theory, we know that rearousal of strong emotions often elicit the stereotypic behaviors involved in the highly charged critical incidents. An illustrative case in point involved a California Highway Patrol officer who was involved in a nonfatal shooting. Three weeks later he was involved in a high-speed pursuit that ended when the suspect's car engine burnt out. As the suspect lowered the tinted window, the officer, who had his service weapon at the ready, "flashed back" to the face of the earlier shooting victim and came very close to "dropping the hammer." I believe this to be a result of reexperiencing a strong arousal state.

CLOSURE

Depending on the magnitude of the CI and the number of personnel involved, the official CISD will typically run two to five hours. It has been my experience that organizations new to CISDs require additional time, as old business often becomes part of the process. Once the officers are familiar with the process, it tends to flow with relative ease. Not that all feelings and cognitions are easy to process, but the nature of the process provides a sense of security and support.

As the stories are told and the feelings disclosed, the facilitator should note which participants have chosen not to share with the group. An invitation or gentle encouragement to do so typically elicits verbalizations from those who have hesitated. If an individual strenuously objects to sharing, he should be treated as someone who has the right to his own reactions and adaptations. As a way of formal closure, I typically present this message: "There is no 'right' way to close this session, but this feels like the time. If anyone has anything they want to put out there, this is the time to do so." Typically there are further "letting go" sharings.

After any additional sharing, I offer my personal reactions to the experience. It is typically an emotional experience for me, and unlike individual psychotherapy, I believe it is appropriate to provide feedback to the group in regards to my reactions to their experience. It provides a way to sum up and synthesize the major elements of the CISD. In this process I do not believe it is troublesome to entertain the issues of transference and countertransference.

Closure is important in the sense it allows the personnel to get back in service with the feeling that the healing process has begun and they are ready for the next set of challenges.

It is also advisable to announce that the mental health professional will remain at the CISD site to consult with any officers who wish to explore individual issues that they believe require a one-on-one dialogue.

VARIATIONS ON THE THEME

CIs involving one officer are, of course, managed much like a psychotherapy session in regards to the processing of feelings and cognitions, educational process, and the identification and assessment of the traumatic impact of the CI. When the CI involves more than one officer but less than 12, the CISD begins as a group process with a fact phase and the educational phase, which includes a description of stress reactions

and symptoms, and the feeling phase follows. Following the closure of these issues, officers meet with the mental health professional to address individual concerns and to allow for the assessment of the impact of the CI on that particular officer. This involves a real pragmatic issue, since most agencies authorize administrative leave of at least three days for those officers involved in CIs.

If the number of involved personnel exceeds 12 and adequate numbers of debriefers are available, the larger group is split into smaller groups of 6 to 12 officers, where further processing of feelings occur. Depending on the magnitude of the CI, those spin-off groups may be comprised of naturally defined entities. For example, major CIs typically involve multiple agencies so that EMTs may comprise one district component, SWAT personnel another unit, dispatchers another, perimeter personnel and support personnel another, coroner's office personnel another, and so on. At other times it might be advisable to combine groups, depending upon the issues that arose during the CI in regards to mutual aid and coordination of efforts, etc. These issues may, in fact, be a major source of stress for the personnel involved. This aspect of CISDs certainly is more art than science and requires adroit coordination when dealing with major CIs.

CONCLUSIONS

The evolution and refinement of the CISD comes with experience, and after one has conducted the hundredth or so, one finally begins to fully appreciate what the work is about. That is not to say we ought to prohibit ourselves from taking the responsibility of leading a CISD if we possess solid clinical skills and an authentic caring for others. In addition, it is important to learn from each other. In that regard, conducting CISDs requires networking with health professionals who have had this unique and specialized training and/or experience. If you become aware of a CI in your jurisdiction or community, contact the appropriate agency and offer your help. Perhaps you will be fortunate enough to care for others and learn valuable clinical lessons.

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THE EFFECTIVENESS OF BRIEF PSYCHOLOGICAL INTERVENTIONS IN POLICE OFFICERS AFTER CRITICAL INCIDENTS

Nancy Bohl, Ph.D.

ABSTRACT

The long-term effectiveness of brief psychological interventions in police officers who have been involved in critical incidents was assessed. Three months after the critical incident, two groups that were similar with respect to age, number of years worked, and number of prior incidents were compared: Officers who had been treated within 24 hours after the incident and officers who had not been treated at all. On formal, written tests, the treated group was significantly less depressed ($p < .001$) and angry ($p < .02$) than the untreated group; also the treated group reported significantly fewer stress-related symptoms ($p < .001$) than the untreated group. The two groups did not differ significantly on a measure of anxiety. Overall, the data provided evidence for the effectiveness of brief interventions in police officers. It is suggested that treatment programs be mandatory for all officers involved in critical incidents.

INTRODUCTION

A major hazard involved in being a police officer is the possibility of being involved in traumatic or critical incidents, incidents in which human lives are lost and/or serious injuries are witnessed. Involvement in such episodes is highly stressful (Stratton, 1984). It is not simply that stress symptoms occur but that they may appear with a long time delay. Specific symptoms include guilt, anxiety, depression, sleep disturbances, flashbacks, and excessive anger (Blak, 1986; Nielson, 1986; Reiser & Geiger, 1984; Stratton, 1984).

The effects of these stress symptoms can be devastating, both at a personal and a professional level (Blak, 1986). Therefore, there is considerable interest (Mitchell, 1986b) in finding ways to prevent, or, at the very least, alleviate the symptoms. A promising approach that has been adopted by some police departments is to have individuals who were involved in a critical incident be seen by a psychologist some time during the first 48 hours after the incident. Psychologists call these treatments "brief interventions" because, typically, the individual is seen only once and for a relatively short period of time (1 to 2 hours).

Although the approach may vary somewhat from program to program, brief interventions share certain characteristics. First, the individual is encouraged to ventilate the strong feelings aroused by the incident. Second, he or she is reassured about the normality of the strong feelings aroused by the incident. Third, the person is warned that some symptoms will have a delayed occurrence. Fourth, an attempt is made to help the individual to assimilate the experience and to see it in context (Mitchell, 1986a).

The important point to note about brief intervention programs is that they are all relatively new. Most have been in use for five years or less. While there is much enthusiasm about their potential usefulness, there is little in the way of real data to show that brief interventions actually work. There have been several published reports (Mantell, 1986; McMains, 1986a; Somodevilla, 1986) in which success was claimed for some particular program. Unfortunately, all of these reports are preliminary only. They cannot be regarded as definitive. One reason is that these are reports that contain no actual test data. Success has been claimed on the basis of an apparent reduction in the incidence of stress-related problems (e.g., quitting after a traumatic incident). Another and even more important reason is that statistical comparisons have not been made between a treated group and an untreated control group. In the absence of such comparisons, it is not

clear that the reported changes would not have occurred anyway. Thus, the issue of how helpful these brief intervention programs are has not been adequately addressed.

The study reported here was designed to yield more definitive information. A brief intervention, 1–1/2 hours in length, was given within 24 hours after a critical incident to one group of police officers but not to another group. To determine whether the intervention was successful in reducing the severity of symptoms, formal tests were administered to both groups. The specific variables assessed were anger, anxiety, depression, and stress symptoms. Because, as already noted, the appearance of symptoms may be delayed by several months, the decision was made to evaluate the long–term effects of the treatment by testing both groups of participants three months after the critical incident.

METHOD

Participants

Participants were 71 male police officers between the ages of 21 and 49 years, drawn from the Inland Empire area of southern California. All participants had been involved in a critical incident three months previously. Specifically, the participant met one of the following criteria (from Mitchell, 1986b; Stratton, 1984): He had been wounded; had killed or wounded a suspect; had seen another police officer injured or killed; had been at the scene of a fatal car crash or other disaster; had narrowly escaped death; had accidentally shot another individual; had seen a child injured, killed, or abused; had witnessed violence; had been unable to rescue a victim who had died. All of the potential participants who were contacted by the investigator agreed to take part in the study.

The treated group had 40 participants, and the untreated group had 31 participants. Individuals in the treated group came from departments that have a mandatory program for psychological interventions after participation in a critical incident. Untreated or control participants came from departments that did not, at the time of the study, have such programs, but there was considerable evidence that the two kinds of departments were essentially similar.

First, they were geographically close. Second, they were similar with respect to size and the socioeconomic level of the populace served. Third, both kinds of departments shared a common philosophy with respect to the kinds of characteristics they felt members of their departments should have. That commonality was shown by the fact that all potential recruits in these departments took the same series of psychological tests and these tests were then evaluated by the same psychologist. Fourth, and most important, the departments which, at the outset of the study, did not have mandatory intervention programs now have them. Thus, there were no fundamental differences between the two kinds of departments. The only difference was the speed with which they implemented changes in departmental policy.

Test Instruments

There were three formal test instruments and a questionnaire devised by the author. All three of the formal tests are known to be reliable and valid. On all of these tests, the higher the score the greater the degree (respectively) of anxiety, depression, and anger.

The State–Trait Anxiety Inventory (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983) was used to assess anxiety. The respondent answers each item on a four–point scale, by indicating the extent to which each item is descriptive (e.g., I feel calm). The first 20 items assess state anxiety (how the individual feels at the moment), in contrast to trait anxiety (how the individual habitually feels). Only the 20 items that assess state anxiety were used.

The Beck Depression Inventory (Beck, 1967) was used to assess depression. The respondent is presented with 21 sets of items. Each set contains four similarly worded statements. The task is to choose the one statement from the set that best describes how the individual feels at the time.

The Novaco Provocation Inventory (Novaco, 1975) was used to assess anger. The test contains 80 items and is designed to provide information about both the range of situations that evoke anger and the intensity of the anger experienced.

In addition to the three formal test instruments just described, a questionnaire designed by the author was administered. It had two purposes. One was to provide information about demographic variables (e.g., age) and participation in prior critical incidents. The second purpose was to provide information about the frequency of occurrence, during the preceding week, of six common stress symptoms that have been reported by other authors but for which there seemed to be no formal test instrument. These symptoms were: nightmares, flashbacks, difficulty falling asleep, difficulty staying asleep, loss of appetite, and excessive hunger. Respondents indicated whether, during the preceding week, they had experienced the symptom often (scored 2), occasionally (scored 1), or never (scored 0). A total score was obtained; the higher the score, the greater the severity of stress symptoms.

Procedures

Testing. Once an individual had been identified as a potential participant, whether in the treated or untreated group, his record was monitored. Anyone who was involved in a second critical incident was secluded from the study. All participants, then, were tested once only, when they were three months past a critical incident. Testing was done individually, at the investigator's office, by an individual who had not been involved in the treatment.

Treatment. Treated participants received a 1 1/2-hour group therapeutic intervention within 24 hours of the critical incident. The format of the intervention was modeled after that used by Mitchell (1983). In brief, there were six phases. Participants described what they had actually done, expressed the feelings experienced at the time of the incident, and talked about the symptoms they were experiencing. The therapist then explained what reactions typically are experienced after a traumatic episode and assured participants that such phenomena as anger, guilt, and nightmares are normal. Participants also were asked to relate the present episode to past experiences. At the end, the therapist summed up what had been expressed during the session.

RESULTS

Table 1 shows the means, standard deviations, and results of the statistical comparisons for anxiety, depression, anger, and stress symptoms. Three of the four comparisons between the treated and untreated groups were significant ($p < .02$ or better). The differences obtained were in the expected direction. By comparison with the untreated control group, the treated group was significantly less angry and depressed and had fewer and less severe stress symptoms. The two groups did not differ significantly on the measure of anxiety.

Table 2 shows the means, standard deviations, and results of the statistical comparisons for four demographic variables: age, education, years worked, and number of prior critical incidents. Only one significant difference was found. The treated group had significantly more years of education ($p < .01$) than the untreated group. However, the two groups did not differ significantly with respect to age, the number of years worked, and the number of prior critical incidents. A chi square analysis for marital status (not shown in the table) showed that the two groups did not differ with respect to that demographic variable either [chi square ($1, N = 71$) = 0.70, $p > .05$]. The average participant was 30 years old, had gone to college for one to two years, had been in the police department for five to six years, was married, and had been involved in five prior incidents.

DISCUSSION

Although the treatment did not decrease anxiety, it did decrease depression, anger, and such stress-related symptoms as nightmares, flashbacks, and appetite changes. Overall, then, the treatment seemed to be successful in reducing the distress caused by involvement in critical incidents.

The results showed that even a single session, 1 1/2 hours in length, can be effective in reducing the symptoms seen three months after a critical incident. The fact that treatment was administered within 24 hours after the incident may have compensated for the brevity of the treatment. Because so little time had elapsed, participants had not had much opportunity to repress and to deny the powerful emotions evoked by the experience (Stratton, 1984).

The importance of the present results is that empirical support was provided for the widespread belief (Blak, 1986; McMains, 1986b; Somodevilla, 1986; Trapasso, 1981) that brief interventions should be used routinely with police officers who have been involved in traumatic incidents. Prior to the time that the present study was undertaken, there was much enthusiasm for such programs, but no empirical evidence had been provided to show that such interventions actually work.

There are two possible weaknesses in the data that deserve discussion. The first is the fact that participants were not assigned randomly to the treated and untreated groups. Lack of random assignment means that any differences found between the two groups might have been due to the fact that the groups were different to begin with and not to the effects of the intervention. The reason why random assignment was not done was that it was not possible. The investigator complied with the regulations imposed by the participating departments. Treated and untreated participants, of necessity, came from different departments. There is reason, however, to argue that the differences reported here between treated and untreated participants on the four psychological variables were not due to preexisting differences between the groups.

One possible preexisting difference was participation in prior critical incidents. However, treated and untreated participants did not differ significantly on this variable. Other possible preexisting differences were demographic. However, treated and untreated participants did not differ in age, marital status, or number of years on the job. The groups did differ with respect to number of years of education. However, although statistically significant, the size of the difference was small. It seems unlikely to be the cause of differences between the two groups on such psychological variables as depression, anger, and stress symptoms.

A further possibility was that the departments that had treatment programs differed in some substantive way from the departments that did not have such programs. As noted earlier, however, the philosophies and hiring practices were similar, and departments that, at the outset of the study, did not have mandatory intervention programs now have them. The conclusion, then, is that, although the possibility of preexisting differences cannot be ruled out entirely, it seems unlikely that preexisting differences between treated and untreated participants account for the results.

In addition to nonrandom assignment to groups, there is a second potential weakness in the data, which is the use of a posttreatment only design. An ideal experiment would have involved testing the same police officers twice. Both groups would have been tested right after the critical incident, before the intervention was administered to the treated group. Then, both groups would have been tested three months later. With the pretreatment test as a baseline, it would have been possible to determine the degree to which psychological adjustment had changed in both groups at the three-month point. However, this experimentally ideal design could not be carried out. Although individual reactions vary, it is not uncommon for a police officer who is seen within 24 hours of a critical incident to be in a numbing and denial stage (Blak, 1986). Anxiety, anger, and depression may not show up until several days later. Consequently, a pretest that was carried out just before the intervention would not have been useful as a baseline measure, against which to assess the effects of the intervention three months later.

A further consideration was that a pretreatment–posttreatment design would not have been in conformity with ethical principles. Clinicians who have worked with police officers involved in critical incidents stress their vulnerability and the need to treat them with compassion (Reiser & Geiger, 1984; Trapasso, 1981). It seemed clear that the investigator could not ask individuals who had so recently been involved in a traumatic incident to spend close to one hour taking paper and pencil tests before the therapeutic intervention.

The conclusion would seem to be that, in spite of the necessity to depart somewhat from an ideal design, the present study successfully demonstrated the utility of brief interventions to prevent the occurrence of delayed symptoms of stress in police officers who have been involved in critical incidents. It is recommended that intervention programs be mandatory. Police officers often are uneasy about seeking help on their own. They view such attempts as reflections on their adequacy and manliness (Carson, 1982; Lippert & Ferrara, 1981; Stillman, 1986). A mandatory program would mean that the decision–making process was taken out of the individual's hands. (Mitchell, 1983).

Table 1

Means, Standard Deviations, and Statistical Comparisons
on Measures of Anxiety, Depression, Anger, and Stress Symptoms

	Treated		Untreated		
Variable	Mean	SD	Mean	SD	t
Anxiety	38.05	10.27	40.45	10.35	0.96
Depression	3.18	3.48	8.10	6.27	4.18*
Anger	206.33	43.32	229.61	31.48	2.42**
Stress Symptoms	2.48	2.29	6.19	2.26	6.77*

* $p < .01$
** $p < .02$

Table 2

Means, Standard Deviations, and Statistical Comparisons
on Demographic Variables

	Treated		Untreated		
Variable	Mean	SD	Mean	SD	t
Years of Education	14.02	1.86	13.39	1.56	3.64*
Age	30.85	5.70	30.42	7.40	0.26
Years Worked	5.83	4.00	5.55	4.11	0.09
Number of Prior Critical Incidents	4.43	5.18	5.81	4.66	1.19

* $p < .01$

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TWELVE THEMES AND SPIRITUAL STEPS: A RECOVERY PROGRAM FOR SURVIVORS OF TRAUMATIC EXPERIENCES

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ABSTRACT

Trauma is widespread in America, causing fragmenting and repetitive aftereffects that have an increasingly destructive effect on individuals, families, and society. The repetitive self-destructive symptoms and behaviors may appear to resemble chronic addictions (van der Kolk, 1987). Historically, individuals with unique disorders and addictions often banded together in self-help groups, the most common of which have been the 12-step recovery programs. Although these programs help participants in many ways, their major emphasis is on surrendering to a Higher Power or God (as individually understood). The author first developed a 12-step program to help Vietnam veterans and later broadened this program to help victims and survivors of a variety of traumatic experiences.

Psalm 55:9: "Destroy, O Lord and divide their tongues, for I have seen violence and strife in the city. Day and night they go around it on its walls; Iniquity and trouble are also in the midst of it. Destruction is in its midst; Oppression and deceit do not depart from its streets. . . "

TRAUMA IN AMERICAN SOCIETY

Trauma has become too commonplace in America. Violent street crime permeates large cities. Intergang warfare and wanton shootings invade many ghettos. Robberies, assaults, and rapes (Roth & Lebowitz, 1988) occur frequently, hanging like a gray cloud hovering over the vulnerable who venture alone into side streets, parking lots, and parks (USA Today, 1989). The rising rate of alcohol and drug addiction breeds destruction and self-destruction. And now there is a frightening increase in the use and abuse of cocaine and associated crime, gang warfare, and hired assassinations.

Trauma can also be found within homes, where wives and children have been battered, assaulted, and sexually violated (Ochberg, 1988), and where children have run away (McCormack, Burgess & Hartman, 1988). There is pornography, both soft- and hard-core, and television violence, all of which reflect and breed societal dehumanization and violence. There are satanic cults whose members violently and ritualistically sacrifice the lives of unsuspecting victims (USA Today, 1989). Subviolent trauma is present in every part of American society where individuals complain of feeling dehumanized, alienated, deprived of justice, victimized (Young, 1988), and without purpose.

POSTTRAUMATIC CONSEQUENCES WITHIN AMERICAN SOCIETY

Psalm 55:4: "My heart is severely pained within me, and the terrors of death have fallen upon me. Fearfulness and trembling have come upon me, and horror has overwhelmed me. So I said, 'Oh that I had wings like a dove! I would fly away and be at rest. Indeed, I would wander far off and remain in the wilderness. I would hasten my escape from the windy storm and tempest.'"

There are consequences to this epidemic of trauma: dehumanization and violence affecting individual victims, families of victims, American society, and the law enforcers called on to respond to the escalation of trauma.

Individual Victims

Victims of severe stress or trauma suffer symptoms of posttraumatic stress disorder, which include nightmares; reenactments; and intrusive memories with associated feelings of fear, guilt, and grief. When they are not feeling "out of control" from those symptoms, they feel "overcontrolled" by amnesia, denial, emotional numbing, and detachment, plus other overcontrol symptoms (Horowitz, 1976; APA, 1987).

Not described in the diagnostic manual is the frequent observation that severe trauma often causes dissociative symptoms (Brende, 1986; van der Kolk, 1987) and fragmentation. Fragmented personality disorders are an unfortunate consequence of the betrayal and shame associated with severe and protracted trauma, often found in sexually abused children, rape victims, incest victims (Roth & Lebowitz, 1988; Herman, 1988), and Vietnam veterans (Brende, 1983, 1986). The fragmentation to self-identity includes dissociation (Brende, 1986; Speigel, 1988) and in extreme cases, multiple personality disorder (Braun, 1984; van der Kolk & Kadish (1987).

Neglected in the posttraumatic literature are descriptions about spiritual alienation in survivors, particularly those who suffer guilt and shame, although described in Vietnam veterans (Lifton, 1973; Mahedy, 1986; Williams, 1988; Brende & McDonald, 1988, 1989).

Families and Society as Victims

There are other less obvious but destructive consequences--the epidemic of deaths from accidents and suicides among our children, adolescents, and young adults; the homeless living in city streets, addicts, repeat offenders, prostitutes, and hardened criminal. Those who have been victimized often perpetuate their posttraumatic symptoms in the form of abusive behavior, broken relationships, addiction, repeated arrests, incarcerations, institutionalizations, and chronic medical problems. As victimization continues, the individual consequences mushroom and the effects on families and society are far-reaching (Ochberg, 1988; Hartman & Burgess, 1988; Stark & Flitcraft, 1988).

The apathy, and even antipathy, of Americans toward victims perpetuates the problem. Victims in this country are blamed and misunderstood, often becoming outcasts from families and society (Hartman & Burgess, 1988; Stark & Flitcraft, 1988). Thousands of Vietnam veterans describe feelings of alienation (Brende & McDonald, 1989) and often seek isolated places to live (Brende & Parsons, 1985). Unfortunately, independent Americans who deny weakness and vulnerability maintain an attitude of denial and emotional detachment about the conditions of the victimized in society.

There are many other examples of cultural detachment and apathy. Americans frequently deny the destructiveness of violent television and pornography. They tend to not believe that easy access to weapons feeds violence. Americans are emotionally detached from the traumatic effects on those who are arrested, jailed, or imprisoned. Most Americans idealistically believe their country will live on forever in spite of the self-destructive lack of attention to pollution of water, air, countryside, and city. They don't want to believe that it is vulnerable to self-destruction or even to destruction, including the threat of terrorists infiltrating, and exploding conventional and nuclear devices.

The increasing self-destruction, alienation, and fragmentation caused by repetitive traumatic events within American society seems to be spiraling out of control. The mental health system cannot keep up with the demand to treat trauma victims and never will. Furthermore, traditional therapy is often inadequate. The government, the legal system, and law enforcement officials are asked to respond to the growing manifestations

of this national disorder, but are also vulnerable to victimization by increasing demands and by repeated exposure of law enforcement officers to violence, frightening close calls with death, survivor guilt, and grief from the deaths of fellow officers and American citizens they are expected to protect.

POSTTRAUMATIC RECOVERY IN A TRAUMATIZED SOCIETY

Psalm 55:1–8: "Give ear to my prayer, oh God, and do not hide yourself from my supplication. Attend to me, and hear me; I am restless in my complaint, and moan noisily, because of the voice of the enemy. Because of the oppression of the wicked; for they bring down trouble upon me, and in wrath they hate me."

Much has been written during the past decade about the treatment of survivors suffering posttraumatic symptoms from a variety of traumas (Horowitz, 1976; Figley, 1978, 1985; Brende & Parson, 1985; van der Kolk, 1987; Ochberg, 1988; Wilson, 1989), but little has been written about the demoralizing effect that traumatic experiences can have on self–esteem, spiritual and emotional integrity, or sense of purpose (Mahedy, 1986; Brende & McDonald, 1989).

Survivors in healthy support systems recover from their traumatic experiences when they receive support, protection, and the empathic understanding of friends, family, church, God, and society. Victims who receive support are better able to find commonly used recovery methods such as nutrition, exercise, and humor (Merwin & Smith–Kurtz, 1988). They may also, with help, find it possible to reflect on and recall the trauma in order to experience self–healing and a restoration of repressed emotion (Krystal, 1988). For those who seek psychotherapy, there can be excellent results (Danieli, 1988; Horowitz, 1982; Lindy, 1988; Ochberg, 1988; Parson, 1988).

But there are thousands, perhaps millions, of victims who have withdrawn––either directly or indirectly––as their only way to cope with feelings of anger, fear, guilt, and grief. They do it in many ways––by living in the mountains, woods, or isolated wastelands like thousands of Vietnam veterans have done (Figley & Leventman, 1980). There are others, finding no ways to break through emotional and spiritual alienation, who have learned to cope with their symptoms through isolation. They live in the impersonal trenches of the big cities––they become the homeless, the incarcerated, and the institutionalized.

There are other thousands who find isolation in much less blatant ways by escaping into wealth, power, quasi–military groups, and a variety of impersonal organizations. They may find no purpose other than the "thrill of the adrenalin" that keeps them going, although they remain emotionally and spiritually alienated.

RECOVERY USING RELIGIOUS AND SPIRITUAL MODALITIES

II Corinthians 1:4–11: "He comforts us in all our affliction so that we may be able to comfort those who are in any affliction with the comfort with which we ourselves are comforted by God."

Healing has frequently been a central focus of religion in various cultures. Historically, societies have used religious rituals to help their traumatized citizenry. For ages, cultures recognized that their warriors needed to have the opportunity for emotional and spiritual "cleansing" before being reintegrated into society, something not provided America's Vietnam veterans (Figley & Leventman, 1980; Brende & Parson, 1985). Native Americans traditionally use the ritual of the Sweat Lodge Ceremony, where survivors of traumatic events meet together in the present of a tribal medicine man for an emotional and spiritual cleansing experience (Wilson, 1988). Traditionally, Americans have helped survivors of traumatic experiences within closely knit families, groups, and churches rather than expect professional mental health services. Church congregations provide support for the bereaved. Groups of people working together will usually find ways to provide mutual support. When law enforcement officers lose one of their "brothers," they turn out as a group for the funeral, help the surviving family, and contribute in concrete ways to cope with the loss. These ways

alone may not always be adequate, however, to help survivors resolve the emotional upheaval they continue to feel for some time.

SURRENDER AS A CONCEPT FOR SPIRITUAL AND EMOTIONAL RECOVERY

Psalm 86:1–3: "Bow down thine ear, O Lord, hear me; for I am poor and need. Preserve my soul . . . Be merciful unto me, O Lord: for I cry unto thee daily." **131:1**: "My heart is not haughty, nor mine eyes lofty."

Recovery from posttraumatic guilt, shame, demoralization, and spiritual alienation is neglected in traditional treatment, which focuses on resolving primary symptoms of intrusive recollections, emotions, and denial/numbing (Horowitz, 1976, 1982). For those survivors with prolonged guilt and shame associated with protracted and repetitive posttraumatic symptoms and personality disorders, recovery cannot proceed without resolution of guilt and shame. Spiritual recovery approaches are best able to help such individuals. These approaches usually emphasize belief and surrender to God and acceptance of forgiveness.

The principle of surrender is a major teaching within most religions of the world. Muhammad, in 610 A.D., preached a message of submission and surrender to the will of God (Allah) and founded Islam, one of the three major religions of the world believing in a single God (Juri, 1946). Within the eastern religions there is a belief in accepting life as it comes, including traumatic events. Buddhists teach that catastrophe and suffering are a normal part of existence, meant to be accepted and dealt with as gracefully as possible and try to find meaning in them (Lee & Lu, 1989). Christians hold to a similar belief in the importance of surrender to the will of God; for example, the total submission unto death by crucifixion by Jesus Christ. Other examples described in the New Testament include a willingness by followers of Jesus to surrender to the will of God in the face of arrests, stoning, imprisonment, and death.

SURRENDER AND TWELVE–STEP PROGRAMS

Alcoholics and addicts recovering through the use of Alcoholics Anonymous (AA) principles, learn to "surrender" their addiction and egocentric attitudes to a Higher Power. This has been called "letting go and letting God" (Keller, 1985).

Surrender is a core concept in 12–step recovery programs and comes out of the AA tradition. This concept was found to be effective by recovering alcoholics who failed to stop drinking through traditional treatments. But when they "let go and let God"; that is, when they ceased their futile efforts at breaking their self–destructive addiction patterns and turned themselves and their addictions over to God, the self–destructive patterns finally ceased.

AA and similar 12–step programs have helped hundred of thousands of individuals from a variety of self–destructive patterns and addictions: Alcohol, drugs, cigarettes, food, gambling, sex, etc.
The most important healing aspect of the 12–step AA program has been described as the recognition of a Higher Power and willingness to "surrender" to that Power, or God, as individually understood, as a way of changing self–destructive, destructive, and self–centered behaviors and gaining power in one's life. This is described in the "Big Book" (Alcoholic Anonymous, 1976) as follows:

> . . . Driven by a hundred forms of fear, self–delusion, self–seeking and self–pity, we step on the toes of our fellows and they retaliate. Sometimes they hurt us, seemingly without provocation, but we invariably find that at some time in the past, we have made decisions based on self which later placed us in a position to be hurt. . .
>
> Above everything, we . . . must be rid of this selfishness. We must, or it kills us. God makes that possible. And there often seems no way of entirely getting rid of self

without His aid. Many of us had moral and philosophical convictions galore, but we could not live up to them even though we would have liked to. Neither could we reduce our self-centeredness much by wishing or trying on our own power. We had to have God's help.

. . . Next, we decided that hereafter in this drama of life, God was going to be our Director. He is the Principal; we are His agents. He is the Father, and we are His children. Most good ideas are simple, and this concept was the keystone of the new and triumphant arch through which we passed to freedom . . .

He provided what we needed, if we kept close to Him and performed His work well. Established on such a footing we became less and less interested in ourselves, our little plans and designs. More and more we became interested in seeing what we contribute to life. As we felt new power flow in, as we enjoyed peace of mind, as we discovered we could face life successfully, as we became conscious of His presence, we began to lose our fear of today, tomorrow or the hereafter. We were reborn. (pp. 62-63)

TWELVE THEMES AND SPIRITUAL STEPS FOR TRAUMA VICTIMS

In 1985, the author, with help from Bay Pines, Florida, VA hospital chaplain, patients, and key staff personnel, drew from the 12-step recovery program concepts to develop a 12-week program for trauma victims--particularly Vietnam veterans with severe and recurring symptoms of Posttraumatic Stress Disorder. The themes defined were as follows:

1. Power vs. Victimization
2. Seeking Meaning in Survival
3. Trust vs. Shame and Doubt
4. Self-Inventory
5. Understanding Anger and Rage
6. Understanding Fear
7. Guilt
8. Grief
9. Suicide vs. Commitment to Life
10. Revenge vs. Forgiveness
11. Finding a Purpose
12. Love and Meaningful Relationships

This psychoeducational program consisted of a didactic, educational, and discussion "Theme Group" held three times a week that became a focus for the treatment program. Each week, the theme changed in a step-wise progression so that by the end of 12 weeks, each Vietnam veteran patient was exposed to the entire sequence.

Eventually, many of the veterans, particularly the recovering addicts involved in Alcoholics Anonymous, became interested in forming a volunteer 12-step group patterned in some respects after the 12-step AA program (Sorenson, 1986). The author found that the veterans who benefitted from this program accepted the concept of surrendering their self-destructive and self-centered life styles to God, as they individually understood Him, and sought His help to gain freedom from the bondage of victimization.

Combat veterans found these steps very helpful because they helped them break through the "addictive" nature of their posttraumatic symptoms and destructive life styles described in victims of other kinds of trauma as well (van der Kolk, 1987). Since survivors of other kinds of trauma besides combat found this program helpful, after leaving the VA system, the author developed a similar program for survivors of a variety of traumatic experiences, using principles similar to other 12-step programs:

1. Believing in a Higher Power, or God, as individually understood
2. An attitude of surrender, appropriate for each of the 12 steps.
3. Recovering is an ongoing and sometimes life-long process.
4. Leadership is to be provided by trained leaders initially and later by rotating leadership within membership of self-help groups.

5. Education about posttraumatic symptoms is important.
6. Group sharing and helping one another during and between group meetings is important.
7. Regular attendance is important.

The 12-step program, called TRAUMA SURVIVORS ANONYMOUS, includes the following five mini-steps:

1. Acknowledging symptoms
2. Seeking help
3. Surrendering to God, as individually understood
4. Taking action
5. Daily prayer and meditation

TWELVE THEMES AND SPIRITUAL STEPS: AN OUTLINE FOR SURVIVORS OF TRAUMATIC EVENTS

Use this outline as a guide to help your own recovery program. All of the steps are important, but certain ones will apply more specifically than others. If you are a group participant or a group leader, focus on any of the 12 steps or proceed through the steps in sequential order as your group meets.

If you have been in other anonymous 12-step programs, these steps are meant to supplement those programs and not replace them. If you are receiving spiritual help, psychotherapy, or counseling, please use the steps as an adjunct to that process.

As you take each of the 12 steps, practice breaking the victimization cycle each time, as follows: (1) acknowledge the symptom, (2) seek help, (3) surrender the problem to God, (4) take action, and (5) pray each day.

Step One: Power vs Victimization

> "We admitted we were powerless over victimization and sought the help of a 'good higher power' (God, as individually understood) to gain power in our lives."

This step focuses on understanding and finding ways to gain power over victimization from our posttraumatic symptoms--meaninglessness, self-doubt and shame, uncontrollable angry outbursts, recurring memories and dreams, frightening dreams, night terrors, panic, violent and suicidal thoughts, and isolation from people; or gaining power over experiences of victimization from individuals, groups, or organizations that have misused or abused their power.

As victims, we recognize that the ways we have attempted to protect or defend ourselves from victimization have often been ineffective or self-destructive, and include isolation, emotional numbing, avoidance, aggressive retaliation, or abuse of others. Unfortunately, these ways merely perpetuate a cycle of victimization.

We can begin to break our self-destructive victimization cycle in the following ways:

ACKNOWLEDGE: That we are powerless to control many or all of our posttraumatic symptoms, protect or defend ourselves adequately from abusive or destructive forces that attempt to control our lives, or control our own destructive use of power.

SEEK: Help from a Good Higher Power--individuals, organizations, and God, as individually understood.

SURRENDER: Our symptoms and destructive uses of power--to God, as individually understood.

TAKE ACTION: As for help from individuals, organizations, and God to intervene in our destructive behaviors and regain power in our lives.

DAILY PRAYER: "God, help me to accept that I have little or no power over symptoms of victimization and destructive behaviors. Help me to recognize which of these I can begin to change. Grant me the wisdom to know the difference."

Step Two: Seeking Meaning

"Came to believe that a power greater than ourselves could help us find meaning."

This step is focused on beginning to seek meaning after a traumatic experience or after the lives of others have been taken. It is very difficult to imagine that meaning can be found, but to begin the search means sharing our experiences with others, accepting their support and understanding, and listening to those who may have found meaning in their own traumatic experiences.

We can begin to seek meaning in the following ways:

ACKNOWLEDGE: That it is difficult, if not impossible, to accept what has happened to us and to find meaning in still being alive, particularly if others were injured or lost their lives.

SEEK: Support, understanding, and direction from God and others in order to help us begin to find meaning.

SURRENDER: Despair, confusion, and meaninglessness--to God, as individually understood.

TAKE ACTION: Seek answers from God, friends, counselors; listen to the stories of other survivors who have survived in spite of their emotional pain and have found meaning.

DAILY PRAYER: "God, help me to seek for meaning out of tragedy; to seek for understanding why I am alive even though others' lives may have been lost. Grant me the courage to seek clarity rather than remain a prisoner of confusion, despair, and self-pity."

Step Three: Trust vs Shame and Doubt

"Burdened with distrust, shame, and doubt, we made a decision to seek the help of God, as we understood Him, in order to learn to trust."

This step focuses on helping us regain our capacity to trust others, organizations, those in authority, those who want to help us, God, and ourselves.

As victims, we may have lost our capacity to trust, even to trust those who have wanted to help us. We may have been abandoned or betrayed by those who should have protected us. And we may have trusted out of blind faith. We may continue to seek someone we can trust, even if we were repeatedly abused or misused in the past. And we may not trust anyone but ourselves, and eventually may have found that we cannot even do that.

We can begin to break the cycle of shame, doubt, and distrust in the following ways:

ACKNOWLEDGE: That we continue to experience shame, doubt, and distrust in ourselves and others.

SEEK: To gradually discover we can truly trust God and others who want to help us resolve shame, doubt, and distrust.

SURRENDER: Our shame, doubt, and distrust--to God.

TAKE ACTION: Put trust to the test--in God, friends, and counselors.

DAILY PRAYER: "God, grant me an understanding of the shame and doubt that lies behind my false pride. Teach me how to trust. Grant me the courage to take the risks necessary to trust, gain freedom from shame, and overcome self-doubt."

Step Four: Self-Inventory

> "Admitted to ourselves, another human being, and to God, our faults, and sought His help to accept our positive traits and change our negative ones."

As survivors, we may have thought of ourselves as worthwhile only if we could master frightening situations, save others, or defeat our enemies. As victims of traumatic experiences, we may repeat victimization patterns and not know why. We may attract abusers or victimizing circumstances and not know why. We may suffer repeated victimization or self-destructive experiences as a means of self-punishment because of hidden traumatic secrets we would be ashamed to reveal to ourselves or others.

A personal inventory can help us discover the truth about ourselves--about hidden destructive or self-destructive life styles or ways in which we may hurt others or destroy relationships. If we are open to listening, a group feedback session can provide us with more truth about ourselves, enhance trust and self-esteem, and help us more easily accept our good qualities and change those that are negative.

We can begin a self-inventory in the following ways:

ACKNOWLEDGE: That we often do not accept our positive qualities and find it difficult to change negative ones; that we are sometimes guilty of doing self-destructive things, hurting others, breaking relationships, punishing ourselves, and keeping shameful secrets.

SEEK: To be free from self-destructive or destructive behaviors, shameful secrets, and self-condemning attitudes; to be open-minded to positive and constructive criticism.

SURRENDER: Our self-destructive and destructive behaviors, our shameful secrets, our resistances to receiving help and constructive criticism from others.

TAKE ACTION: Be open to change and ask for feedback from God, friends, and counselors, in order that we can learn more about ourselves. Then accept what is positive and begin to change what is negative.

DAILY PRAYER: "God, help me to accept my positive qualities, change those that continue to hurt myself or others, and make amends to those I have harmed, when possible. Grant me the courage to accept the truth--both positive and negative--about myself in order that I can begin to grow toward a more accurate self-understanding.

Step Five: Anger

> "Sought God's help to understand anger, control its destructiveness, and channel it in constructive ways."

This step focuses on gaining understanding and relief from that destructive anger that automatically reacts in response to perceived threatening individuals or situations.

As victims, anger and even homicidal rage may have been a normal reaction for us at the time we were victimized. If we continue to be victimized, we will be chronically angry. Anger may be easier to feel than fear, guilt, or grief. In fact, anger may be a "cover-up" for all other feelings.

But our anger, if not blocked, may now be unmanageable, frightening, ineffective, destructive, and self-destructive--destroying property or hurting others. If it is blocked or suppressed, we may not be able to recognize it or express it normally; consequently, we will not be able to assert ourselves or channel it constructively.

We can begin to break the victimization cycle of anger in the following ways:

ACKNOWLEDGE: That we are powerless to recognize normal angry emotions, control angry outbursts, or express anger constructively.

SEEK: Help from God and others to control it or express it constructively.

SURRENDER: Our destructive and self-destructive anger and the blocks that keep us from perceiving it--to God.

TAKE ACTION: When anger is out of control, seek help from God, friends, and counselors. Reduce excessive anger within by exercising and participating in healthy activities. Seek help to recognize blocked anger. Begin to learn to express anger normally, constructively, and directly in a calm manner. Learn to be assertive.

DAILY PRAYER: "God help me to accept my anger as a normal emotion even though it may be blocked or may erupt in destructive and self-destructive ways. Help me to control it when it is unmanageable and be more aware of it when it is blocked from my awareness. Grant me the wisdom to know the difference between destructive and constructive anger."

Step Six: Fear

> "Sought God's help to relinquish 'the wall' around our emotions and His protective presence during moments of terror and risk."

This step focuses on helping us understand and cope with fear. Fear is normal, even life-saving. But the terror that we may experience at times--both day and night--can make it seem as if we are reliving our trauma again and again; and our fear of the unknown may paralyze us from normal functioning.

Fear may have been so overwhelming that we blocked it from awareness. If so, we may take risks to feel it again--in the form of an "adrenalin high" that can both excite us and provide us with an opportunity to control our fear and danger. But we may also be suffering from the consequences of suppressed fear, particularly if we have erected a "wall" around our emotions. That wall causes our isolation, distrust, emotional numbing, panic attacks, and risk-taking.

We can begin to break the fear victimization cycle as follows:

ACKNOWLEDGE: That fear is either excessively in control of our lives or completely blocked so that we take dangerous risks and keep a "wall" around our emotions.

SEEK: The help of God and others that we may be able to relinquish the "wall" around our emotions; to learn to depend on God and others during terrifying emotions, dreams, and memories; and to learn how to take risks in constructive ways.

TAKE ACTION: Seek help, begin to let down the "wall" and learn that fear can be normal again. Discover that depending on God and others is a healthy thing to do. Begin to take risks, but only in positive ways. Face frightening situations with the help of God and others.

DAILY PRAYER: "God, help me to accept the fact that fear is a normal emotion even though at times it controls my life. Help me to relinquish the "wall" around my emotions. Grant me the wisdom to know the difference between normal fear and risk-taking and abnormal fear and risk-taking."

Step Seven: Guilt

> "Sought God's help to face guilt, to make amends when possible, to accept His forgiveness, and to forgive ourselves."

In this theme, we will focus on understanding our guilt and to begin to find ways to gain relief from its destructive consequences. Survivor guilt can be pervasive and self-destructive, particularly if we rightly or wrongly believe we were responsible for the deaths or injuries of others. Guilt can be unbearable if we suffer from repetitive horrifying or guilt-ridden thoughts, dreams, and images; or from persistent depression, physical illness, and suicidal feelings.

On the other hand, we may have no conscious awareness of guilt. Yet its consequences can be destructive for us and for others if we engage in abusive or perverse behavior or teeter-totter between excessive guilt and a distorted or absent conscience. We may have been responsible for the deaths, suffering, or injuries to others--enemies, lawbreakers, or the innocent--but blocked our guilt feelings from awareness. We may have been abandoned or betrayed, feel ashamed because we were not in control of our lives, and continue to feel numb or overwhelmed with the guilt and shame. Excessive and unrelieved guilt will continue to reap its consequences, even when there is lack of conscious awareness of it, until we are free from its bondage.

We can begin to find freedom from the guilt victimization cycle as follows:

ACKNOWLEDGE: That guilt is abnormal when there is not logical reason for it; that it is normal if we were responsible for the suffering or deaths of others; that it is self-destructive if we continue to punish ourselves.

SEEK: Freedom from self-destructive or destructive behaviors, guilty secrets, self-condemning attitudes, self-destructive symptoms, and a distorted or absent conscience.

SURRENDER: Our self-destructive and destructive behaviors and our guilty secrets--to God.

TAKE ACTION: Ask for help from God, friends, and counselors to find relief from irrational guilt. Accept forgiveness from God; seek the forgiveness of others we have wronged, when appropriate; and forgive ourselves.

DAILY PRAYER: "God, forgive me for things I have done or failed to do, particularly if those things have led to the deaths or injury of others. Help me to regain my sensitivity and to make amends to those I have hurt, when possible. Grant me freedom from guilt, self-punishing symptoms, and destructive action that have kept me in bondage."

Step Eight: Grief

"Sought God's help to grieve those we have lost, face our painful memories and emotions, and let our tears heal our sorrows."

In this step we will focus on being able to complete the grief process.

Grieving is a normal response to loss, but often we may have failed to complete the grieving process and remain victims, not only of our losses but of our unresolved emotional pain. If so, we may suffer a variety of consequences--withdrawing from people, denying that the loss ever occurred, intellectualizing rather than feeling emotion, deciding not to depend on others any more, or keeping our relationships at an emotional distance.

On the other hand, we may not be able to control our emotions. We may have outbursts of tears, or anger, severe depression, intrusive emotions and memories that cloud thinking and block normal functioning, or obsessions about the object of our loss.

If we have not completed grieving, we remain victims of blocked emotions, unresolved anger, depression, and emotionally distant relationships.

We can begin to break the grief victimization cycle as follows:

ACKNOWLEDGE: That we may be emotionally blocked, unable to grieve losses, and fearful about establishing close relationships once again.

SEEK: To be free from blocked emotions, blocked relationships, isolation, and persistent unresolved grief.

SURRENDER: Our memories and painful emotions related to losses--to God.

TAKE ACTION: Say "goodbye" to those we have lost, let down the barrier, "feel" anger and sadness and allow the tears to flow. Take the necessary risks to establish closer relationships, with help from God, friends, and counselors.

DAILY PRAYER: "God help me to become aware of who and what I have lost, to grieve my losses, change those attitudes and behaviors that keep me from making close relationships, and grant me the wisdom to learn the difference between 'hanging on' from fear of isolation and abandonment and remembering out of reverence and love."

Step Nine: Life vs Death

"Revealed to God and someone we trusted all remaining self-destructive wishes, and, with His help, made a commitment to life."

This step focuses on helping us gain freedom from our self-destructive wishes and behavior; helping us face the hopelessness, guilt, or self-directed anger that blocks us from embracing life.

Fear, guilt, grief, and rage were once normal responses to surviving traumatic events. However, these emotions, as they persist, chronically lead to depression, apathy, suicidal thoughts, suicide, or death from indirect methods. If suicidal thoughts begin to provide a source of comfort, the risk of self-destruction is high now or in the future, particularly if we keep a "suicide plan" in the back of our minds.

How can we change this? It may not be easy; in fact, facing death may seem easier than facing life, particularly if we believe that we have a "just cause" that is worth dying for. Remember that if we were to succeed in taking our own lives, we will have made a final decision without a second chance. And those who survive us will live with the guilt and pain of our deaths for the rest of their lives. Is that the legacy we want to leave them?

Breaking the cycle of destructive, self-destructive, and suicidal anger can begin in the following ways:

ACKNOWLEDGE: That we are powerless to control our self-destructive and suicidal thoughts and feelings; that we may be contemplating suicide without full awareness of the pain that would remain for the survivors.

SEEK: Help from God, family, friends, and counselors to resolve self-destructive thoughts and feelings, ways to find life worth living, and courage to make a commitment to life.

SURRENDER: Self-destructive and suicidal thoughts, feelings, and plans--to God.

TAKE ACTION: Ask for help from God, friends, and counselors and talk about it with someone you trust. Replace your suicidal plans and death wishes with a commitment to life and find positive thoughts, activities, and relationships to focus on.

DAILY PRAYER: "God help me, to surrender my self-destructive and suicidal thoughts to you and to make a commitment to life. Grant me the wisdom to learn the difference between surrendering my life from motives of selflessness and love, and taking my life due to self-centeredness and hatred."

Step Ten: Justice vs Revenge

> "Sought God's help to pursue the cause of justice, gain freedom from revengeful wishes and plans, and a desire to be channels of God's forgiveness to those we once hated."

This step focuses on helping us gain freedom from our destructive wishes for revenge and face the hatred, bitterness, and relentless anger that victimizes us and blocks us from achieving true justice.

As victims, our homicidal rage has been a normal reaction to feeling victimized, betrayed, abandoned, or losing the health or lives of our friends or family. And it may seem impossible to forgive those who were responsible because hating is easier than living in peace and love, particularly if life has no other purpose beyond achieving "vengeance."

There is a difference between achieving justice and revenge. Justice is the basis for love, peace, and freedom--for ourselves and those we live with. Revenge, although bringing temporary relief, ultimately becomes a basis for repetitive hatred, destruction, and war. Revenge feeds upon itself and causes destructive consequences, further victimization, and bondage. If our hatred persists, we can bring our friends, families, and country into bondage with us. Revenge breeds only destructive consequences that can easily get out of control--an enormous price for ourselves, our friends, and our families to pay.

If we have violent thoughts, if those thoughts are buried within our minds, if we have a mental "blueprint" to kill someone, if our hatred has become dangerous to others and to ourselves--we need help.

Breaking the victimization cycle of bitterness, violence, and revenge can begin in the following ways:

ACKNOWLEDGE: That we are powerless to control our hatred, revengeful thoughts, and bitterness that only victimizes us, our friends, and our families; that bitterness and hatred may lie deep within us, and even though we aren't fully aware, it hurts us and our friends and families.

TAKE ACTION: Talk to others who can help us discover ourselves. Daily renew a commitment to seek God's purpose in our lives. Renew our spiritual strength through uplifting words, thoughts, readings, friends, and activities.

DAILY PRAYER: "God renew me as I surrender myself to You and seek Your purpose for my life today. Lead me on a creative and fulfilling path. Grant me the wisdom to know the difference between my seemingly fulfilling but self-centered way and Your way, a path not easily followed, of selflessness, justice, truth, and love."

Step Eleven: Finding a Purpose

> "Sought knowledge and direction from God and surrendered ourselves to his leadership in order to find a renewed purpose for our lives."

This step focuses on helping us find a purpose for our lives. As victims, our lives once seemed meaningless. But as we have progressed through the first ten steps, we have begun to discover freedom from the victimization of meaninglessness, distrust, shame, rage, terror, guilt, grief, suicidal desires, hatred, and isolation. This freedom, paradoxically, results from acknowledging, seeking, surrendering, and taking action to change old self-destructive "baggage" that we've carried with us for years.

Now that we have surrendered all of our baggage, there is nothing else to surrender but oursleves, the next step toward finding a purpose for our lives.

ACKNOWLEDGE: That we periodically slip back into the bondage of meaninglessness, victimization patterns, distrust, shame, rage, terror, guilt, grief, suicidal desires, hatred, and isolation; that when this happens, we find it difficult to believe there is a purpose for our lives.

SEEK: To "let go" of the baggage of posttraumatic symptoms and find a new sense of purpose; to find a new relationship to God.

SURRENDER: Not only our posttraumatic baggage but also ourselves--to God's leadership and purpose for us.

TAKE ACTION: Talk to others who can help us discover ourselves. Daily renew a commitment to seek God's purpose in our lives. Renew our spiritual strength through uplifting words, thoughts, readings, friends, and activities.

DAILY PRAYER: "God renew me as I surrender myself to You and seek Your purpose for my life today. Lead me on a creative and fulfilling path. Grant me the wisdom to know the difference between my seemingly fulfilling but self-centered way and Your way, a path not easily followed, of selflessness, justice, truth, and love."

Step Twelve: Love and Relationships

> "Sought God's love in our lives, renewed our commitment to friends and family, loved those we found difficult to love, and helped those who have been victims as we were."

This step focuses on helping us remain free from self-centeredness and tendencies to slip back into meaningless victimization experiences through learning to love and help others.

Having had a spiritual awakening as a result of these first 11 steps, we will find that it is important to practice these principles with others. But we may still have some blocks that prevent us from helping others

or accepting and giving love. Thus, it is important to remove any blocks preventing us from accepting the love of God, friends, and family.

To build a foundation of loving relationships, it is important to understand and open ourselves to God's love; to renew our commitment to those friends and family whose love we have taken for granted; and to renew the vitality of love and friendships that had died from neglect. With this foundation we can be open to building new friendships--practicing what it means to give and receive. With an attitude of love, we can then carry the recovery message to other survivors and victims who are mired in the bondage of their own unique victimization patterns.

We can begin to love by following these steps:

ACKNOWLEDGE: That it is often difficult for us to be open to accept the love of others, to accept God's love, to love those we had taken for granted in the past, or to love those who we have found difficult to love.

SEEK: Openness to receive God's love and the love of others in our lives; the capacity to commit ourselves to friends and family; and the willingness to be channels of God's love to those who are difficult to love.

SURRENDER: Ourselves to God's love so that it may flow into and through us.

TAKE ACTION: Commit ourselves to learning how to receive God's love and the love of others. Commit ourselves to our friends and family members. Daily seek to be channels of God's love to those we find difficult to love. And help those who are suffering from victimization in their lives.

DAILY PRAYER: "God renew Your love in me as I surrender myself to You today. Help me to commit myself to those whose love I have taken for granted and who depend on me. Grant me the wisdom to love those I have not been able to love and to know the difference between my self-centered attempts to 'love' and the selfless love that can flow from You to others."

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U.S. SECRET SERVICE CRITICAL INCIDENT PEER SUPPORT TEAM

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ABSTRACT

The U.S. Secret Service, the oldest (investigative) federal law enforcement agency in existence, has recently recognized the importance of critical incident/postshooting trauma and its effect on Service personnel. Per a mandate by the Honorable John R. Simpson, Director, U.S. Secret Service, a Critical Incident Peer Support Team was established in February 1988. Team representatives are presently authorized to respond (in concert with an EAP counselor) to the scene of Service-related incidents involving serious injury or death.

A noted expert in the field of critical incident stress, Jeffrey T. Mitchell, Ph.D., of the Emergency Mental Health Services Department, University of Maryland, defined critical incident stress 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" (1989).

On March 31, 1981, John Hinckley critically wounded the President of the United States, the President's Press Secretary, a Washington, DC, Metropolitan police officer, and one of my colleagues, a U.S. Secret Service (USSS) special agent. As one of the most infamous film clips ever recorded depicts, critical incident trauma affected not only those who experienced physical pain, but the countless number of police, bystanders, agents, and families of those who were present or witnessed the carnage on television.

Although this was not the first assault on protectees of the USSS, nor the first agent physically assaulted, this incident clearly illustrated the need for critical incident familiarization and counseling. As one of the agents at the scene later commented, "We continuously strive in our training to prevent physical assaults, to cover and evacuate our protectees, but we failed to address the inevitable: What do we do when we're shot; when the assault is finally contained and resolved; when the wounded lie next to you on the cold, blood-red pavement?" How do peers react as the adrenaline and fears subside . . .as they begin to question their own vulnerability? As they begin to critique their own responses: Did their reactions cause injury to another? Did they give 100%? Did they do all they could to protect the President? Was a network of peers in place to comfort, to answer questions, to help support and validate emotions? As these and thousands of similar questions engulf each agent, we must ask, "Was any program in place to attend to these 'walking wounded'?" What about the parents, spouses, or children of those wounded, lying on the sidewalk, appearing on every television set in every home? Did we, as fellow agents, do all we could to address the many and various needs of our fallen comrades?

Was any counseling immediately available for the families of those agents on the scene? Was any (age) appropriate explanation offered to the children? Were the spouses and children prepared for the comments, rumors, and innuendoes of neighbors and classmates? Would basic knowledge and understanding of critical incident stress benefit these agents, not only in addressing personal issues, but in discussing it with their families? How invaluable might it have been if a close friend (trained in peer support) could have made brief contact with the agents' spouses and children--to emphasize that their fears and concerns were normal; to inform children that the incident depicted was now over and that their parents were safe; to emphasize the minute odds of another assassination attempt occurring; to explain the media hype and possibility of misinformed and/or irresponsible media reporting; to address the possibility of insensitive and cruel remarks from other children. "We must ventilate and validate," says FBI Special Agent James Horn (1988).

It is imperative that peers assist in attempts to check the second-guessing and issues of self-doubt and guilt; to immediately respond and recommend courses of action for supervisors and management, as well as attending to the needs of the wounded and those present at the scene; to coordinate and recommend professional mental health assistance, if warranted. Traumatic incidents affect all of us in different and very distinct ways. What is a piece of cake for one agent may be described by another as gut-wrenching and unforgettable.

On March 31, 1981, the Secret Service was fortunate in having an established Employee Assistance Program (EAP) in place and operational. Unfortunately, however, no one was prepared for the extent of violence and countless victims, both mental and physical, who were affected that afternoon. At the time of the shooting, no Secret Service personnel specifically trained in critical incident trauma were on hand and available to respond. Due to the nature and uniqueness of the Secret Service, it was impractical and literally impossible to relieve those Agents present at the scene from further duty. Obviously, the safety of not only the President, but the President's family and the increased security for the Vice President took top priority. Because of the unique circumstances, all available personnel were required to continue on duty to safeguard our nation's leaders. Fortunately, within a few days, an astute supervisor was able to detect significant personality and performance changes in a few of the agents who had been present at the scene, and they were referred to the EAP for further evaluation and assistance.

In order for the general public to appreciate the devotion and service, let me relate those days in March from the perspective of an agent assigned to the Presidential detail and who was present as Mr. Hinckley fired his first rounds. For this particular agent, March 31st began as any normal work day for agents assigned to the White House. He departed his residence in the suburbs of Washington at approximately 5:15 a.m. At 6:20, he was on duty outside the Oval Office. Hours later, he would be at the President's side as the first shots were fired. Following the assassination attempt, he and other agents rushed to George Washington University Hospital to establish and maintain security. At approximately 11 p.m., all agents present at the shooting scene were required to meet at our Washington Field Office in order to prepare statements for the FBI. Approximately 21 hours after leaving his residence, surviving the Washington traffic commute and an assassination attempt, this agent returned to his residence.

Day two for this agent began at 5:15 a.m., following a night of little sleep and continuous rehashing of the shooting, with all inherent questions, self-doubts, etc. At 6:15 a.m. this agent was on duty outside the President's hospital suite. Later that afternoon, he was questioned by our internal Inspection Division. He finally ended his "routine day" at approximately 7 p.m. and began his 60-minute commute to his residence. The agent remarked that he was emotionally drained and numb.

Finally he was home and for the first time able to relax and let his guard down. Relax? As his wife, family, children, neighbors, and countless acquaintances inquired as to the day's events, the memories, flashbacks, confusion, smells, and devastation. A wife, suffering her own trauma, questions, "How could you do this to me? Why can't you have a normal job?"--her frustration, and finally her silence. How did this incident impact on the agent's children, who were repeatedly exposed to the television coverage of the event? Were the family needs, questions, and fears discussed or addressed? It was a fitting end to the most horrendous 48 hours he had ever experienced.

As First Lady Nancy Reagan stated following the assassination attempt, "I remember everything about it, everything . . . going into the operating room, the smells, everything. I don't think that's something that ever goes away. You both have your own separate traumas. I'm sure he has his, but I have mine . . . you never think it's going to happen to you, and when it does, it's a shock that stays with you" (NBC, 1986).

Mr. Hinckley's actions continue to affect a number of those agents present at the scene. Some continue to have disturbed sleep patterns, recurring dreams, continuous second-guessing, and hypersensitivity to loud noises. In September 1988, some of those agents attended a Critical Incident Seminar sponsored by our agency. Those in attendance felt the seminar greatly enhanced resolution of some of the issues mentioned

above. Although the majority of the agents present when the President was shot experienced an event that most of the world also witnessed, few could understand or share in their thoughts, their vulnerability, or their needs. Ironically, within hours of the shooting itself, these Agents found themselves on duty within the confines of one of the nation's finest hospitals, as the President and fellow agent Tim McCarthy recovered. What is ironic is that no one from within this great healing institution specifically attempted to identify and single out those agents who might benefit from psychological or critical incident counseling. Also during this time, there was no formal policy of mandatory referral to the EAP or any type of mental health referral. In addition, no peer support team was in existence that would be capable of an immediate response to attend to the needs and help validate emotions of those agents on the scene--to emphasize they were experiencing "normal reactions to abnormal situations" (Solomon, 1988). Of utmost importance is the peers' position of being able to recommend and offer credibility to known mental health professionals dealing specifically with critical incident trauma--to help rid fellow agents of the "John Wayne mentality" (Reiser, 1973, p. 316). In other words, there was no one to tell them not to internalize emotions (or suck it in) as is frequently the case, to dispel the myth that grown men, especially cops, can't cry.

We must ask ourselves how many other agents were affected by the events of March 31st, and, more importantly, do they continue to be affected by this incident? Approximately seven years later, as previously noted, a number of agents present at the scene continued to have one or more of the following symptoms:

Flashbacks, recurring thoughts
Continually questioning their individual response and reaction
Sleep disorders
Difficulty discussing the event
Difficulty discussing the event with wife or family
Children of the agents are developing similar symptoms and/or have nightmares of the incident

In February 1988, the Secret Service sponsored the first critical incident seminar for 13 agents (including the writer) who had been involved in life-threatening critical incidents some time during their careers. The seminar was led by a noted police psychologist with assistance of the project manager for the FBI Critical Incident Team. This three-day course was unanimously rated by the attendees as one of the most meaningful and productive endeavors ever orchestrated by this Service. It was interesting to note that the attendees' reactions to their particular incident fell within the parameters of reactions set forth by Dr. Solomon--the parameters being that one-third of all agents/officers involved in an incident have a severe reaction, one-third a mild reaction, and one-third minimal, if any, reaction (1988).

In September 1988, a second seminar was held for additional agents and/or Uniformed Division officers also involved in critical incidents. Again, reactions feel within these general parameters. Attendees concurred that participation greatly facilitated the resolution of personal issues and questions. It further promoted discussions with family who were equally affected by the incident, but frequently ignored or forgotten. Of paramount importance was the concurrence that attendance greatly enhanced mental preparedness and one's mindset; in other words, the "survival instinct" should they be involved in another critical incident during their career. All attendees felt it was imperative that inoculation to critical incident stress be emphasized to new agent classes. The proper mental preparedness, coupled with the state-of-the-art training currently offered by the Secret Service would greatly enhance the survivability of an agent facing the sudden confrontation of life-threatening aggression. Team members felt it was imperative that they continually update and improve their skills in the field of critical incident trauma in order to avoid the possibility of unintentionally escalating stress and/or trauma following an incident by inappropriate comments and/or behavior. Participation in seminars/workshops such as this one would not only enhance each agent's expertise but would further provide a network of comrades representing the whole spectrum of local, state, and federal law enforcement.

One agent in particular continued to experience a number of the above symptoms following an incident that occurred over 20 years ago. It is important to note that regardless of when the incident occurs, the benefits of formal (CI stress) debriefing far outweigh the philosophy that time heals all wounds or let sleeping dogs lie. The attendees unanimously concurred that they benefitted from the debriefing regardless of the time frame involved. Better immediately after the incident than later, but better late than never.

Attendees concurred that knowledge of CI stress and its possible effects will not only assist the person facing a life-threatening confrontation, but it will also enlighten the rank and file who may have contact with or need to comfort a future survivor or survivor's family.

The following quote was directed towards a financial investment article; however, I couldn't help but note its relevance: "In all my years . . . I have never met a person who planned to fail, but I have met many who failed to plan" (VanCaspel, 1986).

We must do all we can to prepare the new agents/officers for the difficult task and risk they may face down the road. It is said that in battle one reacts instinctively as one has been trained. "Fearing the future, provides in time of peace, As a wise man should, the equipment required for war" (Bovie, 1959, p. 108). In other words, a wise man in time of peace prepares for war. Hopefully, the inclusion of this topic in training, presented by guest instructors who themselves have survived a critical incident, will reduce and eliminate some of these mistakes and risks, to emphasize that their response to attack must be spontaneous and effective. Training Division must address the following: What do you do if you are shot? How will you react to physically prepared to take another's life? How will you react to sudden life-threatening aggression? Do you understand and recognize the physical and emotional reactions you may experience as your body adapts to the fight or flight syndrome? Do you have a plan? Can you succeed?

A picture of the Reagan assassination attempt is displayed at our Office of Training. The following quote is printed beneath it and is attributed to the agent survivors who courageously put their lives on the line that last day of March 1981: "It is for such moments as this that the Office of Training exists."

Noted police psychologist Dr. Roger Solomon defines a critical incident as "Any situation where one feels overwhelmed by their sense of vulnerability and/or lack of control over the situation" (1988). Critical incident trauma affects us all. Some react strongly, some immediately, and some months later. One of our agents in particular was involved in a fatal shooting a number of years ago. This agent advised that he experienced very few of the symptoms we have previously described. Although he regretted being forced to take another life, he responded as he had been trained and in self-defense. Following the death of a co-worker he returned fire, killing his assailant. What is interesting is that this agent began to experience guilt years after the shooting because he felt he should have had a reaction to the shooting incident, but did not. He was also the recipient of a well-meaning but most inappropriate call from a fellow agent who had himself been involved in a fatal shooting but who lacked any formal training in critical incident trauma and/or peer support. Again, the caller was well-intentioned; however, he had never personally resolved his own shooting and was using the victim agent as a sounding board for his continued problems and anger with the Service. As one of the attendees remarked, "It's imperative that you realize no matter how you fight off the impact of the incident, at some time it will leave its mark" (Berthold, personal communication, February 11, 1988).

Too frequently, supervisors are heard commenting after a critical incident, "He's all right; he's a Vietnam vet. He can handle it . . . he doesn't need a shrink or any peer support help." The following article appeared in Police magazine and was titled "I've Killed That Man 10,000 Times."

> To compare war with fatal police shootings is comparing apples and oranges, says Dan Sullivan, a former Santa Barbara police officer (and presently a special agent with our organization) who killed a man. . . and who served in Vietnam. Sullivan went on to comment, "In a war that's what you're there for--to wipe them out. Police work isn't like that. You're certainly not on a search and destroy mission. Vietnam and the 1400 block

> of Gillespie Street in Santa Barbara, they're just not the same thing." Dan Sullivan was not initially upset when he killed a man. Nevertheless he was ordered by his captain to have a counseling session. "After I went," Sullivan stated, "I was glad I did, I felt better having a professional tell me I was okay." (Cohen, 1980, p. 17)

On May 26, 1973, seven Secret Service agents were aboard a U.S. military helicopter that was shuttling them off the Florida coast to an island where the President was vacationing. It was just before midnight when the copter crashed into the water, overturned, and sank. The crew and six of the seven agents managed to escape (underwater) from the upside down copter. They were finally rescued after 45 minutes of hanging on in shark-infested waters. When the copter was later pulled from the water, the remaining agent's body was recovered, still wearing his harness and seat belt. Again, the possibility of critical incident trauma for the survivors and their families--and once again, no specific program in place to assist. No peers to help validate emotions or fears, to address normal reactions to abnormal situations (Solomon, 1988). A number of high-ranking supervisors called to offer support, but no one with any expertise in critical incident stress debriefing was available. No program of mandatory referrals, sessions with a mental health professional and/or days off. No one trained to address issues such as loss of a fellow agent, fear of flying, guilt, and the thousands of questions and concerns of family. One of the agent survivors who continued to work without counseling and without peer support (i.e., peers who have been sensitized and trained in critical stress) found himself, within a few months of the incident, assigned to a shift that was about to be transported at night by military helicopter. This agent requested reassignment for that shift in that he was not ready for another flight--a valid, and most reasonable request from anyone who had experienced the trauma of an aircraft crash, underwater escape, and death of a friend and co-worker. His direct supervisor ordered him to proceed with the flight and when he refused, relieved him of his badge and official equipment. Another survivor, who was sitting next to the agent killed, later asked that consideration be given so that he too would not have to travel by helicopter. A reviewing Headquarters supervisor, oblivious to his exemplary record, recommended that he consider resigning.

Mentioning these issues is in no means any attempt to characterize or imply that the Secret Service is insensitive or not interested in the well-being of its personnel. These are isolated incidents that unfortunately need to be addressed in order that we may learn from our mistakes. They further serve to awaken those skeptics among us (and within the organization) who fail to recognize that we all react and are affected differently to the inherent stressors of our occupation.

The Secret Service continually strives to improve and evaluate its personnel, theories, and practices. We are now just beginning to recognize and realize the importance of critical incident trauma and its effects on our personnel, both physical and psychological. We have made our mistakes; however, of far greater importance is the acceptance and recognition that we (the Service) always strive to advance from the setbacks and address and rectify problems as expeditiously as possible. As many have said, the Secret Service is family. It is by far one of the most innovative, professional, and prestigious law enforcement agencies that exists today. It is hoped that this program will benefit not only the street agent/Uniform Division officer, but also their greatest assets--peers, clerks, support personnel, spouses, and children who truly make up the Secret Service family.

As a direct result of the first critical incident seminar and the recommendations of its participants, our Director has instituted an aggressive and most impressive policy for all supervisors to adhere to following a shooting or other critical incident. Our Employee Assistance Program has expanded its level of assistance and expertise in this field. A cadre of peer support counselors has been identified, trained, and authorized to respond (in concert with an EAP counselor) to assist any fellow agent involved in any type of life-threatening critical incident.

Director Simpson recently commented:

> The Employee Assistance Program has designed a Traumatic Incident Program for Service personnel who are involved in life-threatening situations. The program features a traumatic incident training unit for new agents and Uniformed Division officers, a support network of peer counselors who have experienced a traumatic incident, and the Employee Assistance Program counselors. Recently I attended one of the critical incident trauma seminars. Not only was I extremely impressed by the content of the seminar, but I was deeply moved by the understanding that this program will benefit many employees and give tremendous support to those who have been or may be involved in a traumatic incident." (1989)

In addition to a supportive and most understanding Director and executive staff, we are also fortunate in that we have an extremely caring and well-structured EAP. Mrs. Christy Prietsch, C.A.C., is the program manager and point of contact for agents/officers of the Service to the Employee Assistance Branch. A close and harmonious relationship exists between Mrs. Prietsch and all peer counselors.

In conclusion, recognition of critical incident trauma and the importance of peer support remains in the embryonic stage at the federal law enforcement level. Both concepts continue to gain acceptance and recognition with the Service. Secret Service peer team members have already been utilized following a number of diverse incidents. Feedback from recipients has been positive and most rewarding. None of the respondents felt contact was inappropriate or intrusive. All encouraged expansion of the program. Along with the FBI, our program is in the unique and enviable position of being a trend setter in this most important field. As this seminar attests, the liaison and good will opportunities that this program opens to all law enforcement are endless. We at the U.S. Secret Service will continue to capitalize on these phenomena and raise our program to the pinnacle that has come to be the hallmark of our agency. Unlike many "in vogue" programs that come and go, the stark reality of peer team utilization in future life-threatening situations is not a matter of debate, but a matter of time.

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THE DEVELOPMENT OF A CRISIS CARE UNIT

J. Peter Bush, M.D.

ABSTRACT

Policing produces crisis confrontations for the individual officer in duty assignments and in situations in which members of the public are in crisis. These situations may require immediate and/or long-term resolution and response. Police have been inadequately trained and prepared to provide the appropriate response to crisis in their own lives and that of others. Crises can vary from minor to major, involving shootings and loss of life from disaster. Public crisis situations present stressful occasions for police management.

This paper describes the philosophy, planning, development, and early stages of a project to provide care to persons in crisis in a metropolitan environment involving police and nonpolice crisis-trained personnel.

In 1979 in Melbourne, Victoria, Australia, a seminar was held by the ten recently established Police/Mental Health Services Liaison Committee. As a result of this, a small group of citizens met to discuss the gaps in the facilities in the provision of assistance and care to people in crisis in Melbourne. From this humble beginning, the Melbourne Crisis Care Association was developed. Five years later, the Association represented 270 members and organizations active and interested in crisis care.

To many people the term "crisis" may be vague and meaningless. The Association adopted a relatively simple definition, deliberately nonspecific and comprehensive:

> A time when something has happened to interfere with a person's ability to manage without assistance.

It is well-recognized that the ability to manage varies with circumstance, time, personality, experience, upbringing, and many other factors. An event that may appear a crisis to one may be little more than an inconvenience to another.

The Association's early activities included meetings, discussions, seminars, a study day, production of a concept paper and pamphlet, and circulation of a questionnaire to agencies. In late 1980, the Association approached the Victorian Government (The Minister for Community Welfare Services, and subsequently the Minister for Police and Emergency Services and the Minister for Health) seeking Government support towards further examination and research into crisis care in Melbourne. Melbourne is the capital city of the state of Victoria, the smallest of the five mainland states of Australia, and has a population of approximately 2.5 million.

The Minister established a steering committee in 1981 made up of representatives from the departments concerned, including Housing. The MCCA was also directly represented. The objectives of the Steering Committee were to gain greater knowledge about the adequacy and availability of crisis care services in the community, particularly noting questions of access, coordination, and adequacy. The police, being front-line and on the street, were frequently the first service called upon by the community in any crisis or emergency.

The report of this Steering Committee was finally presented to the Minister of Community Welfare Services in late April 1984. Despite the hopes of the Executive for an early opportunity to discuss this report

with the Minister, this did not eventuate, although the Minister addressed and opened a consultation day on November 24, 1984. In her address, Honorable Pauline Tone stated:

> We all know that sudden crises can have a profound impact on individuals and their families. In some cases there is nowhere to turn. This is particularly a problem when crises occur outside normal working hours. . . Some crises may develop into domestic violence, family separation, children being placed in institutions, and ongoing difficulties. An effective crisis intervention service complements existing services both generalist and specialist and should work well with them. It should, whenever possible, build upon existing services rather than create new organizations which require further coordination.

The rhetoric was encouraging. The subsequent inactivity was not.

After much further consideration and consultation, and despite the encouraging words of the Minister, on May 22, 1985, the Executive reached a watershed. It was then realized that unless the Association itself took action, the prevarication and delaying tactics of the Government would continue. Accordingly, a pilot project was planned, building on existing crisis services. The MCCA and the Victoria Police cooperated to run an experimental crisis service for three months. A crisis team was available for crisis calls initially made to D 24, the police communications centre, between 6 pm and 2 am each day. This team comprised one police officer from the Community Policing Squads and a crisis worker on loan from an agency for a week.

As a result of this pilot project, the need for a Crisis Care Service was confirmed. A further period of frustrating delay by government was eventually interrupted by an impending State election. Promises of assistance and finance were made. In mid-1988, moneys were made available for this purpose. A Project Officer was appointed.

As in the previous pilot project, the service was to be run in conjunction with the Victoria Police Community Policing Squads, in cooperation with workers trained in crisis care management. It was planned that these workers should come from the Departments of Health and Community Services.

In June 1989 I learned that "the whole issue of funding has become a political one . . ." and still much effort is required for its continuation.

At the conclusion of ten weeks of operation, the following results are shown:

133 cases
178 people seen
112 visits
23 phone consultations

132 females 46 males

Type of case:

56 family violence situations
17 child-parent problems
12 suicide threats/attempts
9 psychiatric problems
8 past sexual assault
8 accommodation, including homelessness
6 relationship problems
4 grief reactions
13 other (e.g., drug abuse, assault victim, prowler)

It is not possible from these small figures to evaluate in financial terms the importance of such a service. Finance is not the only nor the most important consideration. There are many who would claim rightly that these services cannot be assessed merely on financial terms. There are, however, several observations that, I believe, are relevant and underline the necessity for such a service to continue and to be developed:

* The clients who have used this service, though small in number, have appreciated its value.
* It has been used for direct "counseling" of police personnel in stressful situations, e.g., after a bombing.
* Domestic violence situations provide major stresses for police for several reasons:
  - risk of violence to police
  - inability to resolve problem
  - repeated calls to same situation
  - frustration
* Evidence from elsewhere of the value of such a service.

The value can be stated as follows:

> The preliminary benefit of the DRT (Domestic Response Team) model, of a social worker teamed with a Community Relations Officer, (Police) is the merging of the two perspectives of social work and police work, and the accumulated experience that is associated with these with resultant benefit to the client. The police bring to a crisis situation experience in, and knowledge of, the law and the legal system as well as experience in dealing with physically violent aspects of a crisis. The social workers, with their experience in dealing with the socio-emotional aspects of relationships, are able to deal with that component of the crises as well as utilize their extensive knowledge of the social service networks in referring clients to the appropriate agency. (From a report prepared for the Canadian Solicitor General)

Such a Crisis Care team, organized within the framework of a police service or not, should provide the link for its "clients" with the many other existing care organizations--statutory, voluntary, church based, general, or specific that will provide the necessary continuing care. The unit is likely to prove complementary to, and not a substitute for, these.

This linking of "client" with continuing support applies equally to police personnel to the professional police psychological (and psychiatric) services and/or peer counselling within a police force.

It would have been pleasant to have provided a glowing report of many success stories from this limited experience in Melbourne. Life is, unfortunately, not like that. One of the great features of the service that I have briefly described has been the dedication of the small number of workers to a task in which they have had complete and absolute confidence and faith, despite the many problems associated with the bureaucratic machine that is unable to appreciate the values of personal care unless it can be seen in a financial balance sheet. This applies to care of police officers as much as it does to the community at large. For the benefit of all police officers and especially those in forces in which the light has not yet dawned, it is therefore incumbent upon us to ensure that sufficient factual evidence is laid before the authorities to substantiate these claims, which, clinically, are obvious to us all.

POLICE COUNSELING UNIT TO DEAL WITH CRITICAL INCIDENTS

Joseph A. Dunne, M.P.A., C.A.C.

ABSTRACT

Looking back 30 years, we can discern three periods of increasing violence when law enforcement officers are directed to control groups seeking social and political change in America. This paper examines the rising degree of stress related to the changing role of police from "peace officer" to a combat level in the war on drugs. The consequent need for support services is served by the Police Counseling Unit, an effective and confidential approach, designed to treat and rehabilitate victims of "burn-out," alcoholism, drug abuse, and gambling, returning officer to full productivity.

INTRODUCTION

America has experienced 30 years of increasing violence as reflected in the Uniform Crime Reports and in the number of law enforcement officers who were wounded or killed each year in the line of duty. The International Law Enforcement Stress Association lists 161 officers killed in 1988 (Donovan, 1989).

The author of this paper was appointed Chaplain of the New York City Police Department in 1958, being in a position to witness the events that brought about change--from the status of "peace officer" to one of "crowd control," confrontation, and violence. We can discern three stages of violence, beginning in the 60's with civil rights marches, which set blacks against city and state police in Mississippi and Alabama. In 1964, following the shooting of a black youth, New York's Harlem exploded into a full-scale riot, requiring maximum effort on the part of New York's police. This Chaplain was pinned down by a hail of bottles and trash thrown from the houses on West 117th Street, while riding on patrol with police in Harlem. The image of law enforcement suffered until unjust laws were changed, but the potential for violence remained.

The second wave of violence involved the "Peace Movement" in response to America's military involvement in Vietnam. Again, the police were placed in an ambivalent position defending national policy on the streets, at military bases, and in our nation's capital. In these demonstrations, however, the presence of drugs contributed often to the physical danger for police making arrests. Ironically, many of the police taking abuse were themselves combat veterans of Vietnam. Having returned depressed, hostile, and guilt-laden to a country that ignored their patriotism, they entered police service, only to be further abused, insulted, and assaulted by their fellow Americans.

At this point, a clear danger signal was given to law enforcement with the issue of the bulletproof vest, to be worn on patrol. This was tacit admission that the police were no longer safe on the street, not feared by criminals but in danger of death at all times. Rather than give them a sense of safety, the vest would force officers to evaluate their role in the community and decide whether their service was worth the risk to themselves and their families.

The third and most recent phase of rising stress in police work is the "War on Drugs" that President Reagan ordered into action. Now there is recognition of an enemy, well-financed, better armed with automatic weapons, and already invading every city, school, and home with death. The police are required to infiltrate, make "buys," and then conduct an assault on deadly killers. At this point, the role and function of law officer truly parallel that of the military, engaging a foreign-based cartel whose goal is the total destruction of our youth by spawning crime and violence across America.

Today, much of the stress and frustration being suffered by police officers stems from an awareness of their inability to perform a military role. They lack combat training, manpower, and services to handle the stress, injuries, and personal loss upon the death of a friend or fellow officer. The peer group gathers at the local bar. The wife and family cannot understand their own hostility and underlying anger and frustration. The complaint we hear often is: "There is no one to talk to and get it all out."

STRESS AMONG POLICE OFFICERS

We are indebted to Hans Selye for an early definition of stress. We are told that reaction to stress is the "general adaptation syndrome," consisting of three stages--alarm, resistance, and exhaustion (Reiser, 1976). Police officers certainly do live in a state of alarm, from the time they dress for work, put on a uniform and firearm, then, go on patrol answering potentially dangerous situations on each tour of duty.

Dr. Martin Reiser, a psychologist for the Los Angeles Police, writes that the nature of stress is not as important as the person's perception of the event and the control responses to stress, i.e., threats to the individual, such as, losing control of himself, a threat to his conscience, or the threat of physical harm. Police desire to serve the people of the community and are above-average in intelligence; but each has his own stress tolerance level, which, when overloaded or underloaded, will lead to symptoms of distress.

Dr. Martin Symonds, a former police officer in New York, divides the stress experienced by police into two categories: that due to the nature of police work and that due to the police organization itself (Symonds, 1969). In the first instance, the recruit is trained to enforce the law and safeguard life and property. He is to be a "peace officer," but, in a changing society, steadily becoming more violent, every arrest is potentially dangerous. Community perceptions of police are often distorted by social and political events, e.g., the movement toward civilian review boards. While more than 90 percent of complaints are not substantiated, the threat to police service remains.

Every organization is capable of creating stress from within. Employees perceive rules and procedures as restrictive and tools of management to punish mistakes. Police personnel complain that leadership is poor and unresponsive to the dangers of the job. "The bosses are not on the scene when the action takes place," is a frequent comment. In addition, promotions based mostly on civil service examination or by political and personal appointment do not guarantee the quality of leadership needed today. While discipline is necessary, in view of the responsibility given to police to enforce the law, the accountability must be shared by superiors. The officers on the street, risking life itself, feel that they need and deserve leadership and support of the department.

Among the numerous manifestations of police stress, Dr. George B. Whitmore includes fatigue, insomnia, headache, backache, hypertension, anxiety, depression, indigestion, impotence, frigidity, and spastic colon (Reiser, 1976; Wallace, 1985).

In view of these studies on stress, most observers conclude that police work is, indeed, stressful, taking a serious toll with sickness, injury, and deaths in the line of duty. If we grant that the role of the law enforcement officer has now approached that of the military in combat stress, we should look to the need for support services akin to those in the Armed Forces; e.g., police chaplains to counsel, identify stress, and supply spiritual guidance in law enforcement; psychological services to evaluate or refer for treatment and therapy; and a police counseling unit. Peer counseling in an employee assistance program has proved very successful for government and industrial employees, reducing absenteeism and health costs by using poor performance as the basis for intervention.

POLICE COUNSELING UNIT

This Chaplain became aware of the stress-related alcoholism in the New York City Police Department early in his ministry. Police officers facing disciplinary charges were often placed on probation after trial,

reporting to the Commander and the Chaplain, for a period of one year. It was soon apparent to me that most of the violations were related to abuse of alcohol. Efforts to establish a program of rehabilitation were resisted until Commissioner Howard R. Leary was willing to sign a written policy on May 12, 1966, authorizing a counseling service (Dunne, 1973).

Reaching the troubled employees in bureaucratic structure, such as a police agency, requires considerable effort to overcome ingrained obstacles. First, there is the traditional "cover-up" (Kenney & Leaton, 1987), which is based on strict group norms of loyalty and protectionism. The stigma of addictions, e.g., alcoholism, drug abuse, and compulsive gambling, not only delays access to treatment but contributes to the denial (Wirch, 1980) on the part of the client that help is needed. Second, the iron-clad cloak of secrecy is maintained in police agencies, resisting "outsiders" seeking change or knowledge regarding even health matters of personnel. Third, there is always concern about the presence of firearms, the symbol of authority, which must be surrendered prior to treatment even when safeguarded for a short time.

Employee assistance programs are effective in reducing stress of police personnel because they offer a rational approach to troubled employees in a military-type organization. Using the command function, the internal resistance can be reduced by the adoption of a clear written policy outlining the goals and philosophy to be adopted as follows:

1. Recognition that alcoholism and substance abuse are treatable illnesses, not disciplinary cases per se.

2. Superiors are responsible for referring employees for counseling on the basis of poor performance.

3. Records of the counseling unit are strictly confidential under Federal law (42 US Code, Part 2, 1975).

4. Employees are assured that job rights to assignment and promotion will be protected.

5. Continued failure and resistance to cooperation may result in discipline or dismissal.

The design and function of the counseling unit holds out several unique features for the troubled officer suffering from the pressure of the job, a cynical mistrust of the agency, an unwillingness to communicate, and an advancing state of addiction to alcohol, drugs, or gambling debts, thinking of suicide because no one seems interested in his/her problems.

Staffing the counseling unit with peer counselors, most of whom are recovering persons, conveys management's concern for the dangers and risks of police work. The intent is that the client will be meeting "one of his own" who understands the pressure and the pain and is willing to share experience, strength, and hope with a brother officer in trouble. A "reveal" and "heal" philosophy is more likely to facilitate coping and personal growth after a critical incident (Solomon & Horn, 1986).

A basic key to success, however, will be establishing the atmosphere of confidentiality, locating the unit away from the police facilities, and training all personnel to respect the integrity of this service.

The effectiveness of this type of program consists in a holistic approach. The assigned personnel present primary education to recruit classes and promotion candidates, explaining the function of the counseling unit as department policy and describing its many skills in serving the stress problems of the force.

A glance at the work-flow chart of the unit reveals the function of case finding, using medical, disciplinary, and performance records plus family complaints as the basis for interviews. Crisis intervention follows for employees referred by commanders, doctors, chaplains, or other agencies. Referrals to treatment

include detoxification, outpatient services, mental health clinics, psychological services, and marriage counselors. These sources are combined with rehabilitation at halfway houses and assignment to limited duty of a clerical nature, without firearms and with continuous evaluation for return to full duty. Family members are also involved, when possible, with the counseling process.

This unit is in an excellent position to perform follow-up on a monthly basis, monitoring attendance at self-help groups and work reports. Follow-up studies indicate that abstinence is often directly related to the quality of follow-up efforts (Dunne, 1973). In another study, privately sponsored, the New York City Police Counseling Program treatment outcomes in 1985 reflected that 82 percent of its clients returned to full duty (Lieberman, 1985).

CONCLUSIONS

This paper has dealt with a recommended philosophy of treatment for police officers currently subjected to an increasing level of stress and serious injury and death. If we accept the theme of this paper that police service in America is approaching that of the military, waging a real war against drugs here, then we must broaden the physical, psychological, and spiritual resources, much like those supplied to the Armed Forces.

The employee assistance program was presented as an effective approach in serving the needs of police officers. Now we can go further, in view of current laws on confidentiality and the National Rehabilitation Act of 1973, Sec. 503, 504.

On December 31, 1970, under the leadership of Senator Harold Hughes of Iowa, Public Law 91-616 established the National Institute of Alcohol Abuse and Alcoholism, appropriating $40 million for prevention, training, and treatment of alcoholism. Part of this bill also required hospitals receiving Federal funds not to discriminate against clients suffering alcoholism and to maintain the privacy of such patients. On May 14, 1974, Public Law 93-282 extended this rule of patient confidentiality to treatment of drug abuse patients.

Today, alcoholism and drug abuse treatment facilities, including employee assistance programs, are required by law to keep records and identifying information confidential unless a proper release is authorized by the client. Confidentiality of alcoholism and drug treatment records is also affirmed by the U.S. Code, Part 3, dated 1975, and renewed by Health and Human Services, 1987.

Thus, a client who presents himself at the Police Counseling Unit seeking treatment for an alcohol problem comes under the law of confidentiality, and his privacy must be protected. If he admits using drugs in addition to alcohol, the same right to privacy exists. Yet some police executives would require that this right be forfeited. Counselors are required in some instances to refer this individual with a double problem to the medical authority to be tested and dismissed. This practice, in my opinion, is a grave injustice to the officer. His right to privacy has been violated. The concern of the administration is centered upon the drug use, not on the rights of the person.

Further, the National Rehabilitation Act of 1973, Sections 503 and 504, has established the rights of alcoholics, drug abusers, and those suffering mental problems to employment and classifies them as handicapped. When this impairment happens on the job, they cannot be dismissed without an opportunity to obtain treatment to correct this behavior. This regulation binds all employers who receive Federal funds by contracts in the amount of $25,000 or more. Here again, we must protect the rights of the police officer to treatment, rather than dismissal.

If we evaluate the treatment for police officers suffering stress, e.g., alcoholism, drug abuse, and compulsive gambling--often viewed as a means to deal with the pain of loneliness, fear, and anxiety of seeing crime and inhumanity day after day--we learn that only one in five agencies provide chaplains, counseling,

or psychological services. We must conclude that the major emphasis is on drug testing, and not on rehabilitating the police officer.

To my way of thinking as a police chaplain, justice demands that the police officer should be given the best care we can obtain, extensive insurance coverage, and access to the best medical care and the best doctors in the country. One such treatment program has been open since July 10, 1989, in Davie Florida:

SEAFIELD 911
Center for Law Enforcement
5151 S.W. 61st Avenue
Davie, FL 33314
305-321-9400

The far-flung frontiers of freedom are now gone into history. The battle is here and now--for our children, our homes, our America. The "Thin Blue Line" of police officers, thank God, stands between us and defeat in the "War on Drugs" in America.

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MITIGATING THE IMPACT OF WORK TRAUMA: ADMINISTRATIVE ISSUES CONCERNING INTERVENTION

Chris Dunning, Ph.D.

ABSTRACT

While trauma debrief, intervention counseling, and peer support programs are increasingly gaining acceptance both by law enforcement officers and administrators, their development and operation has pointed to a variety of unresolved and controversial management issues. These issues have not only affected the effectiveness of intervention strategies but also have raised concerns as to whether programs should be implemented or continued as part of the standard operating procedure of the organization in the event of a traumatic work place incident. While most police officers and administrators express a humane and empathetic desire to assuage the emotional suffering caused by job-related trauma, concerns for maintaining confidentiality; rejection due to occupational and organizational norms that deny the existence of mental injury; legal requirements for reporting admissions of criminal activity, as well as behavior that falls under departmental disciplinary procedure; costs of intervention programming given the approach elected; and the potentially overwhelming costs of workers' compensation including paying for treatment, disability leave, and retirement have caused a reluctance in many departments to implement and/or continue intervention strategies to offset the deleterious effects of duty-related trauma. This paper addresses legal requirements for compensation for work-related mental injuries, administrative concerns for the costs and liability for trauma programming, and legal requirements for administrative intervention for mental injuries affecting work performance, trauma defenses used in disciplinary actions, and the confidentiality issues.

INTRODUCTION

Critical incidents, resulting from natural disaster or through human-induced violence or negligence, are most frequently described by the number of lives lost or of physical injuries. The focus of the event is generally on physical damage, evidenced in pictures of destruction, fire, explosion, rubble, bodies, disfigurement, and injury. To most formal organizations responsible for the resolution of critical incidents the parameters of the event lie between the first person threatened with injury until the last possible survivor or victim is recovered and the cause of the event documented. The goals of critical incident intervention for police include rescue, injury prevention, medical assistance, and investigation of criminal actions.

Subsequent to a critical incident, the attention and resources of most police departments are sorely tested and stretched beyond the point anticipated by any planning effort. Critical incidents, by their very sudden, unexpected, and destructive nature, overwhelm most departments despite efforts devoted to planning, training, coordinating, and preparing for their occurrence. Whether the critical incident involves responding to a disaster for the purposes of rescue, recovery, and protection, or for an incident of human-induced violence resulting in the wounding or death of an officer, the department and its personnel experience a demand of effort and attention that is unlike any previous effort. Manpower demands of a rescue operation or man-hunt tax the department's ability to meet its required mandate to continue the provision of police services to unaffected populations, since rarely is the total governmental jurisdiction involved in the aftermath of the critical incident.

Typically the police administrator's attention is virtually totally consumed by the tactical demands of the critical incident, leaving little time for consideration of anything other than the physical well-being of officers and citizens. Once immediate life-threat has been eliminated and the wounded attended, the attention of the manager turns to overseeing securing the scene; coordinating interviews and reports of participants, workers, and witnesses; and working toward resolution of the incident. Little consideration is given to the potential for psychological injuries to those involved, as the mission of the police department is to "Protect and Serve," not to treat--instead focusing on the security of persons and property. There is no responsibility legally, ethically, or morally--so the administrator assumes--for mental injuries of officers and certainly not for those of victims. The law enforcement purpose, for example, is to intervene to protect the physical integrity of a sexual assault victim, providing defense, necessary medical treatment, and attempted identification of the assailant. The only psychological concern is to immediate emergency medical conditions and sensitivity toward the victim in interviewing and investigation. Concern intensifies and extends when the victim is a police officer injured in the line of duty. Psychological injuries rarely are considered, and then only when accompanied by serious physical injury. It is only such an injury or special circumstance, such as a felonious shooting of the officer, that drives the administrator to the hospital or to the officer's side. Once wounds are treated and heal or the dead are laid to rest, the department and the administrator consider the matter at an end for the department, in effect turned over to others. The duty owed, in the eyes of most administrators, is to protect the physical well-being of officers, and all safety and security training, procedure, equipment, and police decisions are directed toward that end. Considerations of weapons, ammunition, body armor, tactics, training, and certification are all directed to the prevention of physical injury. Clearly, administrators see and assume much in the way of responsibility to forestall the occurrence of such injuries. Few administrators--in fact, few employers--accept and assume responsibility for mental injuries.

Critical incidents, by their very nature, require the police organization to deploy manpower and resources in a manner that strains the capacity of the department to maintain normal functioning. Whether responding to the rescue and recovery tasks demanded in a disaster or mounting a manhunt and investigation in an officer-involved shooting, the department is hard pressed to continue normal response levels to calls-for-service by a distracted force and to simultaneously command the critical incident. Most organizations are so distracted by this burden that to consider the emotional psychological impact on self and other officers receives low priority. As any new recruit learns, the safety of the community comes before the officer's well-being. The commitment to risking life and limb, to put one's life on the line, is one obligation assumed with the badge. The public must be protected. Officers capable of performing are expected to do this duty. In this period of heightened activity, the mental health or injury of officers is of little or no concern to the majority of administrators. It is something that can be handled, if ever, later. It can be put on hold. The officer expects and the administrator assumes that, short of total physical impairment, the police officer will continue to participate to resolve the critical incident.

No one would dispute the responsibility of the governmental jurisdiction to equip and train officers in such a manner as to maximize the probability of their physical security in situations in which we expect the officer to respond. Certainly police managers are expected to deploy and supervise in a manner that presents the least risk to citizens and, within the bounds of the mission of law enforcement, to the officer. Considerations of physical security and integrity drive much of what is involved in critical incidents. While planning to reduce the probability of physical injury is common, it is rare that one would find attention in policy and plan development or on the implementation through training of actions to prevent or ameliorate the possible mental injuries of police work, especially those caused by responding to trauma, disaster, or life-threat. Yet, as we will see, the law under workers' compensation does extend that responsibility to employers.

The issue of traumatic stress related to the duties of police officers who respond to critical incidents incites much disagreement in the profession. Most administrators are wary of any discussion that suggests job-related duties and conditions might produce psychological injury to workers. The protective services have generally believed that their selection and training process produces individuals who can adapt well under stressful conditions, and in fact, that stress can bring out the best in a worker.

Since mental injuries rarely incapacitate immediately and are generally not readily apparent during a critical incident, their incidence is generally not correlated with the management of a critical incident. Rather, mental injuries are seen as something that occurs at the point of appearance, days, months, or years after the precipitating event, and are generally regarded in the context of the contemporary situation or as the result of a personal flaw rather than correlated to the injurious traumatic incident. Management of injuries at that time is seen as a personnel issue, not as one of safety. Manifestation of injuries are viewed as an individual responsibility, not one that relates to the supervision of personnel deployed in a special operation. Where bulletproof vests are universally regarded as preventive safety equipment and firearms certification as preventive training against the possible injury of a bullet wound during the performance of duty, no thought or planning is generally afforded mental injuries that might result from the incident. Yet such injuries are just as much the result of the shooting event as any flesh wound. (Solomon & Horn, 1986; Somodevilla, 1986).

WORKERS' COMPENSATION

To recognize in any formal way the possible existence of trauma reactions that have as their precipitant duty deployment through officially recognized intervention and resolution programs might increase the likelihood of successful workers' compensation claims and duty disability retirements. The usual reaction of many protective service administrators is to declare that current training and support services provide sufficient protection against any injury, physical or psychological. Since 1955, when a landmark court case, American General v. Bailey, extended the workers' compensation law to psychological illness, there has been a burgeoning number of claims that assert that on-the-job stress or unsatisfactory work environment contributes to psychological disorders.

Workers' compensation programs were originally intended as a legislated no-fault insurance policy (Hadler, 1984). Programs were constructed to protect employers from tort suits alleging employer negligence for damages beyond lost wages and medical costs and were intended to provide automatic compensation for relevant medical expenses and lost wages to affected employees. To encourage return to work, less than full wage coverage was awarded, thereby requiring rehabilitative attempts. In order to receive coverage under such a compensation program, the employee must have suffered harm in a work-related mishap. Herein lies the liability to the organization. Historically, such injuries were considered to include only those that were physical and the result of an accident. Today, however, both statutory and case law recognize a broad range of both physical and mental injuries arising out of the consequences of employment. At issue is where injuries and incidents of a mental nature are compensable under the law. Some states allow recovery for mental injuries by state statute (for example, see Chapter 102, Wisconsin State Statutes), some allow recovery by case law (Pappas, 1987), and some specifically prohibit such claims (Larson, 1986; Matteson and Ivancevich, 1987).

The task at hand for protective service administrators is to differentiate between stressors that clearly are job-related and those that are not, and to intervene in job-related stressors if the symptoms grow in intensity and frequency (Dunning and Silva, 1980). Clearly, police administrators can no longer afford to ignore the issue of job stress, such as the traumatic stress of duty-related response to critical incidents, as it has become a legal obligation. Much of the research currently emerging accepts a cause-and-effect relationship between stress and many somatic illnesses. The task of administrators is to reduce liability for the legal risk associated with work place stress, specifically the stress of response to an extraordinary event outside the realm of normal or even infrequent occurrence.

A particular issue to administrators is that in workers' compensation cases the law reflects a liberal definition of work-related injury. In Wolfe v. Sibley, Lindsay and Curr Co. (1975), the court accepted the link between the mental job stressor and the subsequent psychological disability that caused incapability to function properly on the job without considering whether the job stressor caused the disability or aggravated an existing condition or vulnerability.

It should be noted that in the case of a psychological/mental injury, the courts in the past have been reluctant to compensate workers due to the difficulty in establishing either the cause or the extent of the injury (Ivancevich, Matteson, & Richards, 1985). The current advancement in research related to stress and specifically to the traumatic stressors of disaster and life-threat experience resulting in Post-Traumatic Stress Disorder (PTSD) (Mantell, Dubner & Lipon, 1985; Solomon & Horn, 1986) will, in all probability, result in compensation for a wide range of conditions related to work-related stress. Claims that are currently successful generally result in compensation for psychological injury that arises from accidents involving physical injury or death. Discrete, specifically identifiable incidents that are unrelated to the usual performance of the duties of one's job and that result in psychological injury have frequently been upheld by the courts. These claims are further advanced when the issue of psychological injury has physical manifestations. The bottom line in decisions involving workers' compensation is whether the employee should be treated differently for inability to work because of a mental injury caused by employment as compared with a physical injury caused by employment (Lublin, 1980).

If administrators accept the premise that deployment at a scene of a critical incident can result in a psychological reaction (and many don't), then efforts to initiate programs to reduce its negative effect and ensuing productivity and compensation costs must be addressed. Procedures that screen prospective employees rarely examine propensity toward stress manifestation. Such efforts would not appear to be cost-effective for most protective service agencies. Indeed, since no reliable procedures exist to measure stress other than reaction, one must look, like the court, to consideration of claims made by workers against governmental jurisdiction subsequent to a critical incident (Stratton, 1986).

Obviously, it is in the administrator's best interest to identify situations that are stressful before substantial legal liability is incurred. The present all-too-common supervisory response, ignoring lingering problems or disciplining workers exhibiting behavioral effects of trauma reaction, may prove detrimental not only to the operation of the department but to the financial well-being of the agency or governmental jurisdiction. Police administrators need to decide whether they accept the fact that sufficient evidence exists to link psychological injuries, temporary or permanent, with critical duties of the profession.

Mental injuries are just as much a consequence of critical incidents as are physical wounds. There are four categories of work-related injuries that can be compensable under workers' compensation: (1) Officers could have a physical accident leading to a physical injury (physical accident=physical injury). Physical accidents are easily understood. A police officer is shot and receives extensive leg injuries. These physical injuries are generally visible and documentable. Broken legs produce x-rays that can be viewed to document not only the injury but the course of treatment necessary for recovery. Obviously, this is the easiest of the workers' compensation cases to prove.

The next type that could also occur from the same critical incident might be (2) physical accident leading to mental injury (Physical accident=mental injury); that is an officer is shot and wounded, comprising the physical accident. The officer may develop an accompanying mental injury as well as the physical damage. For example, the officer may become phobic, be afraid to work in the same area again or on a similar call, refuse to work with the same equipment or until new gear is forthcoming, become very depressed about physical limitations, experience unresolved chronic pain, or be forced to take leave. People can generally understand and accept the premise that mind and body interact, one causing the other harm. Since the mental injury is an extension of, and an addendum to, a qualifying physical condition, there is not as much resistance to acceptance.

It is also understood to a certain extent that (3) a mental accident can lead to a physical injury (mental accident=physical injury); that is, something that did not involve broken bones, blood, or torn flesh but is a mental accident on the job, such as being shot at but not hit, may be a mental accident. We generally accept that a resulting physical injury like ulcers, heart attack, or dermatological reaction might result from such mental stress. We accept this because the hives are measurable or an ulcer is documentable; that is, we can examine the skin or can conduct a GI barium test and produce an x-ray that substantiates that an injury

exists. Physical damage that is documentable and affects work performance is hard to ignore, yet the mental accident must be of an unusual and dramatic nature to invoke acceptance for job-relatedness.

The most difficult injury, the one that is the least understood and for which there is the most resistance (in fact, a few states do not allow such claims under workers' compensation), (4) is a mental-mental; that is a mental accident leading to a mental injury (Mental accident=mental injury). For example, an officer shoots and kills someone, is himself or herself not injured, and develops Posttraumatic Stress Disorder (PTSD). Shooting someone is a mental accident that is outside the common police experience. When you shoot at someone, or worse, take the life of someone even if they are threatening you, this is an unusual event even for police officers. People increasingly understand this as being a mental accident--that guilt, anxiety, and depression may lead to the mental injury of PTSD, clinical depression, anxiety or panic attacks, or phobic reactions. The problem with administrators comes back to measurement--since we cannot x-ray it, we cannot hook someone up to an EEG, how do you know the worker really has an injury? It is this type of case that causes police administrators to take pause to consider the ramifications of acknowledging the existence of job-related mental injuries. The lack of acceptance for psychological measures of mental injuries as being too easily faked or hard to verify cause denial of job-connectedness (see also Stratton, 1986).

CONFIDENTIALITY AND IMMUNITY FROM LIABILITY

One concern frequently expressed by police administrators is that any formally recognized program aimed at mitigating critical incident stress, such as debriefs, might result in witnessed statements that could be construed as admissions of wrongdoing, either through negligent or intentional actions, on the part of an officer. Since the majority of critical incidents involve departmental, administrative, civil tort, and/or criminal review, any statement made in front of an unprotected witness may be introduced to the appropriate authorities. Official programs such as peer support intervention or debriefing provide the opportunity for such statements to be made at a critical point in the investigation and resolution of the incident. The normal admonition in situations where officer culpability is involved is to refrain from speaking about the incident to anyone other than the investigators and then only with advice of counsel. Such a warning is intended to reduce the likelihood that the officer(s) would make incriminating statements that could be used against them or the department in a court of law. Since guilt is a common factor in critical incident response, it would not be unusual for the officer to blame himself or herself for the outcome of the event. "If only..." and "I should have..." are frequently expressed comments after a traumatic incident. Rather than being construed as **survivor's guilt**, a mental injury, others may accept such statements as admissions of wrongdoing. Yet ventilation is recognized as one of the basic tenets of any critical incident debriefing process (Wagner, 1979a, 1979b; Bergmann & Queen, 1986a, 1986b, 1986c). Attention must be given to allow the therapeutic process to proceed with the constraints of liability and confidentiality.

Police officers are required by state law and departmental rules and regulations to report all knowledge of the possible criminal acts--felony and misdemeanor--of coworkers. Specific obligations in many jurisdictions place a heavy burden on officers to report admissions relating to domestic violence and child abuse, two possible acts that may be related to the behavioral sequelae of posttraumatic reaction. No department can offer immunity from civil and criminal litigation, either as a defendant or as witness, to police officers participating as social support, intervention, or debrief role in posttraumatic psychological treatment unless that officer is protected under certification laws in state statute (e.g., a licensed psychologist). Officers having such knowledge of wrongdoing can be called to testify at departmental hearings, administrative reviews, and in civil and criminal proceedings concerning statements heard postincident. This breach of confidentiality has caused the rejection of numerous intervention programs by administrators and officers alike. The utilization of protected professions with statutorily guaranteed confidentiality and the admission of vulnerability of the traumatized officer are frequent methods of addressing this concern.

BUDGETARY IMPACT OF CRITICAL INCIDENT STRESS

Early identification of symptomatology of critical incident stress and prompt intervention can result in significant employer savings in reduced disability and early retirement claims, decreased absenteeism, trauma-related medical costs, and litigation (Friedman, Framer & Shearer, 1988). The costs attributable to critical incident stress in terms of reduced productivity, inattention to duty, poor decision making, intrusive or avoidant behaviors, over- or underreaction, hypervigilance and exaggerated startle response, memory impairment, and concentration difficulties--all characteristic of sequelae of posttrauma--are incalculable (Gilmartin, 1986). Freidman, et al. (1988) report that the Barrington Psychiatric Center in Los Angeles estimated that the average cost of intervention/relief with cases in which PTSD was detected soon after the traumatic event totaled $8,300 per victim, whereas the average cost of cases in which detection and treatment were delayed amounted to almost $46,000. In addition, employees who received prompt treatment averaged 12 weeks of recovery before returning to work and had a low incidence of permanent disability as compared with 46 weeks in the delayed treatment groups who showed significant long-term effects. These figures represent costs in which employees, in fact, developed PTSD subsequent to a traumatic work event and are not representative of the dollars spent where less serious sequelae was evidenced. The costs of the intervention program must also be computed over the number of victim-survivor employees who did not develop PTSD as the result of the treatment approach. Clearly, the expense of a few sessions for all involved, especially if conducted as a group, would be significantly less than long-term treatment and/or disability leave of a significantly involved few. A proactive approach to preventive intervention would appear to be less costly in the short run than to wait until mental injuries fester to the point at which personal and occupational life suffers.

Many administrators express reluctance to inform their employees of the employer's fiscal responsibility under workers' compensation, fearing a deluge of claims by assumed malingerers. Anger, one common by-product of critical incident participation, often gets displaced from the instigator or perpetrator of the crisis to the employer. The result of that anger can be seeking redress either through legal recourse or through contractual demands (e.g., workers' compensation claims, mandated equipment or procedures, or suits alleging negligence). Mantell, Dubner, and Lipon (1985) report, however, that the number of stress disability claims by San Diego officers was significantly reduced after the San Ysidro McDonald's massacre, in which immediate intervention programs were implemented, compared to retirements resulting from deployment stress injuries following the PSA air crash in 1978. Clearly, the costs of peer support programs, debriefs, and counseling for all workers involved in or deployed at critical incidents should be more cost-effective for the police organization. It is not just workers' compensation claims, disability, retirement, and absenteeism that should be of financial concern to the administrator, but also the legal responsibilities relating to impaired job functioning as a result of an employee posttraumatic sequelae.

Administrators are also fearful that the cost of preventive and rehabilitative programs will prove prohibitive for the organization. It is assumed that mental injuries require the services of highly paid mental health professionals and will generally require lengthy treatment. That is not the case. Rarely do officers experience traumatic reactions that require the intervention of a mental health professional, with most symptoms fading on their own. In the few studies that exist regarding effective coping skills, peer support appears to provide the treatment of choice for traumatic sequelae (Diskin, Goldstein, & Grencik, 1977; McCammon, Durham, Wilkinson, & Allison, 1989). Commitments of officer time and training resources to developing effective Peer Officer Support Teams (POST) seem to be a cost-effective alternative to the more expensive resources of a consulting or on-staff counseling staff (Klyver, 1986; Linden and Klein, 1986). Those cases that do require professional intervention can be handled through private insurance or workers' compensation reimbursement, depending upon the election of the distressed officer(s). That is not to say that the services of a contracted mental health professional or agency or the establishment of an in-house counseling staff is not beneficial to the resolution of traumatic stress. Such personnel could not only treat those officers requiring intervention, but could also participate in debriefing subsequent to the critical incident. Intervention programs do not need to be elaborate or expensive and, if well-constructed, should not interfere with the ongoing operation of the police department (Dunning, 1988). As with physical injuries, the legal

requirement of the police department is to make available money and time for rehabilitative sessions. It is not required to provide those programs, but many departments have found it budgetarily and administratively wise to do so.

LIABILITY AND PERFORMANCE

Mental injuries associated with traumatic incidents frequently result in behavioral manifestations. Alcohol and drug usage, sleep disturbances, flashbacks, hypervigilance, exaggerated startle response, dampened affect, and impairment of concentration and memory associated with posttraumatic reactivity could conceivably have a detrimental effect on officer work performance subsequent to a critical incident. Administrators who choose to ignore the psychological aftereffects of critical incidents in officers under their command risk suits alleging negligent supervision, retention, or training if mental injuries of officers contribute to work actions that injure citizens. Even if the supervisor is unaware of specific individual mental injuries and accompanying behavioral manifestations, an argument could be made that the department should have known of the potential for such situations given that officer's previous involvement in a work-related critical incident. Putting officers back out on the streets after a shooting, without intervention or assessment for mental injury, may expose the organization to liability.

Conversely, intervention in the form of disciplinary acts aimed at behaviors (e.g., alcohol usage) clearly prohibited by departmental rules and regulations, but indicative of the symptomatology of a mental injury due to a work-related incident, may precipitate jurisdictional responsibility for treatment, requirement of work-related disability leave or retirement, or countersuit by the officer. If a department cannot discipline an officer shot in the leg in the course of duty for not subsequently carrying out law enforcement duties in accordance with departmental regulations, so too might work-related mental injuries that impair job functioning be protected. The responsibility of any police department is to field a corps of police officers both physically and mentally fit for police work. The obligation of the department to those officers is to do everything reasonably within its power to provide--with some obvious constraints--training, equipment, manpower, and procedures to ensure both the physical and mental safety.

CONCLUSION

The most important aspect of critical incident recovery management is organizational understanding that police occupational duty can result in psychological/mental injury. The first step in intervention strategies is for police departments to determine the extent to which the organization is willing to program itself to mitigate the potentially deleterious psychological effects of critical incident deployment on officers and the department. Intervention requires that police departments be proactive in developing a critical incident stress response, treating the likelihood of the incidence of psychological injury with the same concern currently expressed for physical safety and physical injury. Reactive measures--POST and debrief response--should be examined in the light of what the organization wishes to accomplish--the prevention or rehabilitation of duty-incurred mental injury. The financial implications of work-related mental injuries points to the need for police administrators to act to prepare for incidents of psychological injuries among workers. This not only represents sound management practice, but has legal and ethical implications as well. Awareness of the legal implications of job-related stress can help administrators initiate intervention programs that can reduce compensation costs, bad relations, and potentially divisive litigation. Matteson and Ivancevich (1987) suggest management strategies involving preventive planning, stress diagnosis, program evaluation, and documentation can significantly reduce an organization's liability.

At the very least, efforts should be made by police agencies to mitigate the occurrence of critical incident stress and ameliorate the traumatic sequelae in deployed police officers. Programs that result from preincident commitment on the part of police administrators would seem to have a greater chance of preventing and rehabilitating mental injuries in police officers involved in critical incidents. The department must assume

responsibility for analyzing tasks and training in relation to the psychological effects of critical incidents, for planning and implementing policies and procedures related to deployment and supervision, and for creating or linking with mental health delivery systems to facilitate mental injury rehabilitation. The goal of a good critical incident stress program is first to prevent duty-incurred mental injuries. But if they occur, the police department has a clear responsibility to the worker to assist in recovery.

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CRITICAL INCIDENT TRAUMA TREATMENT OF AN OFFICER/SON OF A SLAIN OFFICER

Charles R. Fisher, Ph.D.

A body of knowledge is developing relative to crisis intervention, trauma treatment, and therapeutic follow-up for surviving family and colleagues of law enforcement officers killed in the line of duty. A national organization, Concerns of Police Survivors (COPS) has evolved that addresses the unique needs of family members coping with the loss of an officer family member. Given that it is not unusual for children of law enforcement officers to themselves pursue a law enforcement career, this paper focuses on that situation involving intervention with an officer/son of a slain officer father, the premise being that unique intervention may be required when working with a surviving family member who is also a law enforcement officer. In my experience, an officer relative of a slain officer finds it imperative to look at the traumatic event through the eyes of a police officer from his unique experience and training. He will generally require more data from his unique perspective as compared to a non-law-enforcement family survivor.

In my opinion, as a general rule, surviving family and colleagues will question and pursue only that degree of specific data that they are prepared to deal with and that they are emotionally capable of handling at different points in time following a traumatic death. Traumatized survivors will usually ask only those questions for which they are emotionally ready to hear, and cope with, the answers. Therefore, it is important not to provide more detail before the survivor is emotionally capable of dealing with it, as it can be overwhelming if dealt with en masse and prematurely. I believe it is beneficial to allow the surviving family member or colleague to set the pace, timing, and level of detail dealt with at the outset of therapeutic intervention as well as during subsequent follow-up. Allowing the survivors to control the pace and depth of the process during any given session allows them to consciously or unconsciously set their emotional "rheostat" for that level of pain they can tolerate at any particular time. This may be accomplished by suggesting the survivors express any questions they may have surrounding the traumatic incident, some of which may never be answerable, or the answers to which may only be reasonably hypothesized.

The following is a brief case history: On December 26, 1988, the day after Christmas, a 50-year-old, 20-year veteran sergeant of a metropolitan area sheriff's department responded to a family disturbance with two other deputies. They were met at the door by the husband and allowed to enter, whereupon the sergeant directed one of the other two deputies to cross the street to the neighbor's and interview the wife who had initiated the call via the husband's alcohol counselor. When the entering officers requested identification, the husband reached behind him and pulled a .25-caliber semiautomatic handgun and opened fire on the two officers, killing the sergeant and wounding the deputy, who subsequently shot and killed the suspect.

The sergeant's son was an eight-year veteran officer and himself a sergeant in a smaller neighboring metropolitan police department. He had once worked in another department and knew the deputy who was wounded when his father was killed. The son was off duty at the time his father was shot and, upon receiving a phone call from a friend that his father had been shot, he monitored the rescue and ambulance activity on his home scanner before leaving for the hospital.

In subsequent intervention with the surviving officer/son, at his request, it was determined that he had specific and unique needs in handling his father's death that arose from the fact that he himself was a police officer. It had been helpful to him to interview the emergency room physician and thereby determine that death had been virtually instantaneous. In later sessions, he went over the scene in minute detail to validate that his father probably never knew what had happened, that he had not suffered, and had in fact died instantly. As an officer, he felt it necessary to go to the scene and study it on more than one occasion.

During the ongoing sessions with the officer/son, it was arranged for him to go through the entire case file accumulated from the traumatic incident, excluding the autopsy data and photographs. Regarding the autopsy material--he requested official reassurance that all data and photographs would be handled discreetly and delicately within his father's department, being aware that his father's colleagues might exhibit unnecessary curiosity. The department psychologist had been thoroughly briefed relative to the traumatic incident and had been involved individually and in small groups in the debriefing of all departmental personnel. The entire case file was covered in detail by the officer/son with the psychologist, followed by discussion of salient points and new information.

With the consent of the officers involved, meetings were arranged with the other two officers that were at the scene as well as with the coordinator of the peer support team who had attempted CPR with his father en route to the hospital. It was important to this officer/son to listen to the incident from these other officers who were at the scene. The incident itself had been handled well by all officers involved and there was no question that they had all performed appropriately. The surviving officer/son at no time had any doubts on this point--which could have complicated the process. He himself, as a son and police officer, needed to know as much about his father's last moments as he was aware other officers knew. He was not comfortable knowing that other officers knew more about his father's death than he did. It was also important for him to listen to the audiotape of the call and the ensuing emergency response to the shooting.

As he became increasingly able to adjust to the trauma, he became more comfortable being able to talk about his father having been murdered as opposed to simply having died. As an officer himself, he was concerned about his ability to handle family disturbance calls without undue anxiety, and that his officer colleagues might question his ability handling the type of call that had led to his father's murder. Subsequent exposure to family disturbance calls, with attentive cover provided by his team colleagues out of their concern for him, satisfied all of them that he had no difficulties in that area. He was also concerned about colleagues expecting him to leave his law enforcement career. For a brief time, he requested reassignment from graveyard shift because it was traditionally a slow shift and there was not enough activity to prevent him from being preoccupied about the murder.

Had the murderer not died in the incident, it would have been necessary to follow through over time and focus on the officer/son's reactions to the judicial/legal process and feelings about subsequent sentencing, which has been known to test most officers' dedication to their careers.

The above case history has been cited as an example of the unique process that can ensue when working with a survivor/officer whose parent, sibling, spouse, or child has died in the line of duty as an officer. It is presented as an option for intervention in specific individual cases where the department psychologist or therapist believes it to be appropriate and not as a process to be applied in all similar situations.

POLICE STRESS RESPONSE TO A CIVILIAN AIRCRAFT DISASTER

William A. Foreman, M.A.

ABSTRACT

Early work on critical incident stress in law enforcement has focused on postshooting trauma. Such incidents are highly distressing for the involved personnel and their families. The effects are further compounded when an officer is injured or killed. Agencies have developed a variety of responses when their personnel have been involved in a shooting. This paper discusses findings from a civilian air crash disaster. A light plane crashed into a shopping mall at Christmas time (7 people were killed and over 80 burned). Of the 17 responding officers, 14 were reviewed at 6 months and 7 at 12 and 18 months. Similarity of this traumatic incident to postshooting trauma will widen the understanding of stress in police work. Findings suggest areas for further study.

INTRODUCTION

This paper explores selected reactions found among law enforcement personnel after responding to a civilian plane crash. Partial results are reported from a fuller study that includes civilian survivors. Results are consistent with other disaster studies and suggest directions for further study. The design is limited and lacks robustness. The literature of posttraumatic stress disorder (PTSD) is reviewed for features and issues that may be pertinent to law enforcement agencies. The literature regarding traumatic stress reactions is reviewed with respect to a relationship with PTSD.

THE STRESS RESPONSE

The stress response, as first defined by Selye (1976), occurs in the presence of an immediate or perceived threat. This autonomic physiological state of arousal prepares the body to survive injury, and enables the individual to either run or fight. There are stereotypic psychological reactions that occur either simultaneously with, or in reaction to, the physiological response. These psychological reactions distort perceptions and sensations and alter emotional and thought processes.

Job stress and burnout in law enforcement, as described by Mitchell (1981), Fishkin (1988), O'Neil (1986), and others, can be seen as distinct from the stress reactions of critical incidents where actual threats and dangers are immediately apparent. Certainly in police work there are those situations that require adrenalin and singleness of purpose provided by the stress response.

POSTSHOOTING TRAUMA

Postshooting trauma has been recognized by the law enforcement community, with Solomon and Horn (1986) suggesting specific intervention to reduce the stress reactions and maintain officer effectiveness. An officer can be distressed by exposure to danger or actual harm to self or co-workers. Even when all procedures were followed and the shooting of another human unavoidable, the officer can continue to have disturbing reactions. Observing the victims of a gunman can be just as disturbing, especially, as pointed out by Mantell (1986), when the setting or victims are reminiscent of one's own family.

TRAUMATIC STRESS

There are other incidents that are just as charged and also may initiate reactions that seem to develop a life of their own. These have led to the description of "Critical Incident Stress" as a specific response with expected patterns of reactions. Mantell (1988) and Solomon (1988) have described these as "normal reactions to an abnormal situation." Critical incidents can be endlessly replayed and reexperienced. Seeking effective assistance may be prevented by the officer's concern with these reactions. Normalizing these reactions can be crucial to reducing critical incident stress. Such reframing gives a certain predictability to the reactions and assists the officer to regain control of his life.

Critical incident stress can be distinguished from "job stress" by the actual encounter with a horrible or threatening situation. Training and experience can develop mechanisms that allow officers to handle most situations with the necessary professional detachment. Such calm, cool, and collected demeanor can be breached by a life-threatening situation or by a particularly terrifying incident. The critical incident stress reactions may not end with the shift and may emerge much later.

At five months following rescue work and body recovery, Wilkinson (1983) found a significant number of personnel continued to experience guilt and anger. Acute, chronic, recurrent, and delayed PTSD were found by McFarlane (1988a) in a 29-month follow-up study of fire fighters involved in an exceptionally destructive brush fire. These reports show that individuals can be deeply affected by either personal or community loss.

Taylor and Frazer (1982) evaluated those charged with recovering and identifying human body parts from a plane crash and found that, for up to 20 months, individuals can have seriously disturbed sleep and appetite, as well as social relationships. Jones (1985) found among those recovering bodies a greater identification with the victims. The normal defenses of detachment and denial can be overcome by identification with, or degree of exposure to, the victims.

POSTTRAUMATIC STRESS DISORDER

Unless critical incident stress is lessened, Posttraumatic Stress Disorder (PTSD) may develop as a debilitating chronic condition. Horowitz, Wilner, Kaltreider, and Alvarez (1986) describe PTSD as a psychological reaction to an extreme stressor that, at best, may take years to fully resolve.

PTSD symptoms have long been associated with disaster and war trauma. Mendelson (1987) describes the long evolution of the current understanding of the emotional and behavioral reactions secondary to war and disaster. Goodwin (1987) has republished his early work that defined PTSD among Vietnam veterans. A good measure of the current knowledge continues to come from work with veterans. PTSD was standardized with its inclusion in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (APA, 1980). Although part of the legacy of Vietnam, PTSD is not viewed as unique to that war; it is recognized as a long-standing and pervasive disorder caused by exposure to human tragedy.

This disorder can become a personal tragedy as it becomes disruptive and chronic in the officer's life. Ybarrondo (1988) states that a department that responds to a horrible disaster, which includes burned or dismembered women and children, might expect to lose more than 20% of the responding personnel over the next three to five years.

SOCIAL SUPPORT

Social support has been viewed by Kulka et al. (1987) as an important distinguishing factor in the prevalence of PTSD among combat veterans returning from Southeast Asia. Keane, Scott, Chavoya,

Lamparski, and Fairbank (1985) stress the importance of social support in resolving PTSD. Emotional debriefing after critical incidents is, in part, meant to open communication about reactions to allow expressions of support and discussion of coping strategies. The acceptance of a peer group is important to the individual's sense of self-worth. In PTSD, the individual's reaction to the symptoms is often an important barrier to overcome. An officer's first experience of these reactions can cause concern about his/her own sanity. Families and fellow officers require training, as their reactions can prove crucial to the resolution of PTSD.

FAMILY REACTIONS

Following a shooting at the San Ysidro McDonald's restaurant, Mantell (1988) found a wide range of reactions to extend to other personnel and family members. In studying the same incident, Hough et al. (1986) looked beyond those immediately involved in the tragedy, finding seriously disturbing reactions across the local community. Clearly, PTSD symptoms can be found among personnel who were not directly involved and perhaps not on duty at the time of the incident. Mantell (1986) includes family members as having to deal with the reactions of their loved one and with their own reactions.

Troubled police families have been described by Reese (1982), Ribbins (1986), and Stratton (1975) as having issues and patterns of behavior similar to those found among families of those with PTSD. Family patterns of low expressiveness, low cohesiveness, and high conflict were associated by Solomon, Mikulciner, Freid, and Wosner (1987) with high rates of PTSD. Others have noted how other disasters have affected families. McFarlane (1987) found increased levels of irritability, conflict, and withdrawal within families. Erikson (1976) found after the Buffalo Creek flood a loss of communality, demoralization, and increased divorce rate. DeFazio and Pascucci (1984) describe how spouses can become enmeshed in PTSD symptoms. Families can become dysfunctional as described by Verbosky and Ryan (1988). Similar reactions were identified by Coughlan and Parkin (1986) among the women partners of Vietnam veterans.

INTERGENERATIONAL TRANSMISSION

The birth of a child can stimulate a crisis during which reemergent PTSD interferes with closeness in family relations, as found by Haley (1984). Children are shaped by their environment, and "secondary traumatization," as termed by Rosenbeck (1986), can develop among the children of those suffering PTSD. Sigal, DiNicola, and Buonvino (1988) describe this condition among the children and grandchildren of Holocaust survivors.

Although child abuse may be a cause of intergenerational transmission of PTSD, it is not a necessary factor. Brett, Holland-Brett, and Shaw (1986) observed PTSD symptoms in children of Vietnam veterans and did not find significantly high levels of domestic violence or other trauma. Solomon, Kotler, and Mikulincer (1988) investigated wounded Israeli combat veterans and found a significantly increased likelihood of PTSD among those who were children of Holocaust survivors.

DISCUSSION

The possible consequences of PTSD and its ripple effect through a community of people raises concerns for law enforcement beyond the reactions of an individual. Terror is highly personalized, but the effect can be widespread. Given the range of expected disruption by PTSD, law enforcement must take measures to put programs in place to respond to critical incident stress. In a three-year follow-up to a collision at sea, Hoiberg and McCaughey (1984) reported those who stayed on the ship showed less emotional disturbance than those who were removed during the early evacuation. Completion of the mission and peer support may assist recovery from traumatic stress reactions.

Williams (1987) concludes that immediate debriefing and short-term counseling with trained professionals can reduce and manage the PTSD symptoms as evidenced by less than expected disability and workers' compensation claims. Following a workplace trauma, agencies may find disrupted routine and lowered productivity. As the Veterans Administration has experienced, there is a tendency for traumatized people to develop strong transference of resentment and rage onto those in charge and the organization (Williams, 1986; Parson, 1986). Specific and early intervention after the critical incident can diminish, or prevent, the potentially devastating effects of PTSD. Understanding the nature of PTSD will lead to more effective training and creation of early intervention programs.

THE SUN VALLEY STUDY

The Incident

Monday night, two days before Christmas in 1985, over 50,000 people were shopping inside the Sun Valley Mall in Concord, California. A Beechcraft with three people on board had veered slightly off course while on its final approach to Buchanan Field. The pilot had routinely flown in and out of this airport over the past 20 years; he had more than 50 years of flying experience. Santa Claus had been placed in a small plaza where shoppers could look down through a second floor well and watch him talk to young children. Suddenly, the Christmas music was lost to the sound of ripping sheet metal. The light plane had hit directly above the well.

Flaming aviation fuel and melted roof tar spilled onto shoppers on both levels and on the adjacent escalators. Seven people died, and over 80 people were taken to hospitals throughout the Bay area. The last of the survivors were en route to hospitals within 14 minutes of the initial call.

This incident was sudden, unexpected, and particularly tragic in its scope of sheer horror. Images and reactions continue to disturb the survivors. A significant number of police and fire responders were deeply affected by the carnage they witnessed. Of course, other situations and critical incidents occurred before and after the crash that have added to the stress and distress of personnel (and compound this study).

Methodology

This was a panel study that surveyed reactions among survivors and rescue workers following the Sun Valley Mall disaster. Data were gathered at periods of 6 months, 12 months, and 18 months postincident. The survey materials consisted of a cover letter, a demographic sheet, and two questionnaires. The sample size was small and will present limitations on the ability to draw significant inferences. Multivariant analysis will be performed by an independent statistician.

Instruments

A 29-item demographic and symptom-specific questionnaire was developed to round out information sought by other instruments and provided demographic information for independent variable analysis. Most of these questions allowed for multiple answers.

The Impact of Event Scale (IES) provided by Horowitz, Wilner, and Alvarez (1979) has been validated in a variety of cross-cultural trauma studies. Results of this study were related to control and subject groups reported in the literature. Comparisons were made for between-group differences and for independent variables within groups.

The Life Event Scale (LES) was provided by Horowitz, Schaefer, Hiroto, Wilner, and Levin (1977). Comparisons were made of preevent and postevent cumulative stress for within- and between-group differences. This measure was to establish preevent life stress differences.

Subjects

Shoppers are all those who identified themselves as such, even if they were off-duty police, fire, or mall employees. For the most part these were people very close to the crash site. **Police** are those who responded or were already on the scene and may have included mall security. **Fire personnel** are those who responded to the scene. **Mall employees** were working (not shopping on break) that night and were at varying distances from the crash.

Control Groups

No unaffected subjects were sought for a control group. Thought was given to this inherent shortcoming. Other officers in this department could have served as a control group, although they could have been affected, as this happened in their community. The alternative will be to compare groups whose members did nor did not possess a specific condition (e.g. did or did not receive counseling).

Independent Variables

A review of cited literature suggests the following as important independent variables: Age, race, economic status, religion, support system, proximity to danger, injury or death to self or companions, and loss of property. Immediate reaction to the danger and having a role to assume during the danger were thought to be important indicators.

Results

Of the 14 officers who responded to this plane crash, 13 (93%) returned questionnaires at 6 months, 7 (50%) at 12 months, and 7 (50%) at 18 months. Below are the reported reactions.

Reactions

Reactions Related to Incident

Reactions	Months 6	12	18
returned to the mall	1.17	1.17	2.0
stayed home	0.17	0.33	0.29
startled	0.33	1.67	1.43
skipped usual activities	0.58	0.67	0.43
kept distant from others	0.25	0.83	0.71
felt guilty	0.83	1.0	1.57
had poor concentration	0.67	1.17	0.86
used alcohol/drugs	0.08	0.0	0.0

The data were weighted from 0 to 5, such that "1" would read "for several days in the past month," "3" would read "for several weeks in the past month," and "5" would read "still continues to occur."

"I returned to the mall within: " was quite distinctive for groups other than the police. Although there may be some avoidance of the crash scene at 12 months, which was Christmas time, more time at the mall would be expected at the 12-month point than at the others.

"I stayed home: " does not seem to be an issue for this group.

"I startled easily for: " This clearly is markedly pronounced for this group at 12 and 18 months. Such reaction might be due to heightened anxiety or hypervigilance.

"I skipped usual activities for: " Although the average response was not pronounced, this could indicate disrupted routines.

"I kept distant from others for: " This could show further isolation and disruption of routine.

"I felt guilty: " This suggests some degree of "survivor guilt" persisted over the 18 months. These officers responded after the plane crashed and yet express guilt.

"I had poor concentration: " This seems to be an important feature at each measure. Other reactions and symptoms may well interfere with concentration.

"I used alcohol or drugs for: " was not an issue for this group and is taken as valid given the seeming honesty of other answers. Counseling experience with survivors of this disaster has indicated that substance use is not an issue during acute PTSD, as it becomes a hinderance to self-control and suppression of feelings.

The 12-month reactions are the strongest overall and may represent an anniversary reaction, or that defenses became overwhelmed between the 6- and 12-month measures. The relatively high level of expressed guilt persists through the 18-month study and is of special concern, as "survivor guilt" is often associated with chronic PTSD.

Support Network

With Whom Incident was Discussed

	Months 6	12	18
	Discussed with (helped by)		
Counselor	29 (24.5)	59 (42)	0 (42)
Physician	10 (10)	0 (0)	0 (0)
Family	46 (46)	42 (42)	42 (42)
Friends	56 (38)	42 (42)	71 (58)
Clergy	0 (0)	0 (0)	0 (0)
Stranger	0 (0)	0 (0)	0 (0)
No one	0 (10)	13 (13)	13 (0)

Support had been sought by all officers in the 6-month measure. This question was worded such that these would have been made within the past month at each measure. By the 12- and 18-month measures, 13% stated they had talked to no one. Counselors and friends were not found to be as consistently supportive as were the families. Unfortunately, friends and co-workers were not distinguished from one another.

Interestingly, counselors, although not talked with at 18 months, were viewed as having been supportive by 42% of the respondents. This gives hope that counselor effectiveness can have a delayed and continuing impact. Note those who felt they were helped by no one. This is a profoundly disturbing statement.

Impact of Event Scale

The responses to the IES provided average scores of 26.2 at 6 months, 29.6 at 12 months, and 19.2 at 18 months. These are well within the range of, and consistent with, results found in other studies. Horowitz et al. (1979), in describing the IES, found traumatic stress clients, upon entering therapy, had a mean score of 43.7, and after treatment these clients had a mean score of 24.3; in contrast, medical students, one week after witnessing their first autopsy, had a mean score of 9.8. McFarlane (1988b) used the IES and found the mean scores (range 13.1 to 33.4) to have a positive correlation to the severity of PTSD. In this study, the mean scores are elevated with some apparent decline at 18 months.

Posttraumatic Stress Disorder

The survey was designed with the intent to elicit symptoms of PTSD as found in the DSM–III. These questions did not lend themselves to a full coverage of the diagnostic symptoms as found in the revised DSM–III. The earlier diagnostic criteria are used here and do not represent much deviation from the revised diagnosis. The following discussion of PTSD symptoms sufficient for meeting the DSM–III criteria is not intending to represent these findings as clinically diagnosed.

The "percentages" are used to indicate the proportion of respondents in a given condition who report sufficient symptoms to fulfill the criteria for PTSD. Severity of symptoms is presented as mean score derived from the severity of the reported symptoms. Actual clinical assessments would be preferred.

Percentage Reporting Sufficient Symptoms for PTSD

Months					
6		12		18	
%	mean	%	mean	%	mean
50	37.5	71	35.9	43	46.0

PTSD symptoms were reported in the surveys and constitute an important finding. Surveys assume to some extent that those not returning responses are somewhat represented by those who do return responses. Nevertheless, if for the 12– and 18–month measures those who did not return responses were symptom free, the percentages would be 35.5 and 23.0, respectively.

A higher percentage is reported at 12 months, yet the mean score is higher at 18 months. This may show that those suffering symptoms become more distressed over time. The percentages above are very high in respect to the population average suggested by Helzer, Robins, and McEvoy (1987), who found in a financially stable community that had not experienced a disaster in recent memory, the level of PTSD was 1%. Kulka et al. (1987) report PTSD level of 15% among combat veterans 15 to 20 years after leaving Vietnam.

Variables Related to PTSD

The development of PTSD and severity of symptoms have been found to be correlated to aspects of the trauma. In this study, some of the independent variables to be studied are: whether significant others were killed or injured; whether separated from companions; proximity to the crash; and whether the role was active or passive involvement in the disaster.

The 12-month measure seems to indicate that someone who felt in danger or was separated from co-workers might have strong reactions at the anniversary, or alternately, their defenses have worn down. An important observation is that someone who felt terrified might expect to have strong reactions that continue across time. Terror is a highly personalized experience and can be viewed as a perception of internal danger.

Percentage Reporting Sufficient Symptoms for PTSD

	Months		
	6	12	18
in danger	60	100	50
terrified	100	100	100
separated	30	100	100

Social Support

Social support has been negatively correlated with the severity and persistence of PTSD among returning veterans. This study included a number of variables that relate different forms of support. A significant distinction at the 18-month measure shows that those who felt supported by family or friends had a mean score of 28.1, whereas those who did not feel supported by family or friends had a mean score of 49.9.

Counseling

Percentage Reporting Sufficient Symptoms for PTSD

	Months		
	6	12	18
0	50	30	60
once	30	100	0
2 - 5	100	100	0
> 5	0	100	100

The most likely time to seek counseling is at approximately 12 months. Note the percentages not seeking counseling. Those seeking counseling reported sufficient symptoms for PTSD.

Survivor Guilt

Guilt was found among the respondents to this study, but not yet correlated with the independent variables. Guilt was reported by 23% at 6 months, 29% at 12 months, and 29% at 18 months. This finding was unexpected, as these officers were on duty at the time of the crash but were not in the vicinity.

Life Stress

Frequency of Life Stress Events

	preevent	Months 6	12	18
employees	6.6	5.4	7.5	10.4
shoppers	5.4	4.5	7.2	7.1
fire	7.1	2.6	n/a	3.0
police	4.9	3.0	6.0	5.0

The above table shows a significant difference ($p < .01$) between police and employees at 18 months. All other measures were not significantly different. No group expressed any greater preevent level of life stress. Preexisting high levels of stress can affect coping skills following a traumatic incident, but this is clearly not a necessary antecedent. Furthermore, it is of interest that the employees who continued to work at the mall were reporting significantly higher life stress. This has implications for workplace trauma. Future research may better explore life stress following disasters.

Media

Percentage Agreeing with Statement

	Months 12	18
Media coverage		
well done	50	29
poorly done	0	29
important	33	29
disrespectful	17	29
Media contact		
helpful	33	43
harmful	0	14
upsetting	67	43
unnecessary	0	14

The media are a part of any disaster and the results indicate a positive attitude towards news coverage. There is a potential for added trauma through media pressure and news accounts. During this disaster, the media were generally respectful and well-behaved.

Discussion

There is some reluctance to view police as susceptible to the above reactions. The "John Wayne Syndrome" has encouraged real men to just tough it out. Such an ideal is tough to maintain; still, under stress the officer must remain in control of emotional reactions. Candidates are screened for their inclination to suppress emotions in stressful situations.

To officer selection criteria Hargrave and Norborg (1986) add " . . . an extroverted, independent, guarded, controlled, assertive, secretive, authoritarian individual who is average to above intelligence and relatively free of psychopathology" (p. 35). Such individuals are not inclined to discuss fearfulness or self-doubts. They would be unlikely to admit to feelings of guilt, for fear of someone believing them guilty of something. This need to be in control at all times requires the world and people to be predictable and follow rules of probability.

In general, the evaluation of candidates attempts to select for officers who will be honest teamplayers as evidenced by traits for good social adjustment and strong group loyalty. Such a distinction separates police from thugs. The officer may be an aloof leader but remains a member of the herd. Rules of social conduct and tradition may help make the world predictable, and protection of the community becomes a personal responsibility.

The desirable characteristics that make for good officers also make them vulnerable to strong reactions to their own or another's destruction. When these characteristics are lost, so is much of the officer's effectiveness. Fear that the reactions are previously undetected flaws that no one else is experiencing can lead to isolation, irritability, and avoidance. Solomon (1988) describes training methods that acknowledge fear and its usefulness during a life-threatening situation. He encourages officers to learn to cope with their own vulnerability.

The survey solicited reactions with specific reference to this disaster and the course of symptoms are consistent with other disaster studies. Those responding to this plane crash were disturbed by its sheer horror. Kovel (1988) reported similar results from a study of police officers who responded to a plane crash in Wisconsin. The long-lasting reactions were pronounced and the officers took action to resolve their symptoms. All respondents agreed to the need for emotional debriefing for rescue workers and survivors.

Suggestions for further study:

1. Exploration of the relationship between traumatic stress and life stress or hassles.

2. Compare and distinguish the relationship of PTSD with emotional reactions during incidents (e.g. terror, fear).

3. Anniversary reactions have not been clearly shown in the research literature. It is suggested to look at a life stress or hassle index.

4. Explore outcome data for different formats of debriefing and counseling with respect to immediate and long-term traumatic stress reduction.

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AN OVERVIEW OF THE PROCESS OF PEER SUPPORT TEAM DEVELOPMENT

Officer R. A. Fuller

ABSTRACT

A Peer Support Team is an answer to providing law enforcement officers with an opportunity to receive counseling to assist them in coping with the complex stressors of the profession. There are many steps involved in the organization and initiation of a Peer Support Team including assessment of the need for this type of program, obtainment of funding, selection of a psychologist, selection of Peer Support Team members, and training of team members. A functioning Peer Support Team in the law enforcement profession can promote optimal employee performance, minimize the negative consequences of daily stress, and reduce the emotional impact of critical incidents.

INTRODUCTION

You are sitting in the squad room, the shift is over, and you have just arrested a suspect for domestic violence. The suspect is yelling and screaming and very difficult to deal with. He has brutally assaulted his wife and she has been admitted to the hospital. The sight won't leave your mind for a long time. The Sergeant is demanding the end-of-shift paperwork now! You pick up the phone and call your wife to tell her you will be late and will miss the kids' softball game. Your wife indicates that she is disgusted with your job. As you turn in your paperwork the Sergeant harps at you about the way you handled a call last week.

As you drive home the picture of the domestic violence victim runs through your mind. You pull in your driveway, the house is dark, and you curse under your breath--another night staring at the TV. You get a beer, sit down, and question why no one understands what you feel and realize how much you've changed over the years. You also realize how distant you have become from your family. The thought runs through your mind, "What do I do?"

How many times has this scenario been played across the country by thousands of officers? There is a solution to this problem and others like it that the Adams County Sheriff's Department and other departments across the country have developed to relieve this kind of employee stress. The solution is the implementation of a department Psychological Unit/Peer Support Team.

In Colorado this idea is not unique. This type of psychological support program originated in the late 1970s in the Colorado Springs Police Department. Now, in the 1980s, several major departments have similar programs. A Peer Support Program gives an officer a place to go for help and someone to talk to in strict confidence. The American Heritage Dictionary (Boyer, Harris and Soukhanov, 1983) defines peer as "one who has equal standing with another" (p. 506) and defines support as "to keep from failing during stress" (p. 683).

STEP 1: ESTABLISHING AWARENESS OF THE NEED FOR PEER SUPPORT

How do you start a program of this nature? The first step is to show a need for the program. The International Law Enforcement Stress Association (1989) states that stress kills more law enforcement officers throughout the world than do criminals. Law enforcement productivity is also severely hampered by police stress. Alcoholism, divorce, drug abuse, and suicide are additional by-products of stress. Often, stress becomes so severe that individuals internalize the stress to avoid immediate mental anguish (Adams County Sheriff's Department, 1987).

The impact of having an overstressed officer is far-reaching. It affects the officer, the coworkers, the public, arrestees, and the officer's family and significant others. It can lead to faulty decision making by the officer, disciplinary problems, excessive use of sick time, tardiness, on-the-job accidents, citizen complaints, and high officer turnover. All of these results cost the department money. The Adams County Sheriff's Department determined that it costs the department approximately $100,000 to replace a five-year veteran. Included in this figure are the costs of retraining, overtime and benefits, testing for replacement, and background investigations. In contrast, a monetary value cannot be placed on the experience and knowledge that is lost when an officer leaves the department.

In approaching police administration with the request to implement a Peer Support Program, you must show how the program will save the department money. If the program prevents one officer per year from leaving the department, approximately $100,000 may be saved. It is guaranteed that any police administrator will sit up and listen when you talk dollars and cents. Traditionally, law enforcement departments have not been humane in nature towards their employees. The implementation of a Peer Support Program within the law enforcement agency can change the department into becoming more humanistic and caring towards its employees.

What causes the stress in police work? According to Goolkasian, Geddes, and DeJong (1985), police stressors may be classified into "four categories: (1) stressors inherent in police work; (2) stressors stemming from the policies and practices of the police department itself; (3) external stressors stemming from the criminal justice system and society at large; and (4) internal stressors confronting individual officers" (p.4).

Certain critical incidents have been identified as the most stressful events in the law enforcement profession. The Adams County Sheriff's Department (1987) has defined critical incidents as, but not limited to: (a) a shooting involving injury or death; (b) the death of a fellow officer or partner; (c) an assault on an officer involving a deadly weapon; (d) an officer hostage situation; or (e) any other unusual or stressful event such as a serious or fatal automobile accident or an incident involving a family member.

A Peer Support Program can help alleviate the impact and negative consequences of stressors such as these. In addition, a Peer Support Program can reduce the law enforcement department's civil liability. A department can be subject to a lawsuit if no corrective action is taken to alleviate an officer's stress-related problems and job performance becomes impaired because of the problem.

STEP 2: SEEKING FUNDING

Following the needs assessment phase of program planning and obtaining administrative approval, the next step is to seek funding for the program. The Adams County Sheriff's Department has been funded for the past two years by the 17th Judicial District Victim and Witness Assistance and Law Enforcement (V.A.L.E.) Board. The funding was obtained by submitting a grant for $26,000 per year. The grant focused on the concepts of police officers and department employees as victims, and the provision of better public service with the maintenance of mentally healthy employees. For years it has been the focus of the V.A.L.E. Board to provide money for service providers in assisting crime victims. The Adams County Sheriff's

Department portrayed its employees as also being victims of crime and deserving of optimal resources to assist them in dealing with the emotional stress of law enforcement.

The $26,000 grant was solely for the purpose of paying the salary of a psychologist. The grant does not cover the department cost of overtime/compensation time for team members to attend monthly training meetings, office supplies, periodicals, journals, books, or outside training costs. The Adams County Sheriff's Department has figured its cost to be approximately equal to that of the grant ($26,000).

The availability of potential funding sources varies across the country. Some sources of funding may be found within the department. However, with today's budget restraints it is not always possible to fund this type of program solely from departmental sources. In a medium-sized department (300-400 employees), the cost of a Peer Support Program is approximately $50,000. One way to approach the funding problem is to solicit assistance from police officer associations such as the Fraternal Order of Police or Police Protective Associations. Another potential source of funding can be found in the private sector. Grants for community projects are frequently provided by large corporations such as Coors, Anheuser-Busch, or R. J. Reynolds. Each region of the country has different funding sources available. Investigation of the potential funding sources and application for funding is the most difficult phase in the development of a Peer Support Program.

STEP 3: SELECTING A DEPARTMENT PSYCHOLOGIST

Once the commitment for funding has been obtained, the next step in the development of a Peer Support Program is the selection of a licensed psychologist. The psychologist should possess expertise in the area of law enforcement stress. The Adams County Sheriff's Department approached this selection process with several factors in mind. The primary goal was to select a psychologist with extensive experience in dealing with law enforcement personnel and the problems associated with the profession. The psychologist must have expertise in treating posttraumatic stress disorders and be capable of overcoming the suspiciousness and distrust characteristic of law enforcement employees. The psychologist must be available 24 hours a day, 7 days a week for crisis intervention. The psychologist must also be willing to respond to any location to meet with officers as requested. Another responsibility of the psychologist is to respond to the work place and interact with employees. This serves to build a bond between the psychologist and the employees and helps to break down barriers that are present due to the cynicism of the officers.

The Adams County Sheriff's Department began its selection process by recruiting psychologists in the Denver area with law enforcement expertise. Each psychologist was asked to submit a proposal of services rendered for $26,000 per year. The final step consisted of a nontraditional, subjective oral board conducted by the Sheriff and members of the department. Following an extensive review of all the applicants, a final selection was made.

The department psychologist's duties are extensive. These responsibilities include one-on-one counseling, family therapy, crisis intervention, group therapy, critical incident debriefings, suicide crisis intervention, and substance abuse counseling. In addition, the police psychologist functions as a liaison between the administration and Peer Team; provides clinical review for Peer Team members; and develops and implements training for Peer Team members, command level officers, new recruits, and victim advocates.

STEP 4: SELECTING PEER TEAM COORDINATOR AND MEMBERS

Once the psychologist has been selected, the next phase involves selection of a Peer Team Coordinator and Peer Team members. A qualified Peer Team Coordinator should have a strong belief in the program, as well as counseling knowledge and well developed interpersonal communication skills. The role of a Peer Team Coordinator has been described as "a balancing act between police administration and the line staff" (W. Phillips, Denver Police Department Peer Team Coordinator, personal communication, May 1, 1989).

The Peer Team Coordinator is responsible for developing the policies and procedures to govern how the team functions. The coordinator must be knowledgeable on available resources and be capable of utilizing these resources. The coordinator must also prepare the quarterly reports informing the administration of the number of employee contacts and hours spent by the Peer Team members. Additional responsibilities include training new Peer Team members, inoculation of departmental employees regarding the Peer Team concept, presentation of departmental in-service education on stress, and availability to function as a contact person for outside agency requests.

The department psychologist and Peer Support Team Coordinator jointly develop guidelines for the selection of Peer Team members. The criteria used by the Adams County Sheriff's Department in this selection process consisted of: (a) employment within the department for a minimum of two years, (b) demonstration of a high interest in Peer Support and a genuine concern for fellow employees, (c) the capability to adhere to strict rules of confidentiality, and (d) a willingness to devote the time and energy necessary to maintain a high level of commitment to the program.

The recruitment of Peer Team applicants began by providing a brief explanation of the Peer Support Team concept to employees through briefings and training sessions. Officers were recruited on an individual basis and asked to submit a letter of interest for participation in the program. Following a review of the letter of interest, applicants were interviewed in lengthy one-on-one sessions with the psychologist, examining each applicant's qualifications, attitudes, thoughts, and feelings in relation to the Peer Team concept. Based upon this information, the final selection of members was made by the psychologist.

STEP 5: IMPLEMENTING THE PEER SUPPORT TEAM

The Adams County Sheriff's Department currently has 16 members on the Peer Support Team. The team consists of employees from the Patrol, Detective, Jail, and Administrative Divisions. There are sworn and nonsworn personnel on the team. Team members are appointed for two-year terms and are eligible for reappointment following the expiration of a term.

Training for Peer Support Team members covers many topics. New members are given an eight-hour orientation covering basic counseling skills utilizing Rogers' (1951) model of client-centered therapy, client management skills, role playing client-advisor confidentiality, assessment skills, substance abuse counseling, suicide intervention, crisis intervention, posttraumatic stress disorder, and critical incident debriefing.

Team members are required to attend monthly meetings to discuss problem areas and employees in distress. Programs, such as rap sessions for employees and mini-academies for significant others, are planned during the monthly meetings. This time may also be used to update counseling or intervention skills. Each team member develops an area of expertise and reports on this area in the monthly meeting. Specific areas include critical incident debriefing, alcoholism, suicide intervention, and community support services. In addition, the psychologist meets individually with each team member to clinically review each contact and assess each Peer Team member with regards to signs of burnout or overload.

FUNCTIONS OF THE PEER SUPPORT TEAM

One function of the Peer Support Team is to conduct training for departmental employees and significant others. In training for departmental members, the Adams County Sheriff's Department believes that pre-inoculation for stress reactions is one of the best ways to reduce the stressful effects of a critical incident (T. Williams, Psy.D., personal communication, December 1987). The department psychologist and Peer Team members conduct semiannual training within the various divisions within the department. Topics covered in this training have included normal stress reactions to critical incidents; ways to relieve stress; and support

services available to employees such as the Peer Support Team, the department psychologist, the Employee Assistance Program, and the Chaplain Program.

The department psychologist also conducts command level training for first-line officers and above. The topics covered in this training include how to identify a troubled employee and pre-inoculation stress training for traumatic incidents. This training has increased the supervisors' awareness of the effects of stress in law enforcement, limited the administrative pressure imposed on officers, and promoted success of the Peer Support Team.

The Peer Support Team has also acknowledged the needs of significant others. A mini-academy was provided for the significant others of department employees. The mini-academy is an eight-week course meeting two nights per week for two hours each night. Topics covered in the mini-academy range from a brief overview of the various functions within the department to detailed classes on police stress and interpersonal skills among family members. The Adams County Sheriff's Department has found this training for family members to be valuable in reducing the effects of job stress among employees and their families. Positive feedback from significant others attending the mini-academy has emphasized this effect. Another benefit of the first mini-academy was the formation of the Ladies Auxiliary of the Fraternal Order of Police, Lodge Number One, of the Adams County Sheriff's Department.

One role of the Adams County Peer Support Team was put into action on December 26, 1988, when the department experienced the loss of a veteran patrol Sergeant and the serious wounding of a patrol officer. Within one hour of the incident, members of the Peer Support Team, along with Dr. Chuck Fisher, the department psychologist, and Dr. Thomas Williams, a local expert in posttraumatic stress disorder, had met with officers involved in the critical incident. Within two hours of the incident, Dr. Fisher and members of the Peer Support Team had conducted a critical incident debriefing. Attendees of the debriefing included officers directly involved in the situation, dispatchers, and officers that had responded to the scene. Members of the Peer Support Team conducted phone notification to all employees of the Sheriff's Department within hours following the incident.

Dr. Fisher and Peer Support Team members attended all briefings held in the various divisions within the department for five days following the incident to provide explanations and discuss the emotional reactions to a loss of this magnitude. Members of the Peer Support Team were involved in providing support for employees and family members of employees at the funeral home. Close contact was maintained with the members of the department that were working the night the shooting occurred. Dr. Fisher spent an extensive amount of time with several officers who were directly involved in the incident. The officer that was seriously wounded was kept in close contact with Peer Support Team members by daily hospital visits.

The demands of the week following the incident were a strain on the Peer Support Team. Additional assistance was sought from the Chaplain Program and members of the Victim Advocate Program. Officers that requested a rider for their shift were accompanied by a Peer Support Team member, a chaplain, or a victim advocate volunteer. All members of the Chaplain Program and Victim Advocate Program were thoroughly briefed on critical incident stress reactions and grief counseling.

The Peer Support Team logged in excess of 300 hours during the week following the shooting. A critique of the overall response to the critical incident found the years of Peer Support Team and departmental training to be highly beneficial. In reviewing the Peer Support Team members' responses and reactions, the most common themes were burnout and exhaustion. There was a high demand placed on the Peer Support Team during this crisis, requiring the maximum use of all skills and resources, at a great personal expense to each team member. Debriefing of Peer Support Team members uncovered evidence that, during the first week following the incident, the members became overwhelmed with the caretaker role and were not allowed to experience their own emotions. It is imperative to remember that Peer Support Team members are also victims. Debriefings and close networking among team members must be maintained throughout the aftereffects of a traumatic incident.

ISSUES OF CONFIDENTIALITY

A crucial factor in the success of a Peer Support Program is the maintenance of confidentiality. Peer Support Team members use the same ethical guidelines as used by the department psychologist. These are the first eight Ethical Principles of Psychologists adopted from the American Psychological Association (1981). Confidentiality is the issue of most importance to employees working with Peer Support Team members and the department psychologist. Peer Team members must build a trusting relationship with individual members of the department. Confidentiality is openly discussed with employees during in-service training. Employees are educated to the fact that Peer Support Team members are sworn police officers with a duty to take action regarding criminal activity. Employees seeking support from the Peer Team members are informed that criminal activity, such as substance abuse or domestic violence, will be reported. An employee making an outcry for help is then aware of the consequences of revealing certain information. Peer Support Team members will support an employee through the process of reporting criminal activity. The Adams County Sheriff's Department has adopted the philosophy that officers who have violated the law and are seeking help will be dealt with on a case-by-case basis in a humane and caring manner.

The duty to warn is another issue of confidentiality requiring case-by-case examination (D'Agostino, 1986). The Peer Support Team member consults with the department psychologist and a decision will be made regarding the appropriate course of action. Options available to an officer range from reassignment to a less stressful position to taking a leave of absence. It is the employee's responsibility to request a change; however, the department psychologist will provide input into the decision. Details of the problem are not disclosed to supervisors unless consent is obtained from the employee. In severe cases, when an employee is hospitalized due to the possibility of harming himself or others, a very limited report is given to the Sheriff without revealing the details of the situation.

Neither the Peer Support Team nor the department psychologist keep detailed clinical notes. The only forms used by the Peer Support Team are contact sheets that provide information on the date of the contact, the length of time spent, and the general nature of the problem discussed (job stress, marital stress, critical incident, etc.). Peer Support Team members inform the coordinator of the number of contacts and time spent on a monthly basis. This procedure is explained to the employees in the semiannual training conducted by the department psychologist and Peer Support Team members. It is felt by the Adams County Sheriff's Department that an open approach to confidentiality procedures is an effective way to break down the barriers of distrust.

CONCLUSION

In today's complex and changing role of the law enforcement officer there is a great need for law enforcement departments to become more humane and caring towards their employees. With a program such as a Peer Support Team, the law enforcement employee has a place to turn when support or assistance is needed. The benefits of a program such as this are not only to the employee but to the employees' families, the coworkers, and the community at large.

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MODELING INOCULATION TRAINING FOR TRAUMATIC INCIDENT EXPOSURE

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ABSTRACT

Working as a law enforcement professional presupposes exposure to traumatic incidents as almost a fait accompli. Much of the focus on recovering from the severe impact of such incidents has been directed at post-trauma interventions and support processes. This is a cathartic mechanism that also attempts to rebuild coping strategies in order to functionally work through the impact of the trauma. Survivors of such occurrences indicate feeling helpless and out of control. The same elements that generate these reactions after the fact can prepare the individual to handle involvement in upcoming critical incidents. This article explores proactive preparatory measures that could offer effective strategies for coping, both during the incident and in the recovery phase. Steps to construct a functional format that is useful in the officer's environment, as well as field experiences utilizing this training model, will be discussed.

INTRODUCTION

The experience of trauma is highly predictable in the law enforcement profession. When it occurs, each officer then becomes at risk to resultant posttraumatic stress reactions.

Trauma comes in various forms. The officer, or someone with whom he or she closely identifies may be the victim of a shooting or a serious traffic accident, for example. Or the officer could be a witness, a back-up, a squad member, a friend, an acquaintance, or a family member who gets marred by the traumatic incident. Although not as obvious, we must not exclude from this discussion the near-miss incident. A brush with death, escaped by luck, often does not leave physical scars but can leave long-lasting emotional problems (Janis, 1971, Solomon & Horn, 1984).

Kreitler and Kreitler (1987) report that intense, often overwhelming, anxiety is a characteristic response to the stress of a major critical incident. How the officer interprets the situation is crucial to the degree to which his anxiety increases. These emotions can create body reactions out of proportion to the threat and cause feelings of uncertainty and helplessness.

The officer can interpret his or her physical reactions as meaning that he or she was physically overwhelmed by fear and confusion in the heat of the incident. This is further interpreted as a failure to live up to performance expectations, much like many combat veterans returning from Vietnam (Blank, 1982).

Being involved in a previous experience such as a shooting does not make the person less susceptible, but most probably more susceptible, to new traumas if the incident is not dealt with and put into perspective (Williams, 1987). This supports the indication that experience alone, left to chance, may not equip the officer to deal with future effects of a critical incident. Waiting for experience to teach may indeed prove damning by allowing officers to pick up inappropriate strategies that will leave them ill-prepared to act or recover and without the requisite variety of appropriate behavioral responses.

The trauma of a critical incident is a catastrophic event to the person experiencing it. Like any disaster, a critical incident is not a single event in a person's life, but one of a series of events through time, which include events that precede and follow other events (Melick, Logue, & Frederick, 1982).

The police community, just as any community, will adversely reverberate the effects of the interdependence of the officers and their work settings. Melick et al. further state the recovery of an individual following trauma is dependent upon several mediating variables, including the amount and quality of resources available to them in their support system. This implies that not only the recovery process and the social environment are interrelated, but also that the morale and well-being of a department can be dependent upon the ability of the officers to successfully recover after a traumatic event. The critical incident will continue to ruminate in the minds of those involved unless reality and their inner models reach accord (Horowitz, 1980). These stresses could easily result in burnout. In my law enforcement training and clinical experience over the past 23 years I have noted scores of officers who have left the profession as a result of the burnout from these stresses. Yet, developing skills and strategies to counter on-the-job trauma is most often not recognized as a major necessity in law enforcement training.

TRAINING BASIS

Mastery of a situation refers to one's perception of the event as being under control, which in turn reduces the deleterious effects of the resulting stress (Mandler, 1982). Janis (1982) argues that the most promising approach to intervening and countering the disruptive consequences of the stress from a critical incident is to prepare the officers by providing them vivid information as to what they are likely to experience during and after a critical incident while developing skills and strategies for coping.

Janis further states this inoculation process is the developing of tolerance to anticipated loss or impending crisis using preparatory information. This is accomplished by correcting faulty beliefs, reconceptualizing the threat, engaging in realistic self-persuasion about the value of protective action, and developing concepts and self-instructions to enable the person to deal effectively with setbacks.

Wagner and Gagne (1988) indicated belief systems, however they are learned, can be affected by recognizing the cause and effect between behavior and attitude. The resistance to altering beliefs may be lessened by attempting to provide evidence and allowing the listener to entertain these ideas without denying what he already knows to be true. They indicated that providing information without conclusions--by simply helping them to process these data--allows them to draw their own conclusions, taking them to discovery with minimal guidance using information about the existing state of affairs about death or shooting, for example. This is accomplished by selecting components they wish to use and obtaining feedback on how it works vis-a-vis the rules they have learned (Wagner & Gagne, 1988).

Performance issues during a traumatic incident, especially involving a combat setting, are related to the recovery issues of failure to live up to one's expectations, overwhelming fear reactions, poor judgment, and survivor's guilt (Blank, 1982). Barriers to recovery from trauma in emergency workers is their image of self-control during emergency operations, and that one must suppress anxiety and fear in order to concentrate on tasks (Hartsough, 1985). Success is also often unrealistically measured by the outcome of the incident (Hartsough, 1985).

Anchoring is the process by which an external stimulus is paired with an internal state (Van Nagel, Siudzinski, Reese & Reese, 1985). If the negative effects of the trauma are not countered by previously installed positive anchors, the negative anchors from the trauma will develop additional baggage to be dealt with in post-trauma counseling. Van der Kolk (1987) asserted that the overwhelming feelings of the original experience of helplessness can be easily triggered by sounds, smells, or situations. These anchors may often not be identified because they are forgotten or screened out with the tunnel vision frequently experienced during the event (Williams, 1987).

These small steps using positive anchors would help disconnect what Janis and Mann (1977) described as the anxiety that had been conditioned to a whole range of stimuli that form the traumatic situation. This feedback is also a mechanism for them to realize that sounds, smells, or situations easily

stimulate feelings of earlier traumatic events and the helplessness associated with the original trauma, to just the present event (van der Kolk, 1987).

Janis (1971) stated that information processing strategies lessens one's vulnerability during a traumatic event. He added that recognizing the symptomatology attached to trauma as soon as possible allows one to clarify information, interpret the situation, and consider altering their response. Another tool is the utilization of facilitative self-statements in order to create and maintain a sense of self-efficacy (Cameron & Meichenbaum, 1982) during and after the crisis situation.

In discussing factors that contribute to effective functioning, Cameron and Meichenbaum (1982) suggest that the ability to successfully negotiate stressful events in which the automatic adaptive responses are exceeded by the demand of the event can be assisted by preventative action. The prerequisites for effective coping were described as: Possessing the ability to accurately appraise the situation and one's resources to handle it, a repertoire of responses, and the capacity to deploy the appropriate response. The development of a variety of coping responses is more effective than a single coping strategy (Moos & Billings, 1982).

TRAINING DESIGN

Inoculation training may be looked at as moving a debriefing in advance of the critical event to activate some new information pathways for processing traumatic information and building some alternative pathways to add flexibility to respond to a variety of situations that may occur. Three organizing treatment goals were noted as valuable by Horowitz and Kaltreider (1979) in post-trauma therapy: Retaining a sense of self-worth, continued realistic and adaptive actions, and the framing of the traumatic event as an opportunity for additional growth and maturation.

Taylor (1983) described three components of adjustment to threatening events: (1) Understanding how to discover the meaning of the experience, (2) gaining a sense of mastery and control over the event and control over one's life, and (3) restoration of self-esteem. One of the objects of the inoculation training is to install these components in the person's repertoire prior to involvement in a critical incident rather than rebuild them as part of the debriefing process. This strategy restructures one's basic assumptions prior to the critical event, which would diminish the disorientation and resulting anxiety described by Janoff-Bulman (1985).

The object of the inoculation approach to critical incidents is to instill in the officers mastery over each occurrence. This also implies the ability to perform and meet the demands during the situation itself. The skills, techniques, and knowledge available to the officer to manage his or her emotional state appear to have a direct impact on the quality of performance (Mechanic, 1970).

Confidence increases one's chances for success (Arnold, 1970), while anxiety decreases performance (Funkenstein, Ding, & Drolette, 1957), with the anxiety state increasing as the perception of a situation is interpreted as crucial (Lazarus, 1966).

Experience in providing training of this type both at the in-service and academy level has made apparent that using the construct of performance in traumatic incidents is much more palatable to officers than dealing in terms of emotional deficiencies.

Demonstrating the correlation between the officer's emotional state and his or her ability to function makes the rationale of dealing with emotions seem more pragmatic. Since we are all emotional animals and cannot **not** experience emotions, we may as well learn to accept and deal with them.

A strong influence on this model is the treatment approach developed by Cameron and Meichenbaum (1982) to teach general coping skills that could be used under conditions of high stress. Their treatment, called Stress Inoculation Training, consisted of a conceptualization phase, a rehearsal phase, and an application

phase. Their technique has been adapted for various clinical problems and treatment formats. It is found to have direct application to inoculation training for trauma as well. Their evolved process of cognitive–behavioral coping skill training focused on conceptualization, skill acquisition and activation, rehearsal, and application phases.

The process of effective coping has been described by Cameron and Meichenbaum (1982) in terms of performance as being built on an ability to accurately appraise the environment, having an adequate repertoire of responses or skills to ongoing events, deploying appropriate responses at the appropriate time, and an efficient return to the normal after the event has passed. These prerequisites outline a strategy to work through a major trauma. A valuable outcome of this processing could best be observed in the ability to retain a sense of competence and self–worth, continued realistic adaptation to ongoing events, and frame the traumatic event as an opportunity for growth and maturation (Horowitz & Kaltreider, 1979). The search for the meaning of a critical incident and putting it into a perspective of one's responses are crucial to the coping process (Taylor, 1983; McCammon, Durham, Allison & Williamson, 1988). Together these components set the framework for the training package that provides answers as to how to prepare for trauma, how to respond to trauma, and how to recover from trauma.

Denial may reduce stress before the incident but hinder adequate coping during and after the situation (Lazarus, 1968). This type of training program may create some minor discomfort. Its effectiveness becomes evident in the face of a traumatic occurrence. The positive aspects of confronting these issues that may create worry about the existing threats is that fear is actually reduced at the point of contact (Janis, 1962). This work of worry will also allow more opportunity to develop coping strategies with which to deal with the threat (Lazarus, 1968).

TRAINING GOALS

To interact successfully with police officers depends on the ability to establish and maintain rapport (Dilts, Grinder, Bandler & DeLozier, 1980). Just as when working with traumatized victims, the presenter must adapt to the context and expectation of the police population to be effective (Garrison, 1986). Those outside the law enforcement profession often deplore the cynicism and deviance employed by officers as a coping strategy (Williams, 1987; Violanti & Marshall, 1983). Agosta and McHugh (1987) concluded that professionals should not become involved in providing services unless they can set aside their biases, prejudices, and stereotypical attitudes about the police culture. They suggest for the professionals or trainers to understand their own motives for providing this type of material: Personal healing, personal gain, or providing a service.

Presenters of this material must be able to accept themselves and their potential for victimization and aggression to congruently present an understanding model of the world (Agosta & McHugh, 1987). The officers can then accept themselves and their defense mechanisms, which have been pervasive in critical incident debriefings I have conducted over the past ten years: Their gross or sick humor, rage toward things or people that they could not control, their nonacceptance of anything less than total success in an operation, and their need to be competent. These observations were supported by Griffin (1987), Williams (1987), and McCammon et al. (1988).

The denial systems that allow police officers to dissociate from their inner feelings in order to function in a crisis also make it easy for them to discount the message that they need to prepare for a trauma occurring to them. The effectiveness of the training they receive depends upon the officers' perception of the magnitude of the threat, the probability of trauma actually occurring to them, and the effectiveness of the recommendations proposed to provide for their survival through the ordeal (Hovland, Janis & Kelley, 1953; McGuire, 1969; Rogers & Mewborn, 1976).

A graphic presentation of several situations with which officers can easily identify in their work setting is necessary to bring it home. This evaluation increases their predisposition to reevaluate their

meanings on such events and begin planning for their response to trauma. The planning for exposure to critical events needs to be taken step by step and metered so as not to threaten flooding (Horowitz, 1982). Fear must be relieved by reassurances or the officer will ignore, minimize, or deny the importance of the message (Janis & Mann, 1977).

Use of videotape news coverage of actual incidents is beneficial to break the denial of the officers' veil of invincibility in their pragmatic world. Interest is also heightened by supplying specific details or little-known facts of a major incident that hits close to home for the officers. Major incidents that have little relevance for the officers in their work environment will be of little interest to them if they cannot relate to them. The case studies should involve a person they can identify with so that they can apply what they know to be true to the situation.

The attainment of the officers' attention is primary so that they will entertain this information long enough to build a strategy. A method of consideration for building a response potential for a reason to learn about trauma is focusing attention on the aspects of the officers' lives that are seen as important to them and then relating how they will be affected by traumatic incidents. Highly graphic information may be required to penetrate their threshold of interest, in that their tolerance for stimulation is often elevated by their exposure to the intensity of situations on the street.

Stimulating recall of prior traumatic situations or events by polling the class for personal experiences with shootings or death is useful. This pulls out old learning about trauma and creates a personal orientation with the subject. These discussions in a classroom setting are best kept objective and general rather than subjective and personal, emphasizing that self-disclosure is not necessary. This training is not designed as a clinically safe environment to process unfinished business from past traumatic experiences. A need appears to exist to qualify these discussions so they are not judgmental regarding how the individual has reacted to a past traumatic incident. Explain to the attendees that this type of training is designed to bring about familiarization, insight, and preparation in order to lessen the destructive impact of a critical incident on their lives; however, it is not a group therapy experience. Recognition that others have similar experiences normalizes them and breaks down feelings of isolation (Taylor, 1983).

A major underlying goal for this exposure is to frame the meaning for the event, the meaning for life decisions and life processes (McCammon et al., 1988), seeing death and trauma as real and part of life and as something with which to deal. Further, they must see themselves as capable of dealing with each event and surviving it; they must see life as more valuable and formulate decisions on that basis. As one learns first aid and how injury occurs, one simultaneously learns how to avoid accidents (Cameron & Meichenbaum, 1982).

The information is made practical and meaningful so it will be accessible within the recall as needed. For this to happen the facts must be given in relationship to the larger context in which they exist (Wagner & Gagne, 1988). In order for this type of training to be seen as a viable program for learning, basic events of instruction are also necessary (Gagne, 1985).

LEARNING OBJECTIVES

A course design for dealing with traumatic incidents is part of the State of Florida curriculum for stress management and sets out objectives to help officers recognize symptoms related to reactions of critical incident stress (Garrison, 1988). The officers are given examples of the types of incidents that could create posttraumatic stress problems, including which situations for which it would be well-advised to seek out professional assistance. This course also identifies stages of grief reaction common to personal loss and of survivor's guilt. Students in the course are to investigate the purpose, components, and process of a critical incident debriefing program. Discussions are held to develop strategies for providing support for a fellow officer and the availability of organizational support mechanisms. Methods are developed for personal and family use following a trauma. A project designed to integrate the information, which takes place at the end of the class, requires the officer to formulate a personal strategy and support system that would help him or

her during and after involvement in a critical incident. A clear definition of a critical incident is useful as an orientation to an often new line of information that has existed outside the officer's awareness.

An example would be Mitchell's (1987) definition of a critical incident: Any situation that causes the officer to experience unusually strong emotional reactions that have a potential to interfere with his or her ability to function either at the scene or later.

A review of the symptoms that may occur as a result of a critical incident would be presented plainly and factually. This explanation would not carry with it the connotation of being broken, or that something is wrong with the officer. Emphasis should be given to these symptoms as normal reactions in normal people following an extremely abnormal experience.

Discussions about the debilitating effects of these symptoms and that these reactions may not naturally dissipate often lead to a natural conclusion by the group as to where professional mental health assistance becomes required. Police officers have an aberration when professionals appear to be deified, but will accept them when they are presented simply as someone knowledgeable and helpful in returning them to the job.

Dialogue about mental sets that occur on the scene become natural examples to point out the beginning stages of grief. It has been useful to show the utility of these stages as well as their deficit side in order for the officer to understand its process. An example would be denial as a useful process to block overwhelming emotions that could disintegrate performance on a scene when the officer needs to be functional, as compared to blocked feelings after the trauma, which prevents the processing of grief. Examining the value and process of a traumatic incident stress debriefing is important to familiarize them to its purpose. If other systems are utilized to debrief an incident, this is an opportunity to present the components of what will occur. This presents a welcome chance to clear up many misconceptions about the debriefing system that is in operation within the department.

Up to this point, the training has involved defining concepts and examining how they relate to each other. The next step is to begin to develop appropriate solution strategies. The planning of how local resources could be used in the debriefing process and how to personally provide support for a fellow officer or family member following a critical incident are exercises in this type of problem-solving strategy. These tasi s also provide utilization of the concepts, rehearsal experience, and an opportunity for feedback to adjust their perceptions. Other more covert outcomes are identifying cues from the environment that can be used later to automatically trigger these learned resource states of problem solving (Dilts et al, 1980) and building their response repertoire (Cameron & Meichenbaum, 1982). Examining these positive responses to traumatic incidents will increase the officers' sense of self-efficacy and increase the probability of their engaging and persisting in positive coping behavior during and after an incident (Bandura, 1977).

ROLE MODELS

A strong consideration should be given to having someone who has lived the role of survivor available, not just to lend credibility to the professional or instructor, but to act as a model of successful behavior (Wagner & Gagne, 1988). Models of unsuccessful behavior are readily available in almost all departments. Spotlighting the modeling by an expert in thought, process, and action is convincing and directional as it provides options of what to do rather than what not to do (Garrison & Wentlandt, 1988).

OPERATIONAL PROGRAMS

Advanced training on issues of posttraumatic incidents that familiarize the officers with both the expectation of what the officer may experience from a critical incident and the assistance procedures has been incorporated into the Dallas Police Department in-service firearms training and the police academy survival training program (Somodevilla, 1986). Postshooting and traumatic incident training has been provided at the recruit, basic law enforcement, and in-service levels of training for over an eight-year period at the Metro-

Dade Police Department and the Southeast Florida Institute of Criminal Justice. Similar types of training projects have been provided to augment the trauma debriefing process in the Denver Police Department (Williams, 1987). A training package dealing with the aftermath of critical incidents, which is inclusive of these criteria, has been included in the Florida State Uniform Standard Training package on stress management for in-service officers (Garrison, 1988).

PERFORMANCE ENHANCEMENT

In providing the majority of these training projects for the Metro-Dade Police Department and the Southeast Florida Institute of Criminal Justice, an adjunct training strategy has emerged that greatly enhances the officers' self-efficacy as they identify with or prepare for a critical incident. The components of a solid positive role model can be broken down and taught as reproducible by the class, increasing awareness, cutting reaction time, and examining the physical effects of high stress in order to create peak performance during a response to a critical incident. Increasing peripheral vision to increase awareness and decrease reaction time are examples with which officers easily identify and find useful as visible measures of their competency in problem solving and adequacy in performance to the crisis.

In addition to the training curriculum of critical incidents and responses to traumatic incidents, strategies and methods of self-mastery are valuable assets to the training process. These methods are being taught at the Metro-Dade Police Department and the Southeast Florida Institute of Criminal Justice (Garrison, 1986). The training has most recently been attached to a Threat Management Course, which is a Defensive Tactics and Firearms Course preceded by an eight-hour block of mental conditioning. The training includes mental preparation to respond to a critical incident, maintaining a mental set for peak performance during the incident, and recovery from a traumatic situation.

Bandura and Adams (1977) found that people avoid threatening situations they believe exceed their coping skills, while Lazarus and Folkman (1984) found that the fear level is dependent on the perceived efficacy by the individual. Methods to evoke access to the resources taught are a highly functional key to utilization at the time of the event. The method of future pacing is one process of wiring in the resources (Lankton, 1980). This is accomplished by having the participants examine the new alternative resources available to them at the time of the event--then, in an associated manner visualize (look out through their eyes) the imagined event and how it would look as they used each resource.

The ability to access a mental attitude is also a component of getting the resources to function. Installing a positive mental state that can also be accessed when needed will serve to dissipate the negative emotional impact (Solomon, 1988). A method of utilizing the fear generated from an anticipated event to install a resource state was reported as very functional by the participating officers (Solomon, 1986).

The preparation for what to expect, what to do, and how to utilize resources by each officer is an exercise for developing a personal plan outlining his or her support system. This exercise not only enables the officers to develop alternative strategies and when they would be deployed, but allows the methods to be generalized for a variety of circumstances for future use. This allows them to anchor choices with which they are associated now to events that might possibly occur in the future (Lankton, 1980).

Creative exercises at the end of a class in which the officers can actually see a demonstrated difference in their ability to function are very powerful in lending credibility to the training, their personal efficacy, and the future interactions with the instructor.

PROGRAM FEEDBACK

In my experience with these classes, the coupling of performance and recovery are interwoven. Historically the Metro-Dade Police Department and the Southeast Florida Institute of Criminal Justice have added this curriculum to the Basic Law Enforcement classes. Numerous classes have been through this

training. In reviewing the outcomes of this type of training, a research project would be in order to ascertain the observable usefulness of these classes to the officers. Ten years of clinical observations of officers who have become involved in critical incidents indicates a positive utilization of material in both the content of their actions toward recovery and the process of their internal mental strategies for handling the resulting emotional artifacts of the traumatizing event.

After processing several hundred officers through inoculation training over an eight-year period, clinical observations indicate a positive impact has been made. Officers have reported immediate successful processing after the event. If the concepts are in place, they often only need a reminder to bring them into focus. It cannot be determined if the inoculation training is the direct cause benefiting recovery. The training has, however, observably put in place useful concepts in many cases that have facilitated the recovery process, including the ability to provide appropriate support for each other following a critical incident.

Solomon (1988) reports in his research and experience with officers that learning to constructively deal with fear can provide access to the resources of feelings of control, controlled strength, increased awareness, confidence, and clarity of mind.

CONCLUSION

How an officer responds to critical incidents now or in the future is dependent upon his or her previous training (Mandler, 1982). A situation may not be perceived as threatening by an individual who has the necessary skills and experience available to cope (Janis, 1962). Rather than being stuck, the officer needs to realize that he or she has choices from a variety of coping strategies that reinforce that it is crucial to think in critical situations (Alford, Mahone & Fielstein, 1988). Even though an officer is exposed to an event over which he or she has little or no control and is called upon to make life-or-death decisions, the officer does have control of himself or herself (Schaefer, 1985). Training and experience "has to be funneled through the reducing valve of the brain and nervous system. What comes out the other end is a measly trickle of the kind of concoursness which will help us stay alive on the surface of this particular planet" (Huxley, 1954).

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THE PSYCHOLOGICAL IMPACT OF CRITICAL INCIDENTS ON POLICE OFFICERS

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ABSTRACT

The psychological impact of involvement in a critical incident is discussed from a developmental perspective. This perspective encourages an individual to understand a critical incident as a challenge--inviting development and growth--rather than viewing a critical incident as causing a stress disorder, requiring treatment.

A great deal of writing has been done on the subject of officer-involved critical incidents. Many of these studies, articles, and papers have focused on emotional outcomes for officers who have found themselves in situations requiring the use of deadly force. Recently, the generally agreed upon definition of a critical incident has been expanded to include many other situations. Examples are situations in which officers are wounded or seriously injured in the line of duty; officers who witness, or are exposed to, exceptionally violent acts of citizens; and officers who lose a close friend or partner through a duty-related accident or the intentional act of a citizen. In general, the focus of interest and study over the last few years has expanded from postshooting trauma to critical incident.

Postshooting trauma lends itself to a fairly obvious definition. Critical incident is a broader term. Common sense definitions often include references to an event in which an officer is subjected to a sudden serious jeopardy; perhaps a serious threat to his existence or well-being, or the existence or well-being of another person. Other descriptions include a significant element of loss, such as death or serious injury of a partner, loss of a physical ability, a loss in terms of a major disruption of the officer's values, or loss of basic assumptions about his environment or those who live in it.

From a developmental perspective, a critical incident may be defined as an event requiring an extraordinary degree of adaptation by the individual who experiences it. In this type of definition, the main criterion for defending the term has moved from a description of the event itself to descriptions of changes the individual must make within himself in response to the event. This means that determining whether an event qualifies as a critical incident or not depends primarily on how difficult and significant the individual's adjustments will be and secondarily on descriptions of the event itself. Implicit in this type of definition is an assumption that there are no abnormal reactions in response to a critical incident. This definition also implies that problems associated with difficult adjustments will be temporary.

The process of adapting to a critical incident can be described using any one of several psychological theories or models of human behavior. A positively oriented model comes from the field of the psychology of cognitive development. In this developmental model, a person is seen as consciously and unconsciously organizing his experiences into clusters, or categories, of similar items, processes, or activities. These clusters of similar experiences have been commonly referred to as schema.

A simple example of a schema can be found in observations of learning in children. A young child will develop a schema such as "dog." For a while, the child may place almost everything with four legs and a tail into the dog schema. This attempt to force objects such as cows into the dog category is natural. People of all ages do this when they experience something new. This process of attempting to place an object or experience in an already existing category is referred to as assimilation. As the child grows older, he will

eventually develop a separate schema or category for cows (and horses, breeds of horses, cats, etc.). This process of developing a new category is called accommodation.

When people are presented with a situation that requires new learning, the operation that almost everyone invariably tries first is assimilation. If the new experience cannot be successfully jammed into preexisting schema or categories, then the person will begin to attempt to accommodate (that is, make a new category for) that new experience. Accommodation is a more difficult and time-consuming operation because it involves creating a new category.

New learning (or development) can be said to have occurred when the person has successfully organized an event that occurred (or was observed) outside himself into an acceptable and useful representation inside himself. The person has adjusted to reality if he has used the process of assimilation, and/or accommodation, to internalize a novel experience in a way that allows for healthy functioning.

A police officer, by virtue of his job, is liable to have certain experiences that he may find difficult to either assimilate or accommodate. The experience of involvement in a life-threatening event or a situation that includes death or serious injury may prove impossible to assimilate into his current life perspective. Such an involvement may require a very difficult accommodation. Officers who have been able to accommodate this sort of experience have made a healthy and functional adaptation.

Making this sort of adaptive response to a critical incident may include: changes in self-concept; changes in perceptions regarding others; a deeper appreciation of the reality of death; and very often a disturbing experience with intimacy. These changes often require the sometimes difficult process of accommodation. As mentioned previously, this process may take an extended period of time to complete.

The changes in self-concept an officer may need to make in response to involvement in a critical incident can range from minor to significant. The degree of change necessary will depend upon the values, beliefs, and experiences held previously. For example, an officer who views himself as able to maintain self-control at all times and who finds himself obviously trembling or physically sick in reaction to an incident may have to revise his self-concept to allow for this less than perfectly controlled reaction. In another case, an officer who views himself as a caring person and discovers a genuine lack of concern in reaction to an event may need to expand his ability to think well of himself, even though he realizes he lacks compassion in some situations.

Closely associated with changes in self-concept are changes in perceptions and basic beliefs regarding others. An officer in the middle of the adaptation process may understandably perceive colleagues who ask for the gory details of an incident as insensitive, inconsiderate, uncaring, disrespectful, and/or exploitative. Another officer may become extremely suspicious of, or excessively cynical about, other people in general. An officer may feel a new and heightened sense of protectiveness, insecurity, or apprehension about the safety of his family members. Situations have occurred when the children of involved officers have suffered from negative comments of other children who, for example, may have heard about a shooting from the media or their parents. Most often, officers involved in the process of adaptation feel that other people cannot possibly understand what they experienced. As a result, they may then feel isolated, alone, unappreciated, and unrecognized.

Most critical incidents present the involved officer with a deeper appreciation of the reality of death. Though everyone admits the inevitability of death, people generally do not give it much conscious contemplation. Many psychologists would agree that much of what constitutes the normal set of psychological defense mechanisms function to prevent people from thinking too deeply, or often, about their own death. These very normal defenses can be severely disrupted during and after a critical incident. Even though the officer "knows" there are individuals in the world that may try to kill him, it is not unusual for him to react with disbelief when confronted with the fact that someone tried to end his life. This area of adjustment has

so many implications that it nearly always requires a new category (or schema) to represent (accommodate) the reality.

Psychological defense mechanisms of various types act to protect the individual from deep awareness of more than just the reality of death. A critical incident also may expose an officer to a disturbing awareness of a very unpleasant variety of intimacy. Intimacy does not always result in a pleasurable experience. Intimacy occurs when people either allow or find themselves to be vulnerable to another person. Vulnerability occurs when psychological, physical, and emotional defenses are intentionally or unintentionally deactivated.

Critical incidents often disrupt a normally functioning set of defense mechanisms that protects people from an excess of reality, including the uncomfortable reality of more interpersonal vulnerability than a person is prepared to experience. For example, few events include more shared vulnerability (intimacy) than a shooting situation. Most people would describe an event that includes tissue damage and blood loss within an emotionally intimate context as repulsive. In general, critical incidents happen with a very intimate context. Participation in such an event, even though that participation is legitimate and necessary, requires the individual to make significant internal adjustments.

Using a developmental model to view the personal adjustment process in response to a critical incident allows for several very positive assumptions. One of these assumptions is that a person who is exhibiting some of the typical symptoms associated with critical incident involvement has simply not adjusted yet. Such symptoms as nightmares, intrusive thoughts, increased alcohol consumption, marital difficulties, sleep disturbances, may be understood as signals that the person is still attempting to assimilate the experience into an existing schema (or category) in which it will just not fit. In addition, these symptoms may signal that the individual has not finished with the task of accommodating (making a new schema, cognitive and emotional) that allows him to successfully and usefully incorporate the internalization of the experience into his overall pattern of living.

The developmental model also provides some explanation and acceptance regarding officers who seem to take critical incidents in stride. If an individual already has a schema in which to assimilate the experience, he will likely have a very rapid and much less difficult adjustment. This strongly suggests that officers who have made healthy and successful adjustments to previously experienced critical incidents do not necessarily seem to do better because they have become harder or more rigidly defended. They may, however, have developed a broader view of themselves and the world and may, in fact, have increased their abilities to demonstrate sensitivity and tolerance for others.

This model also suggests that an individual who seems to display symptoms for an extended period of time may not require "fixing." Instead it may make much more sense to assume that he might benefit from some assistance in accommodating the experience. This may imply an educational intervention, rather than a medical treatment.

The degree of psychological impact of a critical incident on an individual depends mainly on how much internal room or space he has to incorporate the implications and meanings of the experience. If the involved individual does not already have enough internal room to usefully incorporate the physical, psychological, emotional, and perhaps spiritual implications of the experience, he will need to accommodate or make room. This new construction may take some time and effort to accomplish and may happen quicker with considerate support from peers and/or professional assistance.

ADJUSTING TO DESTINY WITH GRACE AND DIGNITY

Deborah N. Gold, R.N., M.Ed.

ABSTRACT

Death may end the life, but it need not sever the bond. Love and attachment do not die and are not limited by time.

It does not matter how long you knew the person who died. What matters is what the person meant to you, who he or she was to you.

Loss hurts. It leaves one feeling so empty. Some empty spaces can never be filled and some spaces that do get filled forever feel empty. We search for meaning from the pain and emptiness we feel. We try to make sense of why. We search for, we long for, we ache...for what could have been. We remember, wishing instead we were planning.

Grief is the pain of the loss, all-encompassing, overwhelming, all-consuming. It has no boundaries. Mourning is the process survivors go through to soothe the pain of their loss.

Loss does, however, set the stage for further creation. It is hard to look back upon any gain in life that does not have a loss attached to it--the moon comes up, the sun goes down and as the day is lost, the night begins. In all ends, beginnings.

To transcend the heartbreak, the heartache, to go on, to find peace in our heart, we must forgive the injustice as well as any person who may have been responsible for it. The path to inner peace is through forgiveness. The hostility in our heart must be turned into love. Where there is hatred...let me sow love. Where there is injury, pardon. Peace can only come from within.

INTRODUCTION

When Almitra spoke, saying, We would ask now of Death.
And he said:
You would know the secret of death.
But how shall you find it unless you seek it in the heart of life?
The owl whose night-bound eyes are blind unto the day cannot unveil the mystery of light.
If you would indeed behold the spirit of death, open your heart wide unto the body of life.
For life and death are one, even as the river and the sea are one.

In the depth of your hopes and desires lies your silent knowledge of the beyond;
And like seeds dreaming beneath the snow your heart dreams of spring.
Trust the dreams, for in them is hidden the gate to eternity.

Your fear of death is but the trembling of the shepherd when he stands before the king whose hand is to be laid upon him in honor.
Is the shepherd not joyful beneath his trembling, that he shall wear the mark of the king?
Yet is he not more mindful of his trembling?

For what is it to die but to stand naked in the wind and to melt into the sun?
And what is it to cease breathing, but to free the breath from its restless tides, that it may rise and expand and seek God unencumbered?

Only when you drink from the river of silence shall you indeed sing.
And when you have reached the mountain top, then you shall begin to climb.
And when the earth shall claim your limbs, then shall you truly dance. (Gibran, 1926, pp.71–72)

A GUIDE TO HEALING

Death may end the life, but it need not sever the bond. Love and attachment do not die and are not limited by time.

It does not matter how long you knew the person who died. What matters is what the person meant to you, who he or she was to you. The significance of the loss rests deep within each of us and is determined solely by the one suffering the loss. No age is preferable. No situation, no disease more palatable. No one wants to lose someone they love. There are no conditions that make it right, no conditions that say it is OK.

Suffering is not measurable. There is no scale upon which this pain can be weighed. Each loss is different and each loss is the worst. Suffering enters the depth of our being and that is a place into which analysis cannot go because words are inadequate, they cannot explain this loss, this ache. In the world of the grieving, words have no power.

Each loss is terrible and each loss is the worst.

Loss takes you beyond yourself and it hurts. Losses are not greeted readily, they are hardly welcomed. No one looks forward to their next loss. Losses are feared; they are always initially denied because they are impossible to comprehend. They do not fit into our picture of our very own private little world.

Losses cannot be prepared for. Even when death is anticipated or imminent, as in catastrophic disease or terminal illness, it is impossible to comprehend the impact of the loss before the loss actually takes place. Emptiness and loneliness are feelings that do not come into fruition until they have been felt. Some empty spaces can never be filled and some spaces that do get filled forever feel empty (Arnold & Gemma, 1983). Emptiness is that void, that unmistakable void that nothing or no one seems able to fill. Loneliness is that ache, that ache that touches us in a place all its own.

We search for meaning from the pain and emptiness we feel. We try to make sense of why. But this is beyond what we can comprehend. This makes no sense.

Loss is to have no longer. We search for, we long for, we ache...for what could have been. We remember, wishing instead we were planning.

Loss through death seems so permanent. What is gone through death cannot be reclaimed, cannot be reconnected (Arnold & Gemma, 1983). When a relationship is gone, there are no new memories to make.

Loss evokes feelings of panic and fright. Panic that life as we knew it is over. Panic because death makes us realize the impermanence of all things. But all flows as it will, the continual changing of life as it unfolds with nothing remaining the same. What is constant about change is that it will continue to do so. Change precludes security. Moment to moment, life unfolds as it should with a rhyme and reason that serves a purpose even if that purpose eludes us. We suffer because we dwell on what could have been, what ought to have been, what might have been. The possibilities of the if–onlys are endless. What we expected, did not

happen; what happened, we did not expect. We feel entitled to more. There is so much chaos, so much confusion, so much suffering; we ache for how it used to be, how we thought it would always be.

There is fear that there will not be happiness again, that there will not be love again; fear that there is not the strength to withstand the pain. We feel that love and happiness have eluded us, that a former life had been better than anything possible. From where this fascination, this worship of the past? We all want to extend the past into forever, but who is to say that the past was the best? The past was familiar and familiarity provides tremendous comfort in our need, but the past is past; the best may be yet to come.

It is hard to grow in a relationship once it is gone. There are no new memories to make. However, we need to be cautious of choosing a world made up of memories exclusively. Balance must be found between a yesterday that deserves to be remembered and a tomorrow that awaits its creation.

The thieves of time are the past and the future. Emerson (in Atkinson, 1940) has said, "But man postpones or remembers; he does not live in the present, but with reverted eyes laments the past, or, heedless of the riches that surround him, stands on tiptoes to foresee the future. He cannot be happy and strong until he too lives with nature in the present, above time" (p.157).

Yesterday is forever beyond our control as are its circumstances. No matter how hard we wish, how much we plead or cajole, how much and what we are willing to give as part of our bargaining powers, life will not be returned. We cannot undo or bring back yesterday. As we have no control over its events, so is our mastery of tomorrow out of our bounds. Tomorrow is full of its uncertainties and its challenges, but it is still a dream and one we are not promised. Do not let life go by, unexplored. Honor the moment.

The balance...is in being here now.

Grief is the pain of the loss, all-encompassing, overwhelming, all-consuming. It is without boundaries. It cannot be contained. It is about feeling abandoned and about fears of severed connectedness. But we remain connected, we are often most connected, most close, when there is death. We hang onto our griefs, we hang onto our regrets, and we remain connected.

Grief can tear us apart. We feel bewildered, we feel angry, and we feel a sense of total disbelief. Grief is so extraordinarily powerful. It touches us in our essence, in a place deep within us that makes us question if, in fact, we should join the one we loved who died. Thoughts of suicide are not uncommon. Grollman (1971) says that in the darkest moments of life, 80% of us toy with the notion of suicide. These desperate thoughts help us gage our alternatives. It is our ability to see choices, to make choices that is part of what makes us human. To make a wise choice about how to handle our hurt and our loss, we need to feel that the entire spectrum of options is available to us. We must allow for every choice in another's mind, for we do not know another's pain--therefore, we do not necessarily know better. We can succumb, we can survive, we can choose the myriad paths in between.

Suicide does not prove a point, except to tell us that to have opted for that choice, one was obviously tortured and tormented beyond anything imaginable. Hope was gone, faith destroyed. However, rather than solving a problem, suicide forever precludes a solution from being found. Says Levine (1982), "Suicide often arises not from a hatred of life, but from a lust for it, a desire for things to be otherwise, for life to be full when it appears not to be" (p. 215).

> One night a man had a dream. He dreamed he was walking along the beach with the Lord. Across the sky flashed scenes from his life. For each scene, he noticed two sets of footprints in the sand; one belonged to him, and the other to the Lord.

When the last scene of his life flashed before him, he looked back at the footprints in the sand. He noticed that many times along the path of his life there was only one set of footprints. He also noticed that it happened at the very lowest and saddest time in his life.

This really bothered him and he questioned the Lord about it. "Lord, you said that once I decided to follow you, you'd walk with me all the way. But I have noticed that during the most troublesome times in my life, there is only one set of footprints. I don't understand why when I needed you most you would leave me."

The Lord replied, "My precious, precious child. I love you and would never leave you. During your times of trial and suffering, when you see one set of footprints, it was then that I carried you."

(Anonymous)

Grief shared is mostly grief relieved; much grief is eased by its sharing. However, some grief catches us off–guard, seems to go beyond bearing, and leaves a residual of sadness beyond the range of comforting.

Where do all the tears keep coming from? Crying touches a place within us that can only be reached by crying, can only be mended by crying. Crying only means you need to cry. For what armor guards the feelings that live within the heart? Tears are the jewels of remembering (P. Beauregard, C.O.P.S., May 13, 1988).

Part of grieving is about the inability to accept the inevitable. As we one day realize that our worst fears are indeed true, that this is not a nightmare from which we will awaken, that our loved one is really gone, we then begin the journey of the mourning.

Mourning is not a process you can prepare for, that you do prepare for. Its pace is a most private one, there is no schedule. Each death is mourned differently because each person mourned has meant something different to the survivor.

Mourning lasts until you get your sense back about yourself. It is an inner dialogue with your spirit, a process to soothe the pain. Arnold and Gemma (1983), whose work with families of dying children has been inspirational, have most poignantly understood it (and who among us is not somebody's child?). They say that mourning involves coming to terms with the loss, learning to live without, learning to live with the emptiness, learning to adjust to the changes, to carry on differently, without. Mourning is learning how to continue living in the world with our losses.

And how this is done is through remembering repetitively and over an extended period of time experiences that were shared with the one who died. The memories are played over and over again in one's mind, neutralizing the devastating potency of the loss. What initially is too overwhelming to deal with all together and all at once, slowly, memory by memory, gets absorbed in our minds in such a way as to begin to be understood (Adler, Stanford, & Adler, 1976).

This is not a process that can be rushed, nor should it be. Mourning is a healing process that involves time. It has been said that time heals all wounds. It is not so much that time alone heals the wound, but rather what is done in that time, what is done with that time that allows for healing. It is understandable to want to get through mourning as quickly as possible because it is such an uncomfortable feeling; it is as if life has stopped within, that we too have died. Death seems to possess us, to be part of us. Accepting that frees us to go through this most sad of life's experiences.

It has been said that the haziness at the beginning was a comfort; reality, sheer terror. It seems to take, though, that first set of all of the anniversaries for reality to finally sink in--maybe. All of the first holidays, the first birthdays, the new seasons, all of the first firsts are felt so keenly. But there remains a quilt

of protectiveness that still numbs us to the impact of the loss. With the milestone of the first anniversary of the death complete, the unthinkable begins to sink in--this must have really happened, there really has been death, the person is gone.

If there has not been anger yet, anger will now come bounding out in all directions, bullying its way in. It will come at the most unexpected, inconvenient times. When that initial numbness has worn off and that feeling of disbelief has changed to stark reality, look for anger. It will not disappoint. Expect it, it will be there.

We are mad at God--what kind of loving God would do this to me, to someone I loved? We are angry at the person who died or the situation that was responsible for the death. And we are very, very angry at the dead person himself. After all, we feel the dead person is responsible for the pain and suffering we, the survivors feel. He is responsible for these terrible feelings of abandonment, this desertion.

We feel we are being punished for a crime we did not commit. We can be very angry with ourselves for not having cared enough, for not letting it be known how much we did care, for last words spoken in anger or frustration. We are angry at life for being so hard, so chaotic, so frustrating, so painful. We feel angry because life seems so unfair, so unjust.

Whether or not these feelings are rational is irrelevant. They are feelings nonetheless and deserve the respect accorded feelings. Feelings are without rights and wrongs, without moral judgments attached to them. They are our feelings and they are a part of us.

If the anger cannot be soothed, cannot be quieted, if it is not directed toward those deserving of it, we can become so burdened with hatred that our lives become diminished. And what hatred for another does is actually, ironically, the antithesis of what is desired--it hands over the very control of our life. He whom I hate, controls me, consumes me.

Some people stop right here. They become stuck and immobilized and embittered and resentful. And they remain victims. But anger can stimulate curiosity. And it can become a meditation on life. It need not remain a distraction.

If there is guilt, and there usually is, it needs to be sorted out and dealt with. This can be a particularly difficult task because the guilt often comes from myriad sources and it is often felt that no specific actions will absolve it.

Guilt implies regrets and regrets imply unfinished business. No matter how well you treated your loved one, there are usually things you regret having done, having said, or not having done, not having said. It is the sense that the relationship feels incomplete that usually mobilizes guilt.

Desire is a big part of unfinished business--desire to be able to do it over--this time differently, this time better, this time more wisely.

Finishing business is really not that difficult. It is not about tallying the score. It goes far beyond that--it is about letting go of whatever is still desired from that person. "It means going into your heart so that you can feel the pain of another and let go of it. Forgiveness occurs when the holding mind sinks into the spacious heart and is dissolved" (Levine, 1982). It is about sending out love. Says Emerson: "When we discern justice, when we discern truth, we do nothing of ourselves, but allow a passage to its beams" (in Atkinson, 1940, p.15). So it is with love.

The tides of grief and mourning ebb and flow. Recovery is so painstakingly slow. Human pain does not let go of its grip all at once, at any given point in time. The journey back is fraught with detours. It was Emerson who said that "The voyage of the best ship is a zigzag line of a hundred tacs. See the line from a

sufficient distance and it straightens itself to the average tendency. Your genuine action will explain itself and will explain your other genuine actions...The force of character is cumulative" (in Atkinson, 1940, p.153).

The end of mourning makes itself known: there is now a new relationship--you are part of me and you are also gone.

Whatever prepares us for death enhances life. We have come to think somehow that death is something different from and opposed to life, that life and death are at opposite ends of the continuum when, in fact, they are one and the same. Death makes no deals, it grants no special exceptions. Death ultimately comes to us all. The laws of nature are always impartial and apply to everyone and at all ages. Life cannot be prolonged by refusing to let it end. No one is guaranteed a long lifetime, just a lifetime.

Death makes us notice. It is usually pain rather than joy that opens people to life. It is the unexpected, the unwanted that makes us question. However, we must trust the pain as well as the light. Whatever happens must be used as a means of enhancing our focus. Every sorrow, every joy is an opportunity for awakening. One must be open to whatever happens, excluding nothing.

Levine (1982) tells the story of a Thai meditation master who was asked,

> In this world where everything changes, where nothing remains the same, where loss and grief are inherent in our very coming into existence, how can there be any happiness? How can we find security when we see that we can't count on anything being the way we want it to be? The teacher, looking compassionately at this fellow, held up a drinking glass which had been given to him earlier in the morning and said, "you see this goblet? For me, this glass is already broken. I enjoy it, I drink out of it. It holds my water admirably, sometimes even reflecting that sun in beautiful patterns. If I should tap it, it has a lovely ring to it. But when I put this glass on a shelf, and the wind knocks it over or my elbow brushes it off the table and it falls to the ground and shatters, I say, 'Of course.' But when I understand that this glass is already broken, every moment with it is precious. Every moment is just as it is and nothing need be otherwise" (pp. 98-99).

Levine (1982) continues and says that, "When you live your life as though you are already dead, life takes on new meaning. Each moment becomes a whole lifetime, a universe unto itself" (p. 99).

Loss does set the stage for further creation. It is hard to look back upon any gain in life that does not have a loss attached to it--the moon comes up, the sun goes down and as the day is lost, the night begins. As the breath we breathe now ends, so a new one begins. In all ends, beginnings. The end is not a curse nor a blessing, but a challenge. The end establishes a relationship between ourselves and the universe. The end never comes before its time. When it comes, it is because it is time.

We look at life as if it were a straight line; a longer line indicating a better life, a fuller life. But longer does not mean better. It just means longer. Longevity must not be confused with quality. It is not the length one has lived but the fullness with which one enters each moment that strengthens character.

To recover, to become a survivor, to make peace with the memories of the catastrophe and its wake, there must come the realization that some events are simply out of our control.

In those times, when we cannot control the universe, what we do have control over is the attitude we take toward those situations that are just beyond our control. Viktor E. Frankl (1959), renowned psychoanalyst and author who survived three years at Auschwitz and other Nazi concentration camps during World War II, says that even, and actually especially, when the atrocities at the camp were at their worst, "...everything can be taken from a man but one thing: the last of the human freedoms--to choose one's attitude in any given set of circumstances, to choose one's own way" (p. 104).

It is within us, within our power, to choose how we deal with our catastrophe. We are not being asked to deny our anger, to deny our rage, to deny our sadness. They are ours, they are the legacy left us. We have earned them. But we need to find a place for them and think about letting go. At our own pace, in our own time, we need to let go.

Helprin (1984) says that, "...every action in this world has eventual consequences and would never be forgotten as if it were entered in a magnificent ledger of unimaginable complexity" (p. 179). Not everything in life is fair or just, not everything is always within our understanding. There are so many unanswered questions in life and pondering them and trying to make sense of these most senseless of acts tries our patience in a most unique way. Says Helprin, "We learn that justice does not always follow a just act, that justice can sleep for years and awaken when it is least expected, that a miracle is nothing more than dormant justice from another time arriving to compensate those it had cruelly abandoned" (p. 559).

We receive only that which we give. With astounding accuracy, our deeds and our words return to us. "Whatsoever a man soweth, that he shall also reap" (Kapleau, 1971). This is the law of Karma, which is Sanskrit for "comeback."

To transcend the heartbreak, the heartache, to go on, to find peace in our hearts, we must forgive the injustice as well as any person who may have been responsible for it. The hostility in our heart must be turned into love. Says the prayer of St. Francis, "Where there is hatred...let me sow love. Where there is injury, pardon." The path to inner healing is through forgiveness.

It is only natural to wonder if there can be forgiveness in our hearts for this terrible injustice, for this person whose heinous crime shattered our world. Open...to the possibility. Forgiveness is blocked by resentment, and hatred, and pride. Allow for forgiveness of others, and in so doing, we learn to forgive ourselves.

It is a tall order, this business of forgiveness, and it asks that we let go. It asks that we let go our resentments, our hatreds, our pride. This does not imply forgetting and in no way diminishes our loss. Rather, it frees the way for compassion and with compassion, some of our pain is soothed. And as our pain is quieted, space is made for pardon. And with the pardon, there is room for hope and faith, and light and joy. If there is rancor in our heart, it will divide us against ourselves.

"Nothing can bring you peace but yourself" (Emerson, in Atkinson, 1940, p. 169).

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STRESSES, SPOUSES, AND LAW ENFORCEMENT: A STEP BEYOND

Don M. Hartsough, Ph.D.

As programs for the alleviation of critical incident stress in front-line officers become a standard operating procedure, it seems appropriate to take the next step--the provision of services for spouses and families. The rippling effect of traumatic stress from breadwinner to family has been examined (Figley & McCubbin, 1983; Kishur, 1984), and the theoretical basis for application has been established.

As the title indicates, this paper discusses how the spouses of law enforcement personnel relate to the stresses of police work. It provides a conceptual framework, describes three sources of stress, examines the officer-spouse relationship following critical incidents, and suggests elements of a program of services for spouses in law enforcement. A basic conceptual framework for work with families of law enforcement officers is provided by systems theory. I have found it useful to approach the family as an **open system**. An open system has **boundaries**, but can be influenced (sometimes very strongly) from the outside. It also has **subsystem parts**, in this case individual family members. What affects part of the system affects the whole system. What affects the officer at work is going to influence the rest of the family members, directly or indirectly, whether the officer believes that it does or not. Finally, an important property of systems is that they seek to **restore balance** and to reestablish a **steady state** after a severe disturbance. This means that there is a natural tendency toward healing and health within the family following a family member's exposure to a critical incident. One of our major tasks should be to facilitate and encourage the natural healing process that occurs in families following such a disturbance (Figley, 1986).

In 1983, I was privileged to conduct a project for the National Institute of Mental Health, describing the stresses of emergency and disaster workers (Hartsough & Myers, 1985). I visited three disaster sites and attended one of the early conferences on emergency worker stress sponsored by Jeffrey Mitchell and the University of Maryland, Baltimore County. I identified three major sources of stress, as experienced by the people with whom I talked and observed. These were **occupational**, **organizational**, and **traumatic incident** sources. The same three categories provide a useful structure for looking at the sources of stress for the wives and husbands of law enforcement officers.

SOURCES OF STRESS

Occupational Sources

There are some types of stress that are inherent in the nature of the work, and these are labeled as occupational. They "come with the territory." For the spouses of law enforcement officers, occupational sources of stress include shift work, unpredictable absences from home, and interrupted days off (e.g., to make a court appearance). Long hours, irregular hours, and a second job in order to make ends meet are other sources of occupational stress. As you can see, these are often in the nature of everyday stresses, and are usually accepted as just part of the job. It does become obvious to the family that police work is different from other work when there are holidays lost or family celebrations missed because of job requirements. Another type of occupational stress, very much on the mind of spouses, are the threats to personal safety that may be experienced by the husband or wife. Such threats can reach the traumatic incident level when the officer is fired upon, severely injured, or taken hostage. Still another type of occupational stress, depending upon the officer's assignment, is the constant contact with "low life" individuals and unsavory places. The husbands and wives of officers of narcotics and vice seem to be especially aware of this type of stress.

A common occupational stress for the family is what Vicki Harris calls "defusing at home" (1988, 1989). Letting off steam about the workday is a healthy practice, especially if family relationships are supportive. The officer gets to ventilate feelings, and the family gets a more realistic sense of life on the job. This practice is a two-edged sword, however, because defusing at home can also become a source of stress for the family, especially if the emotions are mostly negative, the complaints are prolonged, and the family becomes frustrated when nothing changes.

Finally, the positive motivations that law enforcement officers often maintain toward their work can be a source of stress for the spouse and family. Law enforcement personnel can become so preoccupied with their jobs, show so much excitement, and experience so much cohesiveness within the department that spouses feel left out and only of secondary importance to the officer. Many spouses also describe a gradual decrease in intimacy, an erosion of the healthy emotional bonds that they experienced early in the officer's career. Although it is most noticeable following trauma, it can occur even without the advent of a traumatic incident. To other family members, it may seem as if becoming a police officer tends to wall off that individual from the rest of the system.

Most of the foregoing occupational sources of stress cannot be eliminated, but they can be understood, and this understanding can be conveyed to the family. I think it is important to validate the experience of the spouse by simply recognizing that he or she is not unusual in experiencing these stresses.

Organizational Stress

The officer's own department can be a source of stress for both the officer and the spouse, even though there is not bad intention toward either one. For example, the competing demands of home and job may put the officer in a role conflict. Spouses may find that notification procedures in the case of severe injury or accident may be oriented toward departmental requirements rather than benefiting the spouse or family. Spouses who must deal with an officer who feels demoralized because his department did not support him during a crisis such as an officer-involved shooting, are feeling the brunt of an organizational source of stress. Spouses also find themselves having to defend departments that become the target of bad press, or when departmental conflicts are exposed in the media. I think it is very important to thoroughly understand organizational sources of stress on law enforcement officers (and their spouses) because these are often types of stresses that are unnecessary and can be prevented. Unfortunately, there are many examples of such stress. An officer assigned to body recovery for several consecutive days is one example (E. Nielsen, personal communication, August 1989). Another is the officer being assigned to remain at an aircraft disaster site overnight, especially when one of the bodies at the scene is a friend (Hartsough, 1988).

Traumatic Incident Sources

The exposure of a law enforcement officer to a critical incident seems to carry two types of stressful themes to the spouse. One is the threat of physical loss (serious injury, death) of the officer, and the second is the threat of emotional loss regardless of the physical danger. It will not be necessary to enumerate in this article the types of critical incidents to which police officers are exposed. They are found in other articles in this book. Until we learn otherwise, I think it is safe to assume that the critical incidents most likely to produce severe stress in officers are the same ones that seriously upset the spouse. These would include line-of-duty death, suicide of another officer (especially a partner), major disasters, officer-involved shootings, and any other incidents involving life threats. Spouses may experience these incidents as direct threats to themselves because of their close identification with their husband or wife. As we all know, harm to a loved one is experienced as harm to oneself. Spouses and significant others may also be affected by these incidents in an indirect way because of changes in the loved one and the relationship brought about by the incident. A frequent complaint is that the officer has become emotionally distant, moody, irritable, or preoccupied with the incident. Loved ones in the officer's family are greatly relieved to learn that these effects may be normal, are usually transitory, and represent the officer's beginning attempts to confront the emotions involved in the

incident, and thus are part of the healing process. An important part of the educational process for spouses and families is reframing the behaviors that they may find so unsettling.

OFFICER–SPOUSE RELATIONSHIP

Social and emotional support for the survivors of trauma are critical to successful coping. In research that was done at Purdue University, we found that the most important social support for survivors came from their preincident social support network. Victims of robbery, rape, fire, and disaster evaluated the support of family and friends as significantly more important to them than support derived from people they got to know only after the trauma occurred (Wojcik, 1986). The point is that protection and enhancement of the officer–spouse relationship may be critical to the officer's successful coping with a traumatic incident. Wojcik's finding and the experience of other professionals point to a need for developing systematic programs to include spouses and families.

The spouses of officers exposed to a critical incident may be either supporters or victims. This is illustrated by the foregoing discussion, which describes spouses as very significant social support, but also as victimized in some instances. Frequently they find themselves alternating between one role and the other, at times being able to give support and nurturing to the officer involved, but at other times feeling terribly vulnerable, alone, and in need of help for themselves. I think it is useful to conceptualize these experiences in terms of social role theory. As indicated in the Appendix, we usually think of the law enforcement family following a critical incident as consisting of the officer as victim and the spouse as supporter (condition 1). If this is the case, the support given to the officer is extremely important to him or her, as already indicated. A critical incident stress debriefing or other form of professional help in the department may assist the officer in being more open to the support being offered by the spouse.

Sometimes the roles are reversed, with the officer becoming the supporter and his or her spouse becoming the victim (condition 2). As we know, a critical incident may not be traumatic for an officer, and it is the spouse who becomes more distressed. In this case, the officer has the possibility of taking on the constructive role of being a supporter in the family. Again, a critical incident stress debriefing can be of assistance in giving the officer a framework for being supportive. Information, reassurance that the spouse's distress does not represent weakness, and the usual reframing techniques may be very helpful.

Again referring to the Appendix, a third set of conditions may find both the spouse and the officer in the role of supporter (condition 3). In this case, neither is traumatized by the incident, and there is the possibility of helping other officers' families. Finally, it is not unusual to find that both the officer and the spouse have become victims of a critical incident (condition 4). In this case, the couple, and therefore the family, is psychologically quite vulnerable. Neither can give the support that is so highly prized by victims of trauma. Because neither one can give it, neither one is receiving it from within the family. Parenting, work performance, and other socially important activities may decline significantly. It is clear that help from external sources is needed for a family system in this situation.

INTERVENTION GUIDELINES

When to Intervene

Decisions about whether or not to mobilize intervention for the spouses of officers in law enforcement is always a judgment call, either by command, administration, professional helpers, or some combination of these personnel. Services to spouses should be considered by the same decision makers who determine whether support services are needed for front–line officers following an incident. Some general rules of thumb may be helpful. In disaster psychology, the general rule is that support services are needed in proportion to

the extent that victims outnumber survivors. In law enforcement, this is illustrated by the last condition of the Appendix, when both officer and spouse have been victimized by a traumatic incident.

There are types of critical incidents for which one can assume that spouses need some type of intervention. These include line-of-duty death of the officer, serious injury to the officer, and when the officer is held hostage. In general, any situation that combines life threat with a feeling of helplessness by the spouse merits attention. Also, remember that a previously victimized family may be more vulnerable to later insult, and therefore more in need of support services. A simple but effective guideline says "when in doubt, ask." An offer of support to the spouse and family from the officer's department is rarely inappropriate and may be deeply appreciated, even if declined by the family. What seems to hurt spouses very deeply is the impression that their needs are being ignored, resulting in a feeling of isolation from the rest of the department.

How to Intervene

Determination of what to do for spouses depends upon an accurate understanding of their needs. What is helpful for the spouses and significant others of an officer following a critical incident? Needs vary with individuals, of course, but I would suggest the following needs as basic to most all situations:

(1) **Validation of the experience.** The spouse needs to hear the communication from others that his or her experience of the incident has been real, is understandable, and is a normal and human reaction.

(2) **Acknowledgement of individual needs.** The spouse needs to be recognized by the department as a unique individual, not just an extension of the officer. This includes acknowledgement of needs for material help, emotional support, and just "being there."

(3) **To feel competent.** Grief, fear, anxiety, and anger may be very distressing, but they do not necessarily eliminate the capacity for being a competent adult or parent.

(4) **To be treated as an adult.** It is a mistake to assume that people shattered by a critical incident become childlike, dependent, and incapable of responsible behavior.

Crisis management will be appropriate for most situations. The usual steps in crisis management are making contact and offering help, assessing the situation and the resources available, being proactive in giving emotional and material support, and following up once the critical period has passed. The assignment of department personnel as crisis managers is extremely important and should be given careful thought. Inexperienced helpers may become overly involved, or too directive, or ignore signs of distress that are communicated by the spouse. For example, a husband or wife who has just been widowed is likely to express strong emotional needs for nurturing and support, and an opposite-sex helper may misread these feelings as an invitation to an erotic or romantic relationship. One suggestion is to establish a male-female team of officers from the department of crisis helpers. This not only provides for better balance in the helping relationship, but also means that the helpers can provide each other with mutual support.

Strategic Points for Intervention

The most effective intervention for spouses begins before the incident ever happens. It is strongly advised that departments begin to establish a relationship with the spouses, significant others, and families of officers early in their careers. This allows for communication, good reality testing, and a feeling of trust to develop between the officer's family and the department before a crisis occurs. Rookie training is not too early to begin this process. A family night during training is used by many departments to increase socialization and is also a good time to discuss openly the stresses of police work and how to manage them.

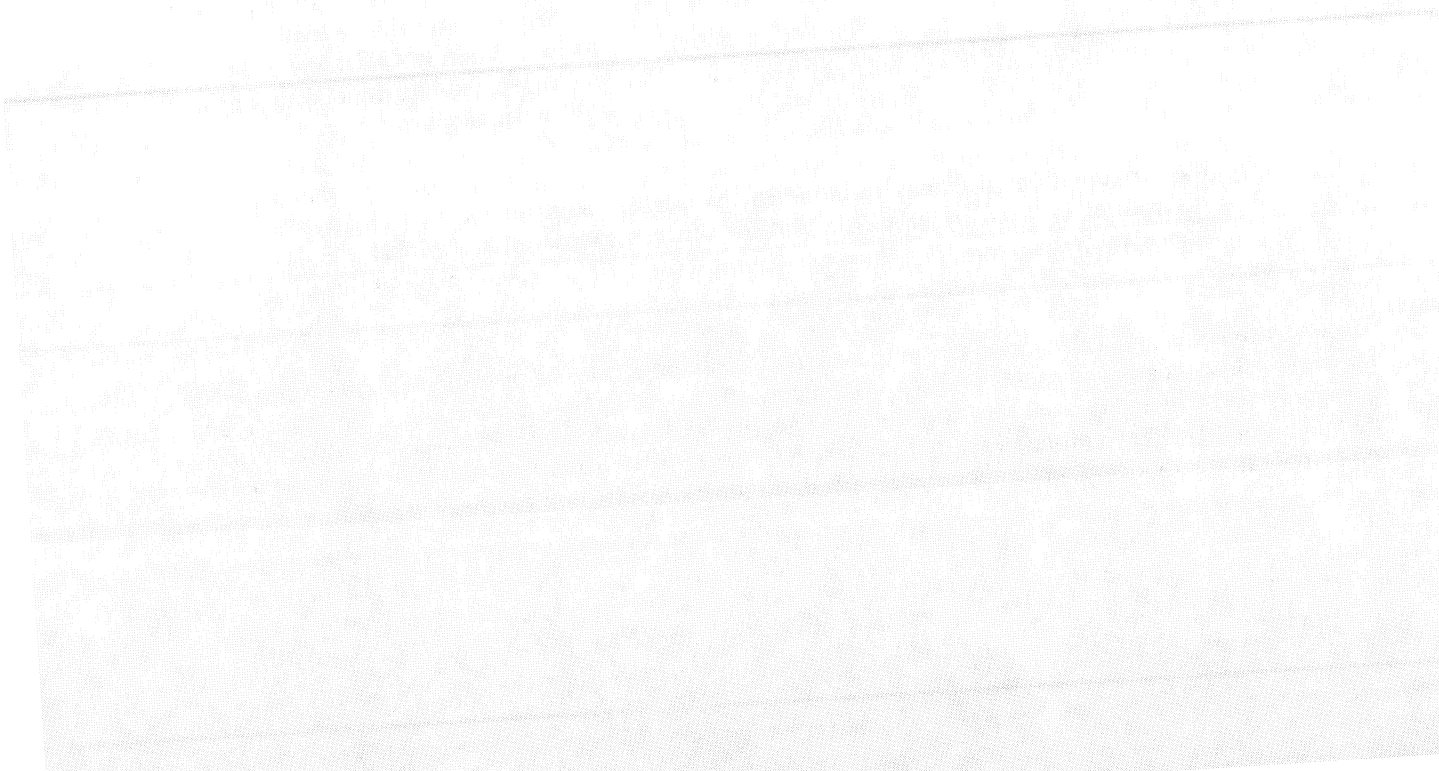
Departments may find it useful to request young officers (or all officers, for that matter) to designate someone of their own choosing to be a primary support person for the family in the case of serious injury or

APPENDIX

Stresses, Spouses & Law Enforcement

Condition	Victim	Supporter	Comment
1	Officer	Spouse	a) conventional, expected b) most meaningful of all support to officer c) CISD may help officer to be more open to spousal support
2	Spouse	Officer	a) a naturally occurring role reversal b) a constructive role for officer c) CISD can assist officer in support-for-spouse role; e.g., information, reassurance
3		Spouse Officer	a) "no problem" situation b) capability to help other officers' families
4	Spouse Officer		a) couple/family psychologically vulnerable b) neither can give support, so each is missing support from the most valued support resource c) other roles (work, parental) suffer also d) help from outside needed e) in addition to CISD, one or both may need individual counseling, material support

Four conditions that may result when the role of victim or the role of supporter is taken by an officer and the officer's spouse after a critical incident.



death of the officer. In this way the situation can be avoided in which the tragedy of a critical incident is magnified by the presence of an unwanted member of the husband's or wife's department in the home. It may also increase the sense of control over the situation on the part of the spouse.

In-service educational programs are another good means of preventive intervention. Such programs not only provide information, but they can change attitudes and help spouses identify people within the department, including psychologists, who may be helpful in times of crisis. Most departments have some form of employee assistance program, and these provide another point of intervention. Employee assistance programs typically provide therapeutic services for a wide range of physical and emotional needs. I would strongly recommend that departments negotiate for the inclusion of spouses and families in the employee assistance program of the law enforcement agency. (A model program is currently in existence for the Indianapolis Police Department and the Marion County Sheriff's Office in Indianapolis.) In this way, the family as a unit can be treated following a critical incident, and continuity can be given as part of an ongoing program.

Many departments have established peer support programs, which provide a further point of intervention with spouses and families. Again, the selection of personnel for providing support to the family must be made carefully.

Spouses are not usually included in the critical incident stress debriefing process following a critical incident, as such debriefings are ordinarily designated for persons directly involved in the incident. However, many departments have found it useful to have separate critical incident debriefing programs for spouses of front-line personnel. In group process meetings with spouses, care should be given as to the composition of the group. It may be extremely upsetting for the spouses of officers who have just died to meet in an intense group process with spouses whose husbands and wives are still living. The sensitivities of the situation and the judgment of responsible professionals and command officers are much more reliable indicators about what should be done than the prescriptions of any general model for critical incident debriefing. The model provides the framework, but local personnel need to give it substance. At the time of the critical incident, one of the most sensitive things that a department may do is to activate the natural support system surrounding an officer and his or her family. As indicated previously, these may be the most highly valued supporters in times of crisis. If this is true, then it is equally important that departments stress to officers the importance of having a "life outside of the police department." Officers who become preoccupied with their careers leave themselves and their families vulnerable when crisis occurs.

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CRITICAL INCIDENT DEBRIEFING: RITUAL FOR CLOSURE

Victoria J. Havassy, Ph.D.

ABSTRACT

The need for psychological intervention with police officers and other emergency personnel following exposure to a traumatic event has been widely accepted by police personnel. Debriefing has been the most common method of intervention used because it provides an opportunity to process the event both cognitively and emotionally, and because the concept fits well within the police culture. This paper focuses on the aspect of debriefing for closure and the importance social "ritual" plays in providing that sense of closure.

The importance of early psychological intervention following a traumatic event has been widely accepted in working with law enforcement and other emergency personnel. Mitchell (1983), Barnett-Queen and Bergmann (1988), as well as others, have written extensively about the purposes of such intervention, which include ventilation, validation, and education. What has not been focused on is the need for closure following a traumatic event, and the importance social "ritual" plays in providing that closure.

Throughout the course of civilization, social rituals have been created and utilized to facilitate a sense of closure and aid in integrating loss into the ongoing lives of survivors. According to Vernon (1970), rituals generally represent an opportunity for "controlled expression of anger and hostility, and also for a lessening of guilt and anxiety." Whatever the particulars, rituals serve as a culturally condoned means for coping with the fact of death or other significant loss and provide a vehicle for closure.

Social ritual also mitigates the sense of vulnerability people feel in the face of death or other trauma. Gallows humor, an oft-employed ritual used by police officers, is a way of thumbing one's nose at death. It tends to diminish anxiety and helps confront fear. The essayist E. B. White wrote, "to confront death, in any guise, is to identify with the victim and face what is unsettling and sobering" (in Guth, 1976, p. 558). Gallows humor is an attempt to create distance and thereby avoid identifying with the victim. However, gallows humor is often ineffectual with certain kinds of trauma or when the magnitude of the traumatic event is great.

Dealing with the trauma of war also requires some social ritual to provide closure. For example, Schwartz (1984) writes that:

> Primitive societies intuitively knew the value of cultural ceremonies that marked the end of hostilities. Rites of passage were provided for the soldiers and the society to make the transition from the regression of combat to the structure of integrated living. These rituals acknowledged and sanctioned the otherwise forbidden acts of war. They thanked the soldier for his protection, forgave him his crimes, and welcomed him back to life.

Schwartz notes that "Our failure to provide such a cleansing for our warriors and ourselves has left our culture struggling for closure." In some ways police officers are warriors of modern urban society, and it has only been in recent years that the police community has recognized that officers are affected by the traumatic situations they encounter. It has been even more recently that we have begun to respond to that recognition and those needs and to provide opportunities for validation and closure.

In the last two decades, police psychologists and police managers have been addressing the issue of the psychological impact of the use of deadly force and have had to incorporate the concept of the police officer as a secondary or tertiary victim. They have come to realize that the emotional aftermath of a shooting incident, even a nonfatal one, can be traumatic. Since then, other potentially traumatic incidents for police officers have been identified. Such incidents include, but are not limited to, death or serious injury of a fellow officer, death or serious injury of an infant or child, a particularly bizarre or gruesome traffic accident or homicide, multicasualty event, a failed rescue, e.g., suicide--especially a protracted incident involving a great deal of energy and commitment of resources--or accidental death caused by the officer or emergency equipment. Though there are many other incidents that would likely be traumatic or "critical" to the average citizen, because of the nature of their work and frequent exposure to trauma, police officers generally have a higher tolerance or threshold for trauma. Mitchell (1983) defines a "critical incident" 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."

Support groups are increasingly providing assistance to those faced with loss or trauma. Smaller families and increased mobility have changed the traditional support systems once available. In modern times, survivors of trauma have sought this much-needed support by finding others with similar concerns and experiences. Such groups as widows' groups, families of suicide victims, parents who have lost children to sudden infant death syndrome or drunk drivers, extend support beyond the initial burial ritual and provide resources and help that might otherwise be unavailable. The Lo Dagaa people of Africa, for instance, assign a "mourning companion" to the grieving family. This "mourning companion" assumes responsibility for the bereaved's behavior during the period of intense grief (DeSpelder & Strickland, 1987).

Survivor support groups are based upon the concept of perceived similarity of experience or background. An additional, though often unrecognized, function is to diminish or break the shame cycle. That is, feeling victimized in any significant way threatens or contradicts one's self-image as a survivor, which, in turn, causes shame, and one of the most common responses to shame is withdrawal and isolation. Thus the support group also functions to break the isolation and allows the person to reconnect with peers. Though support groups differ in emphasis, approach, and methodology, they share a similar purpose and function.

Historically, the law enforcement culture has fostered the myth of individuality and superiority. Training, too, has created and maintained the image of being able to handle any crisis without being affected. Control has been the essential theme. Further, the fact that police officers are often isolated from the larger community makes a private ritual with members of the police community that much more essential.

Police officers have been "debriefing" themselves, e.g., "choir practice" or "attitude adjustment," for as long as anyone can remember. Such "rituals" are at least partially effective. "Critical incident debriefing," a formal, structured, psychoeducational approach, is a more effective and constructive method of dealing with the aftermath of trauma.

The debriefing structure outlined by Mitchell (1983) involves six phases, beginning cognitively, working through emotions, and ending with participants receiving information about successful coping. This model and variations of it provide the basis of an ideal ritual: It is culturally condoned (i.e., police culture) and shared by individuals of similar backgrounds and experience. (A variation the author uses is asking each participant to imagine a snapshot of the worst part of the incident. After a few seconds, the participants are asked to picture themselves tearing up the snapshot and throwing it out.) Further, these individuals have all been exposed to the same incident. Processing the same incident together allows the participants to be "mourning companions" for one another during and following the ritual of debriefing. Finally, an opportunity for feelings to be validated as normal and common to most, if not all, of the participants, mitigates feelings of shame and the group experience prevents isolation. The experience of participating in a shared social ritual with one's community and of knowing one has the ongoing support of colleagues greatly facilitates closure and integration even of traumatic events.

The importance of psychological intervention following exposure to trauma is expanded when considering and including the concept of social ritual as an essential vehicle for closure. The ritual of debriefing is exceptionally well-suited to police officers and other emergency personnel as it is a discrete process whose effectiveness is maximized by the fact that the support group members are all known to one another prior to the debriefing and continue to work together following it. Thus, the debriefing becomes another shared experience, one that is positive and validating.

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CRITICAL INCIDENTS FOR LAW ENFORCEMENT OFFICERS

James M. Horn, M.F.S.

The following was taken from a videotaped presentation on the Law Enforcement Satellite Training Network national teleconference, "Stress Management for Police," on December 9, 1987.

What are critical incidents? Most of us tend to think in terms of shooting incidents, and yet what is a critical incident to a law enforcement officer? A critical incident is any event in our lives that we experience on or off the job that's outside the realm of the normal human experience that could be expected to produce significant emotional reactions. Law enforcement officers are constantly responding to other people's critical incidents. A critical incident produces what have been called abnormal reactions, but let's think for a second about what really is an abnormal reaction to a critical incident. As Viktor Frankl told us, an abnormal reaction to an abnormal situation is not abnormal; on the contrary, it is normal. There is nothing that as law enforcement officers we need to know more than that the reactions we experience after a critical incident are not a sign of insanity, are not a sign of a yellow streak running down our backs, are not a sign that we are not made of the "right stuff." They are a sign that we're human beings.

What prepares us for critical incidents? What prepares the FBI Agents and the police officers out there right now near Templeton, California, walking around on a hillside amongst the debris of an airplane and 43 bodies. What really can prepare us for such a job, to walk amongst that kind of debris? Nothing really can.

Jerry Vaughn, the former Executive Director of the IACP, stated in an article that of the United States police officers who kill, 70% are out of law enforcement within 5 years. How are we handling those kinds of critical incidents? Can we handle them better?

In his Florida study, Jim Sewell asked hundreds of police officers to rate the stressors on the job. They listed them by priority, and 8 of the top 10 stressors are violence, on and off the job. Violent events are critical incidents. You know the other two things that got into the top 10? The other two things were getting fired, which was #2, and getting suspended, which was #10. These are also critical incidents, aren't they. And yet, what happens after many of our critical incidents, such as a shooting? We automatically suspend police officers. We have just gone from one top-ten stressor to two top-ten stressors, and so in our educational program, we plead with people: don't use the term suspend. It has a negative connotation, even for us when we read about a police officer being suspended.

For law enforcement officers, the worst part of a critical incident sometimes is not the critical incident itself, it's what happens afterward--because they feel like they've done the best they possibly could under the set of circumstances that existed at the point that they made a decision. Yet, they are second guessed, maybe all the way up to the Supreme Court for a decision they made in a split second. It seems grossly unfair, but as we say back at the FBI Academy, life isn't fair and even in law enforcement, that's something very important to us to recognize and accept.

The bottom line to me, though, is that if we have police officers involved in critical incidents and we respond to them inappropriately, not objectively, not sincerely, without concern, then I think we create in the system, through the inquiries and through the courts, what Marty Symonds in the New York Police Department calls the "second injury" and maybe sometimes a third and fourth injury. And it concerns me that the 70% of police officers who quit after killing somebody may have quit not just because they pulled the trigger, but because we did not respond to them properly and support them after they were involved in one of these critical incidents.

One of the things I think that we can get hung up on very easily in this society, particularly for men--but also women with "Calamity Jane" being around--we call the commandments of masculinity. Wagenvoord spells these out in a book called Men, a Book for Women. The Commandments of Masculinity read like this:

He shall not cry;
He shall not display weakness;
He shall not need affection or gentleness or warmth;
He shall comfort but not desire comforting;
He shall be needed but not need;
He shall touch but not be touched;
He shall be steel not flesh;
He shall be inviolate in his manhood;
He shall stand alone.

And yet over and over again, what I hear from mental health professionals and fellow law enforcement officers is that the people that have the toughest time coping with and recovering from critical incidents are the men and women who apply those commandments to themselves. They are the ones who shove it down inside, who don't reach out. They cannot accept the fact that what they experienced emotionally was normal and they don't let anyone help them. They try to do it all by themselves. It just doesn't work in some types of crises. Yes, there is a lot of personal control. There is a lot we can do for ourselves, but sometimes we all need help. It can be a fatal mistake, in fact, not to respond and reach out for or accept that help when we need it.

Let's briefly look at some of the reactions that some law enforcement officers have after a critical incident.

The first one I'd like to talk about is shock. I think it is the most important reaction, because we know that mortality is not just a factor of the lethality of the wound. A wound is one thing, but people also die of shock, especially in conjunction with a serious injury. And yet it amazes me how little time we spend on training on how to counter shock to help keep our police officers alive. Thank goodness there are people who understand the importance of responding to a critically injured person and countering the effects of shock. And thank goodness I can stand here today feeling very good about a debriefing I did just this past week that resulted from one of our agents being critically injured when he was shot three times. Everybody at the scene, except one agent, and I'm including the victim agent, thought it was all over; that death was either there or imminent. One person refused to believe that. One person touched, one person cared, one person talked, one person rode in the ambulance to the hospital and spoke positive statements such as, "You are going to make it, you are going to make it, hang on, hang on, you're going to make it." Even though the victim got to zero radial pulse, that agent is alive today and doing extremely well considering the injuries he suffered. The medical personnel at the hospital said this man would not have lived had it not been for the actions of that agent who countered the effects of shock.

Let's look at some of these other reactions rather briefly here. The reactions are very diverse. They could be severe, there could be no reactions at all and still be very normal. Muscular tremors, which we tend to think are signs of cowardliness, are actually normal responses. There could be nausea, headaches, crying, hyperventilating, fainting, sleep disturbances, nightmares, flashbacks, and depression. Once again, these things are normal responses, as are anger and hate toward a subject. Does it make sense we would be angry at somebody who forced us into a situation where maybe we had to take his life? Emotional isolation and withdrawal can occur, and I think that's an important reaction to focus on, because the thing we need most sometimes is support, and yet if we respond by withdrawing from that support, you see, we hurt ourselves. It is a self-destructive reaction.

The last reaction you saw listed on the screen was perceptual distortions and that's a wild experience to be involved in a critical incident, an accident, and experience perceptual distortions: to see an accident, to

be involved in a shooting, and all of a sudden everybody starts moving differently, as if they were on drugs. Everything is in slow motion and we wonder what in the world is going on. It's a perceptual distortion. We don't even hear our gun go off, and yet it did. We don't hear our partner yell, "police, drop the gun," but he did. He yelled it twice, but you can auditorially block that. We can experience tunnel vision, as if we are looking through binoculars, as well as tunnel hearing. There are all sorts of perceptual distortions that once again are very, very normal. They are followed quite naturally in a critical incident by a very common reaction of numbness. The critical incident can be severe enough that we have a right to be numb because it's part of the denial process. If we are exposed to something that is completely outside the realm of what we are expecting to have happen that day, we may deny part of it or all of it and we can have an immensely numb feeling. When we start to break down the denial and start to face the reality of this really happening, we may think, "I really was involved in a shooting; somebody really did try to kill me, somebody tried to stab me, or I was involved in a serious accident." Then we may start to really think a lot about the incident and sometimes it's hard **not** to think about it. We try to go back to work and the intrusive thoughts keep recurring and we go back and forth between numbness and intrusive thoughts. This can lead obviously to an inability to concentrate when we do go back to work.

Some of the reactions may be partially due to our own intense need to reestablish some of the control that we felt was so totally lacking during our critical incident. Police officers hate to be out of control. And especially, in a life-or-death situation, it's the most unpleasant feeling in the world to think that for a few seconds of our life, we may not have been in control of whether we lived or died. But herein lies one of the most important keys, I think, to why maybe we lose some people that we shouldn't lose after a critical incident, and that's this fact that we want to be in control all the time. Who gets criticized more among law enforcement officers--those who shoot, or those who are shot? In my opinion, it's the shootees, the ones who get shot. I think that as law enforcement officers we're much more ready to criticize someone who got shot than someone who shot a subject--for a very selfish reason. If I look at Bob and say Bob got shot because Bob screwed up, and I continue to say that for weeks, for months, for years, I am denying Bob one of the most important types of support that he could ask for--peer support. What I am really doing for myself is I am telling myself I am not going to get shot because I am not going to screw up. **I am denying vulnerability, mortality**. I am denying it can happen to me and that's a lie, and we all know it. But when we lie to ourselves like that and we fail to support our fellow officers, especially the ones who are injured in the line of duty or who are shot in the line of duty, we can do an extreme amount of harm to those individuals. That's something we need to stop and think about before we get wrapped up too much in criticism.

Regardless of the reactions that somebody has after a critical incident, I believe it is the unresolved emotional responses that can cause the biggest problems. The fact that many of us try to keep things inside us can produce serious consequences. Norman Cousins approaches that issue when he talks about people's worries and fears being converted into genuine physical symptoms that can be terribly painful or even crippling. And I think immediately of a case that I responded to. It was an FBI and police officer shooting of a subject, and when I got there, I found this incident wasn't the worst shooting. The worst shooting had happened a few months before when several officers went down. A psychotic individual had taken another person's life and one of the seriously wounded officers that I worked with had gone from being described as "the best detective we have" to "this individual is no longer capable." Now that he is seemingly physically recovered, he can't work the street anymore and he can't even answer the telephone inside the office. We are talking about 100% basket case, aren't we? This guy was totally disabled. What disabled him?

It took several hours of talking before we got down to the root of the problem, which was unresolved emotional issues. I asked, "What's the problem? Why does it bother you so much that you yelled, cried, and screamed when you got shot?" And he said, "Because John Wayne never cried one single time in any movie when he got shot." And I thought, it's true. Marty Reiser was accurate. The John Wayne Syndrome for some of us is so literal that we would try to be something that no human being could be. It didn't make any difference to this man that he had been decorated for bravery. The medal didn't mean anything to him. What hurt him was that he hadn't measured up to John Wayne. He also had not shared that very important reaction that he had with the most important person in his life. He later shared it. He first admitted that what he did

was normal, and then he shared his experience. Two weeks later I got a call and it was reported, "He's back on the street, he's working cases. Interestingly enough, he says 95% of the pain in his leg is gone." What kind of pain did he have? **Unresolved emotional issues**.

There is good news about critical incidents. Half of us who go through them don't have severe reactions; it doesn't make basket cases out of us. It all depends on the circumstances, on our involvement, how things are going for us, whether or not our support system is in place. We see some people, I think, bouncing back and being even stronger, evidencing what Nietzsche said, "That which does not destroy me, makes me stronger." So what if it breaks us--is that the end, are we through? Hemingway said life breaks us all but many of us heal and are stronger at the broken places.

How do the officers who come back from such adversities as what we are talking about here, bounce back? Well, sometimes we can look at the best possible scenario and say, well, look what happened. Look how they were handled. I think we are seeing around the country people becoming more and more educated in this process and realizing this is the best possible scenario. This is what we must provide for our police officers involved in these incidents, and when we do, they are handling it better and better. They are coping better and they are bouncing back better.

(1) The officers must perceive that they receive support from administration.

(2) They must perceive that the investigation is supportive of them, not with a prosecutive or persecutive slant.

(3) They must perceive that supervisors are supportive of them, and

(4) They must perceive that peers are supportive of them.

One state trooper told me, "I can handle the adverse publicity created in the media; that's part of the job, we know that some people are always going to respond to us negatively no matter how clean a situation is. I can even handle the fact that this has created some adversity within my own family. But you know what--**if I don't have the support of my department, I won't make it!**" Who is the department? Ladies and gentlemen, **you are the department**. It is your support, regardless of your rank, that enables people to get through anything. Dr. Roger Solomon and I, in our research out in the Rocky Mountains, found after a critical incident that when the law enforcement officers perceive both the inquiry and the supervisors to be supportive of them, that tends to have an inverse relationship with the trauma of the experience. What I'm saying is the higher they perceive the support from supervisors and the investigation, the lower they tended to rate the trauma of the experience, and vice versa. But for long-term coping, these officers said **peer support is the most important** type of support of those four that we discussed. Indeed, the FBI Agents who have been brought back to our seminars the last four years for critical incident trauma listed peer support as their number one resource for recovery. It was even slightly ahead of family support.

I submit that most law enforcement officers involved in a critical incident need a chance to not only debrief the details of the incident, and they will get a chance to do that through their statements, but that for most of us, **it is essential that we debrief emotionally**. It's important that we forget about those commandments of masculinity and that we support each other; that we talk to each other, and we have a goal of being able to discuss with each other our feelings, our fears, and our worries, **without losing status**. That is not easy for some of us to do, because of the way we were raised.

What is the best approach for overcoming problems? I would like to submit that three approaches can be very helpful to us. Number one, **acknowledge the problems**. Until officers stop trying to make the situation come out the way they want, they will never find peace. There is a prayer that had three key words in it for us. It says we need the **courage** to change the things we can, the **serenity** to accept the things we

cannot change, and the **wisdom** to know the difference. We must go forward. We press on despite anything that is going on around us or to us.

Number two, we must view the challenge we experience as a new **opportunity** to grow. In every adversity there is a seed of opportunity, some way to improve ourselves, to improve our departments. We can grow even from our tragedies. As one door closes, another one opens. Just this past week, we had a guest instructor at the FBI Academy, Detective Richard Pastorella of the New York Police Department Bomb Squad, who lost his eyesight in a bombing on January 1, 1983; a terrible tragedy. He also had most of his right hand blown off and lost 75% of his hearing. Is that the end of the world for Richie? Is he no longer valuable to law enforcement? Richie is a winner! Some people cannot be defeated. And in fact, we don't have to be defeated by anything. Richie made a positive choice. He started the Self-Support Group for the New York Police Department as a result of his critical injury. And now he has 25 other disabled officers who help the 30,000 New York Police Department officers who go through critical incidents. They help the officers to recover.

Number three on the list is **be of service to other people**. When we commit ourselves to a positive goal such as giving ourselves in service to others, we seem to transcend illness and infirmities. I think Richie Pastorella might be the first in a group to say, indeed. Viktor Frankl told us after his experience in Auschwitz and Dachau during World War II that sometimes living is suffering; to survive is to find meaning to the suffering. Some of you out there in that audience today and some of you right here have suffered on this job and others have suffered off the job. Nothing will help us heal quicker than to learn from our suffering, to give it meaning and to recognize indeed you're more qualified as a result of your suffering to reach out to someone in your department who is now going through that same experience. You can help them work through it. You will legitimize their reactions when you explain to them what your reactions were. And you'll see in some of the debriefings there may be a lot of smiling and a lot of nodding and sometimes some tears, and that's okay. The process legitimizes and validates our reactions. That means our reactions are indeed normal and acceptable.

There are some stress resistance traits that people seem to have in common, the people who do handle traumas successfully, and I would like to look at those for a few minutes. Dr. Bessell van der Kolk of the Harvard Trauma Center, in his book, Psychological Trauma, has these listed. He points out that number one, "personal control," is very definitely an important part of stress resistance for overcoming trauma. Attitude is a very important part of personal control. The quality of our lives, ladies and gentlemen, is determined by our attitudes. We've seen people lose arms and legs, and functions of their bodies, and often these people have a better attitude than some of us. Those people have made choices as Charlie Plumb did when he was in an 8' x 8' box in the Hanoi Hilton from 1967 to 1973. He said they had the same choices over there we have today when we face adversity. They had two choices: they could cower away and die, or they could become better. He said he found that bitterness was not only not good for him, bitterness would destroy him. He saw people feel sorry for themselves, he saw people become bitter and he watched them sit down in a corner and right before his eyes, not going through anything that he didn't go through, they atrophied and died. He says those who came back chose a different route. They chose to be better. They chose to pick up the pieces of this puzzle of life, even with a few of those pieces missing, to put them back together as best they possibly could and press on with faith in themselves and their country. They chose to be committed to stand up for what they believe is right and to fight for that commitment. Faith and commitment are two traits that law enforcement officers have. Plumb said they had to have pride. Pride, even when they had been tortured, even when their bodies had been mangled and partially destroyed for life. They found they could be proud of themselves even under those circumstances. Faith, commitment, and pride, and look how well that goes together with pride, integrity, and guts. This is what you people stand for in this society, and this is what will get you through. When we reach out to help other people who happen to follow in our footsteps and wind up in a critical incident just like we experienced some years back, it gets us outside of the problem and makes us focus on the solution.

Law enforcement officers are part of the solution to society's problems. Number two on Dr. van der Kolk's list is "task involvement." Our task of preserving and protecting this society is as important a task as there is in this country.

Number three on that list is "certain healthful lifestyle choices." These choices amount to taking care of ourselves so we can take care of our jobs.

Number four is "utilization of social supports." Have them in place and nurture them constantly. Survivors not only had them in place and nurtured them, they also were people who had emotional bravery as well as physical bravery. They had emotional bravery to reach out and say, "This is bothering me. I am hurting." There are now support groups all over the country for every type of problem imaginable. We need to be able to ask for and accept support.

There are two other things that are being researched that I think are going to be added officially to that list. From my experience, I think both humor and religious beliefs are critical. We practice humor. We've all done it to break the tension. We can't be tense and laugh at the same time, so we do it quite a bit in law enforcement. We also see people come back from what should have been fatal injuries, what should have been fatal diseases, through their strong religious beliefs. So I think the power of those traits, for me, are unquestioned.

When Jim Reese and I went to Northern Ireland two years ago, we went because the police of Northern Ireland, the Royal Ulster Constabulary, asked for help. They said, "We have a problem here. It's a tough job over here. We have a lot of casualties and we don't have an employees' assistance program. Would you look at the situation and tell us what you think." And we did. We rode with them, we talked with them, we got stoned by kids while riding inside those armored rovers. We started to feel what it's like to be a member of the RUC. And indeed, in my opinion, they have the toughest job in the world. But ask me what department that I have ever been around anywhere in the world has the highest morale. I don't know who number two is, but I know who number one is. In my opinion it's the RUC.

How can that happen? Well, there is a lot of pressure from the outside, and the more the pressure from the outside, sociologically speaking, the tighter the in-group gets, and they are very close. And we said, "Why are you still here in West Belfast? Your tour was up a year ago, you could have gone back to a soft area." "I don't want to leave my friends," they said. "Well, how can you stand to lose nine people in one day?" They came to work one day and nine people were gone. Their eyes pinpointed and fixed and they said, "It only increases our resolve. They are not going to drive us out of here." And so, why can they tolerate what they are going through? Because of what we have talked about. Because their social support, their family support, their peer support, and their spiritual beliefs are strong; also the fact that they use humor, the fact that they take personal control, that they have faith, pride, and commitment. They recognize that together, we as brother and sister law enforcement officers can make it through anything. Thank you very much.

Copies of the three-hour teleconference, "Stress Management for Police," can be obtained for $35 by sending a request written on department letterhead stationery to:

Regional Police Academy
Video/Seminar Unit
3201 S.W. Traffic Way
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WHAT VALUE ARE COGNITIVE DEFENSES IN CRITICAL INCIDENT STRESS?

James Janik, Psy.D.

ABSTRACT

Anecdotes are offered, asserting that cognitive manipulations of psychological distress before, during, and after a trauma are a common human occurrence. They allow individuals to continue to function in what otherwise would be overwhelming situations; an occurrence frequently confronted by public safety personnel such as police and fire fighters. It is argued that these cognitive manipulations also reduce the dissonance created when traumatic events challenge the egocentric beliefs and neurotic assumptions that may have, in fact, propelled individuals into public safety vocations. Though such cognitive defenses are commonly used, therapists generally believed that they offer little or no benefits, in some cases may extract a psychological price in delayed and cumulative stress reactions, and, in fact, are neurotic in and of themselves. However, it is unclear which aspects of these various cognitive defensive mechanisms are helpful and which are corrosive. Preincident identification of individuals vulnerable to the negative effects of traumatic experiences and the resulting cognitive manipulations to manage them cannot yet be reliably achieved. Some considerations for such identification may include the assessment of the level of successful accommodation to previous traumas, the frequency of previous traumas and their severity, and anticipated exposure to traumas of a similar kind. This paper argues that psychotherapists involved in mandatory critical incident debriefing sessions should examine the benefits of supporting acute cognitive defenses, rather than reflexively demanding that they reexperience psychotoxic emotions and thoughts that they have laid aside.

Psychoanalytic theory postulates that ego defenses develop soon after the emergence of self-awareness to maintain a psychic equilibrium between an individual's survival instincts and the pain and anxiety that his/her frustrations in reality can cause the self (Freud, 1967). The "discovery" of the potential to "turn away" from reality in the defense of denial is not only considered a milestone in the development of the ego, but denial, itself, also becomes a building block upon which more cognitively sophisticated defenses, such as rationalization and sublimation, can eventually be built. Among other mechanisms, the denial of distress has been used to account for why some individuals are not immediately affected by traumatic experiences that cause physical and psychological symptoms in others. However, psychoanalytic theory postulates that the denial or distortion of internal and external realities carries a price of both tieing up otherwise available libidinal energies and handicapping the reasonable assessment and utilization of potential coping strategies that one could utilize with continuing and similar problems. The chronic maintenance of ego defense mechanisms has been assumed to play a pivotal role in the development of delayed and accumulating stress reactions that can develop into a posttraumatic stress disorder. However, the relationship between continued use of ego defense mechanisms and resulting chronic stress was postulated from theoretical considerations and may be oversimplified. This relationship appears, from a review of the literature, not to be universal or linear and may require an understanding of moderator variables to be predictive.

WHAT IS ONE MAN'S STRESS

Human life is invariably marked by events that would be perceived as stressful, if not a crisis, if an individual has inadequate or unprepared resources to cope with the demands placed upon him or her. One's coping responses to such situations are multidetermined by one's biology, culture, psychology, and previous pattern of success and failure in coping with stress. Some of these stressful situations occur in the normal

course of psychosocial development and have prescribed resolutions (e.g., rites of passage), while others are traumatic and lie outside the experience of most people. They all, by definition, tax an individual to the fullest and may precipitate the use of previously successful, albeit more primitive, coping mechanisms that may be marginally effective in the present situation. Currently, not enough is known about what constitutes poor, minimal, good, or excellent adjustment to a traumatic event, much less the relation between the initial choice of coping strategy and the long-term consequences of that coping. For example, Mitchell (1988) reported that, in general, 20% of public safety personnel admit to acute psychological or physical symptoms following a critical incident (rescue, shooting, etc.); yet, only about 4% of them develop a formal diagnosis of PTSD. Thus, 80% of public safety employees were able to successfully utilize ego defenses and suffer no acute ill effects from participation in critical incidents. Further, 80% of those whose cognitive defenses were acutely inadequate and experienced initial symptoms apparently recovered. While this initially appears optimistic and to support the increased use of cognitive defenses, it is unclear from Mitchell's report what percentage of the group of nonsymptomatic or improved public safety workers received psychological debriefing to assist their own coping mechanisms. It also should be noted that the 4% of public safety workers who develop formal PTSD is twice the national average (Mitchell, 1988) and remains an unacceptably high number of casualties.

There are many other unanswered questions that remain regarding the relationship between the use of cognitive defenses and the development of PTSD. For example, is the use of denial always a pathognomonic sign, or can it simply reflect an individual who has successfully accommodated to higher levels of stress than most of us experience? Are there individual personality differences, or differences in one's (un)successful use of cognitive defenses in the past, that make some individuals more effective in their use than others, or does everyone have his/her own absolute breaking point? Are there situational variables, such as the frequency, severity, and quality of previous experienced stressors that universally make one more or less vulnerable to being overwhelmed in the future, or do stressors of the same kind, e.g., death of a child or co-worker, more quickly erode one's resistance to stress? Are there social variables, such as the support of fellow workers, that mediate the impact of stress and give the use of cognitive defenses strength through consensual support? Are there characteristics of the cognitive defenses themselves, e.g., their sophistication, rigidity, comprehensiveness, and pattern of maintenance in the face of conflicting evidence, that differentiate "the grace of forgetting" experiences of pain and anxiety, from that denial that can become the genesis of psychopathology? Do we, as a society, experience more cumulative stress over our lives now than generations in the past, or do we now have higher standards for individual job performance that makes us more sensitive to deterioration that in the past would have been noncritical? Does the breadth of one's stress history identify individuals who are at more risk for disorder, or does it simply identify people who are more efficient in coping with stressful experiences? Beyond the use of psychological defenses, what else accounts for some individuals' accommodation to traumatic experiences that can leave others with residual psychological and physical symptoms? For example, what determines if an individual perceives a situation as either a threat or a challenge, and further, what situational and personal factors can lead to errors in the initial appraisal of stressor magnitude, reoccurrence, and the affective deployment of coping resources? Are there common cognitive assumptions made by individuals in public safety work that facilitate or put them at greater risk for the effective use of psychological defenses such as denial? Lastly, what is the measure of adequate adjustment to stress? What yardstick for mental health do we utilize; is it the ability to function at previous levels of performance, or dies it necessarily include continued aspiration to self-awareness and growth.

While neither this paper nor the literature has answers to these many important questions, this report will review the relevant studies of the effect that the use of cognitive defenses have had upon distress experienced by public safety workers. It offers some considerations that health providers should examine before reflexively advocating that trauma victims must relive their experiences before they can master them.

MODERATOR VARIABLES ON THE EFFECTIVE USE OF PSYCHOLOGICAL DEFENSES

Recently, Lavie (1989) compared 10 male and 13 female World War II Holocaust survivors who were judged to be functioning well in public and private life with less well-adjusted survivors and an untraumatized control group. He found that while controls recalled their dreams 80% of the time and less well-adjusted

survivors recalled their dreams 50% of the time, surprisingly, well-adjusted survivors could not recall their dreams more than 33% of the time. Further, the dreams reported by the less well-adjusted survivors contained significantly more anxiety and aggression than the dreams of the well-adjusted survivors. His results imply that those individuals who were best able to repress disturbing images and emotions in their dreams, or at least were better at later consciously suppressing or denying them in their reports, were better adjusted and functioning more normally. In a similar group, DeAnglis (1990) reported that Segliman and Vaillant recently examined 99 Harvard graduates who had difficult experiences during World War II. He said, "the team found that the (extent of the) excuse-making style for the negative life events experienced in 1946 and tracked longitudinally up to 1988, significantly predicted (better) physical health, especially for physical health measures taken at age 45 and every 5 years thereafter" (p. 22).

Other moderator variables were reflected by the work of Nadlier and Ben-Shuman (1989) who, not surprisingly, found that 34 male and female Holocaust survivors were generally psychologically more worse off than nontraumatized controls. However, they also found that rural male survivors who overrigidly adhered to their perceived sexually appropriate roles as protectors and providers and male survivors living in the city without familiar support, were significantly more impaired than Holocaust survivors who were emotionally expressive and who could be codependent upon fellow kibbutz members, especially if those members had shared similar experiences. Thus the effectiveness of their accommodation to their Holocaust experiences was moderated by variables of social support, self-image, and perhaps even their (young) age at the time of the trauma. Nadlier and Ben-Shuman wrote that these male, isolated survivors deteriorated from their initial level of functioning as they "repressed the trauma and dealt with the world by trying to rebuild what was lost (from their youth) in old age. When these tasks were over, attention was no longer centered on tasks in the external practical world and the psychological effects of their traumatization resurfaced" (p. 291). Pennebaker (1989) would call these distressed individuals "low disclosers." He found that research interviews that reexamined Holocaust experiences caused an increase of physical problems and physician visits for "low disclosers" who had otherwise apparently been leading successful and productive lives, without psychosomatic problems. This phenomena did not occur for "high disclosers" who presumably had "worked through" their experiences, through social contacts. He concluded that accommodation to stressors is moderated by the probability of reexperiencing previous traumatization or being confronted by new traumas that bring those previous traumatic experiences to mind. That is, previously traumatized "low disclosers" individuals may be less "stress hearty" and stress resilient than nontraumatized individuals. This may be relevant to the choosing of peer counselors, who are often selected for the credibility that they achieve by previously experiencing and accommodating to traumatic experiences.

Similarly, there appear to be moderator variables such as age, previous experience with trauma, and identification with the victims of trauma that also contribute to the effective use of mental imagery to ameliorate the gruesome sensory stimulation of the sights, sounds, and smells involved in disaster situations. These experiences, more than any other, lead to the disturbing memories and intruding thoughts that Baum believes are pathognomonic of the development of subsequent posttraumatic stress disorder symptoms in public safety personnel (Adler, 1989). Jones (1985) wrote that military mortuary workers who responded to Jonestown, Guyana, found it "difficult to convey to someone who has not had first-hand experience what a week in a tropical climate can do to human remains. The changes in color and size, infestations by various insects, and above all, the overpowering and unforgettable odors of just one body are beyond imagination" (p. 306). Jones found that youth who were inexperienced with disaster work and who had cultural similarity to the young victims were least effective in dealing with their experience and complained of subsequent disturbing dreams and interrupting thoughts from the ordeal. However, one of the better adjusted, "seasoned" rescue personnel who were not subsequently symptomatic revealed to Jones the cognitive defense imagery he used. He said, "at first, the magnitude of the operation prohibited me from realizing that they were really humans instead of, frankly, just slabs (of meat)."

Similarly, Taylor and Frazer (1983), in their follow-up of body recovery personnel after the 1979 air crash in Antarctica, found that 30% of the experienced rescue personnel spontaneously used denial imagery to help them cope with a task that they described as "visually offensive and somewhat hazardous underfoot.

Those on the ice strip had to cope with short and tense bursts of heaving and throwing slithering loads of juicy flesh as each helicopter arrived with an underslung cargo of bodies from the mountain for repacking" (p. 7). Of the mental imagery that rescue personnel used, they reported: "23 regarded the bodies as some kind of object, 16 as either frozen or roasted meat, 7 as plane cargo, 4 as wax works, and 4 as scientific specimens" (p. 8). Taylor and Frazer (1983) found that those rescue personnel who used this denial imagery were significantly unrepresented in the high-stress group and were significantly less likely to report PTSD experiences. They concluded, "if the use of imagery were demonstrated beyond a doubt as being helpful for those engaged in accident and recovery work, it could have a place in their training instead of being left simply as an incidental chance occurrence. Indeed, this sort of imagery may be helpful in dealing with the involuntary recall of intrusive memories from disaster experiences." Longitudinal data on these groups' adjustment were not available, so it is difficult to determine if the use of "denial imagery" was effective in more than the short-term adjustment of "seasoned" rescue personnel.

Another moderator variable in the determination of the stress heartiness of rescue personnel appears to be their ability to utilize a variety of cognitive defensive mechanisms rather than to rely on a few favorites that may not always be effective. Durham, McCammon, and Allison (1985) began the process of identifying a taxonomy of cognitive coping strategies and reported on 31 different mechanisms reported by public safety personnel. In the main, they fell into three major categories: (1) simple denial (e.g., concentrate on other things, put the feelings out of my mind, withdraw from people, spend more time listening to music, writing, or getting in touch with nature); (2) rationalization (e.g., think about good things in life, turn to religion or philosophy for help, figure out which things you feared really could happen, look at things realistically, think about the humorous parts of the event); and (3) focusing on work (e.g., be more helpful to others, devote self to work, figure out the meaning of being in rescue work). In a similar effort, Taylor, Wood, and Lechtman (1983) identified five cognitive mechanisms, which appeared to be types of rationalization, that public safety personnel told them were helpful in their coping with distressing situations. These included: (1) comparing one's self with those less fortunate; (2) selectively focusing on positive attributes of one's self to feel advantaged; (3) creating a potentially worse situation; (4) construing benefits from the victimizing experience; and (5) manufacturing normative standards that make one's adjustment seem normal.

COST/BENEFITS RATIO OF COGNITIVE DEFENSES

Janis postulated in 1962 that individuals who were unable to deny the severity of a situation through defensive mechanisms would fare more poorly than individuals who could turn away from reality long enough to gain a sense of mastery over the traumatic situation. I am sure that rescue personnel were intuitively using defensive cognitive mechanisms long before that. However, what do public safety workers do when the rescue experience challenges deeply held beliefs, at the foundation of their sense of self--for example, beliefs that they live in a just world, beliefs in their own competence, and beliefs that they will be rewarded for their sacrifices. Since critical incidents represent only a small fraction of the daily experiences of public safety personnel, it is quite understandable that using a strategy of encapsulated and perhaps temporary cognitive manipulation or denial on one's inner (physical and emotional) and external reality makes more sense than substantially altering the basic assumptions upon which one bases one's personality, sense of self, and essential "meaning-in-the-world." For example, Gur and Sockeim (1979) found that individuals with high scores on a scale measuring the denial of common human failing were less depressed and showed fewer signs of mental disturbance than individuals with low scores. They maintained that those who were self-deceptive were, at least in some respects, mentally healthier than those who were not. Thus, these cognitive defenses allow public safety personnel to hold off cynicism and maintain optimistic beliefs about the value of life and their efforts to save it, over the course of their careers, in the face of repeatedly confronting self-destruction, injustice, incompetence, and disregard of others.

Another focus of public safety personnel has been the use of cognitive mechanisms in dealing with specific experiences of intruding thoughts. Adler (1989) reported, from his recent research, that intrusive imagery and thoughts were pathognomonic of subsequent symptoms of PTSD. He reported that intrusive imagery was more predictive of chronic stress in 34 Vietnam veterans studied by Andrew Baum than the

amount or kind of combat experiences they had. He also reported that the inability to keep fears related to the 1979 TMI accident "out of mind" also differentiated those who suffered from chronic stress years later. He suspected that many of those individuals who suffered from intruding thoughts were "across-the-board denials" who became obsessed with keeping certain thoughts out of their mind--a strategy certain to keep those thought erupting into consciousness. Adler reported that these individuals were initially seduced by the immediate effectiveness of simple denial because it affords a temporal and emotional distancing from the trauma and imparts an immediate sense of mastery in finding a solution to their problem. However, it carries the seeds of self-limitation in it, as one is conditioned to be constantly vigilant for an erupting idea that needs to be denied. For example, Wagner (1989) noted that intentionally suppressed thoughts occur about twice as often as thoughts that subjects were told not to suppress. Pennebaker (1990) found a strong correlation between chronic complaints of intrusive thoughts and complaints of "depression, low self-esteem, and whining." It is very likely that those who may become vulnerable to PTSD because of this strategy to complaints of intrusive thoughts will be distinguished not by the denial of their problems but rather by the way that they cognitively store and recall information. For example, he may find overrepresented in the distressed category those with rigid personalities, whose opinionated stances leave little room for flexible and alternative coping and whose felt need to control over life experiences propel them into controlling experience they ought not, and cannot, control. It appears, then, from this evidence that public safety personnel's use of cognitive mechanisms in controlling intruding thoughts is largely limited to initial success, and their continued use may even exacerbate their distress.

A variable affecting the efficiency of cognitive defenses is how important and relevant to basic life support is that which is denied. Hobfoll (1988) recently advanced an economic theory of a model of conservation of resources in the face of stress. His economic model defines stress as a threat to the accumulated resources that individuals invest in for reasons of mastery, self-esteem, independence, and social economic status. These resources might include physical objects (such as a home), conditions (such as marriage or tenure), characteristics (such as moral virtues), and energies (such as time, money, and knowledge). Environmental circumstances (such as a disaster) can threaten and deplete an individual's resources and make one vulnerable to a net deficit of resources. In this model, then, the obvious disadvantage of cognitive defenses is the lack of preparedness that it could incline an individual to, should one not replace depleting resources that impact directly upon one's physical security.

This model also shows that a lack of realistic assessment of one's psychological resources could put one at jeopardy for emotional bankruptcy, if psychological resources are depleted without renewal. For example, Mitchell (1983) described the price paid by part of a North Sea oil drilling crew, whose lack of realistic self-assessment led to their further distress. Their oil platform toppled over in a storm and there was great loss of life. Survivors were brought into port in two groups, arriving several hours apart. The first group was hospitalized and received a psychological debriefing, but the second group, which was told of this, denied the need for debriefing and refused contact with psychological personnel. Members of the first group, who were psychologically debriefed, were reportedly adjusting and functioning normally in life, some in their old jobs. Many members of the second group, who essentially did not have the benefit of debriefing to boost their psychological resources of mastery, esteem, independence, status, and self-resourcefulness, reportedly continued to experience delayed stress reactions and physical symptoms. Interestingly, Mitchell reported that some of those in the second group were unable to perform any work even though they received debriefing several months later, indication that they may have, in fact, used their cognitive defenses such as rationalization to accommodate their depleted level of psychological resources. The price they paid for their refusal to replenish their psychological resources through debriefing may have been a willingness to slip into a lower psycho-economic status.

Thus, the long-term efficiency of cognitive defenses in distressing situations depends upon one's motivation for making changes in the situation that would reduce future distress and chances of future victimization. For example, Wortman (1983) found that the less rape victims utilized denial, the more they were likely to change their behaviors to be less vulnerable to victimization in the future. However, she also indicated that the cost paid by these women for not using cognitive defenses was the challenging and altering

of their closely held beliefs about the world (e.g. it is just and fair). She reported that women who shunned the comfort, albeit temporary, of denial and other cognitive defenses became more bitter, angry, hostile, and cynical, and, in some cases, gave up and became more passive and withdrawn; neither extreme of which was helpful in addressing their circumstances.

TREATMENT OF DENIAL: IS IT AN ALL-OR-NOTHING PROCESS?

It appears, then, that the utilization of cognitive defenses in the traumatic experiences of rescue personnel are moderated by many variables, some of which are difficult to assess and measure, and the efficiency of some of which may be idiosyncratic to individuals. These variables would have to be assessed by a therapist/debriefer in evaluating the helpfulness of a public safety worker's cognitive defenses to his present and long-term situation, especially in view of the characteristics as shared by many of them. For example, Lefkowitz (1977) has confirmed the observation of many by documenting the predominant lack of self-disclosure among police officers compared to other populations. Although he believed that low self-disclosure was reflective of the type of person attracted to police work, Parker and Roth (1973) found disclosure to decrease with time on the job and situational concerns generic to all public safety personnel, like not wishing to worry a spouse at home by talking about experiences on the job. Additionally, the desire to appear confident, unbothered, and undiminished by high-stress situations and even "macho" to fellow workers is well understood among public safety workers. Thus, either by preselection or adaptation, it should be presumed in treating public safety personnel that a condition of low self-disclosure exists. As previously noted, this makes them more vulnerable to PTSD and more inclined to utilize cognitive defenses in an attempt to deny their psychological and physical distress.

Even if a therapist chooses to increase self-awareness of the use of cognitive defenses by confrontation or other techniques, it will not be an easy task with most public safety personnel. First, denial and all of its derivations in ego defenses are difficult to recognize and treat because they are only indirectly discerned from their effect on other systems. However obvious, denial is rarely admitted to, though sometimes clients are willing to admit to malfunctioning psychological, physical, or social systems, if they appear unrelated to the denied distress and especially when they can be attributed to the actions of someone or something else. For example, public safety personnel are apt to manifest acute, delayed, or cumulative stress in complaints of marital or job difficulties, somatic distress that makes them unfit for duty, or substance abuse. Even here, self-reports may be biased by a client's desire to seek secondary (financial, power, status) gain from another or to make himself or herself appear more attractive or sympathetic to fellow workers, bosses, or spouse. Thus the self-awareness sought after is always apt to fall short of expectations and may, in fact, rob public safety workers of defensive mechanisms that enable them to perform adequately.

In the ordinary course of clinical events, the hypothesis of denial is presented to the client by interpreting his/her behavior (especially verbal) for derivations and unconscious meaning that may be oblique to the client. For example, the inconsistency of blaming the innocent victims that the client has sworn to protect and criticizing the rescue effort that he/she is a contributing part of, is evidence that other issues are bothering the client. In instances of self-destructive behavior (substance abuse or fighting on the job) or even corrosive behaviors (marital infidelity, poor performance or absence abuse on the job), confrontation of the denial is essential in reestablishing a healthy equilibrium between the individual and the world. However, whether it is necessary to confront all psychological defenses is not well-addressed in the literature. Purists, in especially the psychoanalytic and human potential movement, who advocate a constant striving for peak performance, ideal self-realization, and ultimate self-insight, would advocate the timely confrontation of all defenses. However, brief therapy models, especially those used with individuals exposed to acute stressors in military situations, recognize the benefits of stimulating self-adjustment and propelling an individual to strive for his/her own mental health by returning the person to functioning. A brief therapy would not necessarily confront the acute defensive use of mental imagery upon "seeing the decomposed bodies of children (Jones, 1985, p. 7).

Deciding on whether a public safety worker's response to a traumatic situation is pathological is quite complex and much is left to a diagnostician's discretion in assessing a Posttraumatic Stress Disorder's symptoms as to their frequency, their severity, and their impact upon the individual (APA, 1987). A necessary part of such an evaluation is an assessment of the quality of the client's cognitive defenses; information necessary to have before those defenses are routinely confronted. Aside from the idiopathic concerns of prematurely stripping a client of acutely needed defenses, there may be no need to spend time confronting temporary defenses that will abate with accommodation to the crisis. This is not only a more cost-effective use of psychological resources, but it is also a more "client respectful" position for a therapist to take. The rigidity vs. flexibility of those cognitive defenses must be assessed. The longevity of their use should, as well, be looked at and their specificity to the crisis. For example, is the defense, however rigid, only temporary and only used in response to specific stimuli (underwater recovery of bodies) or has it begun to generalize to other areas of life (sex, hugging children). Defenses can be multilayered and vary in their level of ego-sophistication reflected by the defense. For example, sublimation requires significantly more ego-sophistication than the simple denial often used by children (Freud, 1967). The breadth of the defenses and their cultural support (e.g., from fellow workers) should be inquired about. The plausibility of the defenses and the resultant impairment that comes from their use should also be assessed.

Left to their own devices, there is apt to be peer support and approval for the denial of distress in public safety personnel. They suspect that any vulnerabilities admitted to may be used against them by supervisors in consideration for promotional opportunities and the assignment of additional responsibilities. The preferred crucible, then, for the evaluation of the defenses utilized by public safety personnel is critical incident stress debriefings. These, first proposed by Mitchell (1983), have become quite formalized and readily put participants through phases of introduction, recounting of facts, emotional exploration, symptom experiences, and instructional techniques of coping with their situation and reentering their peer group. Here, in the familiar group setting, experienced clinicians can recognize the limited numbers of ways that inappropriate cognitive defensiveness can be manifested. For example, undue withdrawal, jocularity, motor agitation, and physical manifestations of anxiety can be observed. Verbal behavior can be analyzed for its clarity of communication and unconscious meaning, and how a client handles the restrictiveness of appropriate expression, especially during reflective silences, can be quite revealing about his/her cognitive defensive structure. Here, then, therapists can decide which areas of defensiveness may be more important to confront than others and avoid the concern of Williams (1987) that premature confrontation of denial reactions, especially in peer group settings, only serves to solidify that denial and commit the client to it among a group of familiars that he would have to sustain it for on a daily basis.

In assessing whether to confront an area of defensiveness, it is important to consider the following qualities. For example, is the defensiveness an insignificant, temporary device to save face, or has it become an ingrained defensive device that touches upon many other aspects of the person's life? How resilient and rigid is the defensiveness to the introduction of new ideas and beliefs that directly confront the denied position? Does the client admit to the possibility of the denial? Does the client's emotional reaction to confrontation of the denial give one the feeling that a person's life would become unsettled without rigid adherence to the denial? What consensual support from respected peers, family, and community is there for the denied position? To what extent is it only a contrivance of social attractiveness and role adherence? Does it involve the denial of physical sensations, which may be later reflected in other physical symptoms? Does it only involve the denial of a gruesome reality not often experienced by others, or of more commonplace occurrences? What cognitive assumptions that make life worth living and meaningful to the client would be challenged by confronting this denial?

Perhaps the inability to face negative information about the limitations of ourselves and the world around us makes us a less mature species than we could be. Perhaps, having the wisdom to know that no matter how desired, nothing good will last and being tough enough to live without illusions or even the hope of illusions is something that will bring us closer to the reality of our "being-in-the-world," and something to aspire to. However, most of us cannot afford to stop our lives and dedicate ourselves to the quest of self-development while there are people in distress who can benefit from our attention and energy. While we as

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THE UTILIZATION OF POLICE PEER COUNSELORS IN CRITICAL INCIDENTS

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ABSTRACT

The use of peer counselors in law enforcement is a relatively new phenomenon. Between 1955 and 1981 they were used on a very limited basis, primarily to help officers deal with alcoholism. In 1981, the Los Angeles Police Department began using police officers for a much broader range of situations, and in 1982, Drs. Linden and Klein developed a formalized peer counseling program that was adopted by the State of California.

Since about 1982, peer counselors have been utilized to assist other officers involved in critical incidents. These incidents were primarily officer-involved shootings. However, they could also include such things as officer-involved fatality accidents or handling the death of a child. Recent research has shown that any individual involved in a traumatic event can benefit from counseling. Without counseling it appears the prognosis for a complete recovery is decreased. Conversely, when [peer] counseling is provided the symptoms are lessened and the person can return to normal functioning sooner.

The most recent use of peer counselors, and the one that holds a great promise for the future, is the use of peer counselors in disaster situations. Here the police peer counselor can assist not only officers but also paramedics, fire fighters, citizens, and family members.

Peer counseling is a win-win situation. If officers feel better, they function better. If they function better, they benefit, the department benefits, the citizens benefit, and their families benefit.

HISTORY AND RATIONALE FOR PEER COUNSELING

The utilization of police peer counselors is a relatively new concept. Peer counselors began to be used back in the mid-fifties. The Chicago Police Department began a program in 1955 as an approach to dealing with alcoholism within the department. About the same time, the Boston Police Department's stress program began as an informal alcoholism counseling program.

New York City established an alcohol program in 1966. Its concept was that when the department recovers a sick member, it gains a highly motivated person, a more compassionate peace officer, and a grateful family. Although individuals with personal problems were helped by the program, the thrust was still on alcoholism.

In 1968, the Los Angeles Police Department, under the direction of Dr. Martin Reiser, established an in-house behavioral science unit. It was one of the first departments to develop and implement a fully department-supported peer counseling program in 1981.

In 1982, Drs. James Linden and Robin Klein conducted the first peer counseling training program for the Long Beach Police Department. Later that year this program was certified by POST (the Commission on Peace Officers' Standards and Training). This program, designed to train police officers in basic counseling skills, has been utilized by over 40 departments throughout California. Additionally, a number of specific subjects that the peer counselor is likely to encounter are included, such as relationship problems, chemical

dependency, stress, women and minorities, suicide, posttraumatic stress disorders, and more recently, disaster management.

The purpose of the peer counseling training program is to structure the practice of police officers helping one another in a more positive manner. It has been said, and probably rightfully so, that no one better understands the problems of a police officer than another police officer. With the built-in trust that police officers have for each other, peer counseling becomes a "natural."

The purpose of peer counseling training is to train a cadre of peers to do counseling. There is no intention to make them psychologists. They are trained to recognize problems and to be at least the first step in the ultimate solution of them. This ultimate solution could be provided by the peer counselor or could be in the form of a referral to an outside agency or outside psychologist.

From a tactical perspective, we typically do an outstanding job of handling critical incidents. Whether the incident is an officer-involved shooting or an airplane crash, we do a very thorough and complete investigation. However, until very recently we have totally overlooked the "forgotten victims"--the officers and other emergency rescue personnel who are involved in the incident. We have not provided for their psychological well-being.

Increasingly in the last several years, we have begun to recognize the importance of providing psychological assistance to the officers. The prognosis for recovery seems to be the best when there is counseling for the officers just as soon as practicable. The peer counselors are the logical people to provide this initial assistance. They are typically readily available, trusted by the officers, and familiar with the type of situation that the officer has just experienced. With the proper training, they can provide at least the first step towards psychological resolution.

The remainder of this paper will discuss the use of the peer counselor in posttraumatic stress situations (primarily officer-involved shootings) and disaster management.

POSTTRAUMATIC STRESS

The Longman Dictionary of Psychology and Psychiatry and the DSM-III-R provide an encapsulated review of PTSD (Posttraumatic Stress Disorder). Longman (Goldenson, 1984) defines PTSD as:

> An anxiety disorder produced by an uncommon, extremely stressful life event (e.g., assault, rape, military combat, flood, earthquake, death camp, torture, car accident, head trauma, etc.), and characterized by (a) re-experiencing the trauma in painful recollections or recurrent nightmares, (b) diminished responsiveness (emotional anesthesia or numbing), with disinterest in significant activities and with feelings of detachment and estrangement from others, and (c) such symptoms as exaggerated startle responses, disturbed sleep, difficulty in concentrating or remembering, guilt about surviving when others did not, and avoidance of activities that call the traumatic event to mind. (p. 573)

DSM-III-R (Diagnostic and Statistical Manual of Mental Disorders) (APA, 1987) defines posttraumatic stress disorder as:

> The development of characteristic symptoms following a psychologically distressing event that is outside the range of usual human experience. . . . The stressor producing this syndrome would be markedly distressing to almost anyone, and is usually experienced with intense fear, terror, and helplessness." (p. 247)

The peer counselor will primarily encounter officers who are suffering from PTSD in the case of officer-involved shootings. However, this syndrome is certainly not limited to officer-involved shootings. Other events that might precipitate this disorder are the death of a child; a fatal traffic accident, especially where the officer is involved; rape victims; and major disasters such as airplane crashes (which will be discussed later in this paper).

Much can be done by the peer counselor to help an officer who is involved in any of these situations. The limited research that has been done in this area indicates that if assistance is provided in a timely manner, the prognosis for a fast recovery and adequately dealing with the event is very good.

Following is a list of the psychological and physiological symptoms that may result after an officer is involved in a shooting or other traumatic situation. Depending on the circumstances of the event, the personality of the officer, and the way it is handled (by the department, the media, and his/her family), an officer involved in a traumatic event may or may not have some or none of the following reactions. He/she may experience these reactions immediately or the reactions may be delayed.

SYMPTOMATOLOGY

1. FLASHBACKS are a typical part of the syndrome. The officer will relive what happened at unpredictable times afterwards; the flashbacks may take the form of nightmares or simply vivid waking experiences. Typical nightmares when the officer has been involved in a shooting involve dreams of shooting the person and the person doesn't go down, that the bullet just drops out the end of the gun, or that the gun turns to rubber.

2. TIME DISTORTION is common. Time slows down during the event so that it seems things are going in slow motion. It is such an emotionally impactful experience that each and every detail passes by and is remembered vividly. It's like watching the event frame by frame. In this category is also sound distortion (the sound of gunfire might not seem nearly as loud as it usually would), tunnel vision, and being incorrect in the number of rounds that were fired.

3. FEAR OF INSANITY AND LOSS OF EMOTIONAL CONTROL are common. The officer feels he is "losing it," that he's never going to get over the initial horrendous shock of having killed another human being, and that he will be emotionally crippled for life.

4. There is sometimes a perceived HEIGHTENED SENSE OF DANGER after the shooting. Relatively innocuous situations pose much more danger than they ordinarily would. This can also take the form of the officer being afraid to return to the location where the event occurred or to handle a similar type of situation. This fear often generalizes to other officers so there is a hypersensitivity to the particular type of event.

The following is an example of a systematic desensitization process that I did with an officer who had been involved in a shooting. This same process could be done by any peer counselor.

> An officer had been involved in a shooting geographically in the middle of his beat; thus it was virtually impossible for him to handle calls and still avoid this area. This officer was terrified of returning to this particular location and sought counseling to assist him with this problem.
>
> I started off the desensitization process by having him sit in my office and just talk about his fears. I validated them and told him that they were normal for the situation. I also reinforced the idea that there was nothing wrong with him for being afraid. Then I had him go through a visualization process and imagine what it would be like to return to this

location. Next I took him and drove past the location without stopping, and we discussed the feelings involved. Finally we drove to the location and got out and walked around the area, after which we again discussed his feelings.

The officer then went back to work and was, admittedly with a little fear, able to return to the location by himself to handle calls.

5. There is often a great deal of SORROW AND GUILT, even if there was absolutely nothing else the officer could have done than what he did. This irrational, but common, "if only I would have done this or that. . . " This is magnified many-fold when the victim/suspect is a child. Feelings are not necessarily rational. It is often helpful to have them look at the differentiation between guilt and sadness.

6. A common defense against the trauma is called EMOTIONAL NUMBING. There is a flattened affect, or apparent lack of feeling, that is designed to protect the officer against feeling anything. Life at this point is too terrible to risk confronting it head-on; it is easier to suppress all feelings and live at the surface, so to speak.

7. If the officer were about to confront a PREDICTABLE LIFE CRISIS at the time of a fatal shooting, the shooting, itself, may precipitate this crisis sooner. For example, if the officer were beginning to deal with moving into middle age, losing some of his vigor from youth, experiences which all of us face, a shooting might expedite or exacerbate this crisis and force him to deal with it sooner than he would have ordinarily.

The following is an example of how a traumatic event can serve to exacerbate an existing life crisis.

An officer was involved in a fatal shooting. Unfortunately, as is all too often the case, the report was on the news before he got home. When he walked in the door his wife said, "Welcome home. I never realized that I was married to a cold-blooded killer."

While this relationship ended in divorce, obviously there were problems in the relationship prior to the shooting.

8. SURVIVOR GUILT. This concept was reported as a result of the German concentration camps where whole families of Jews were decimated. Like Holocaust survivors, the officer may feel guilty for having survived. This is especially true if his or her partner was killed or seriously injured. This phenomenon is experienced most often by partner officers, but is also experienced by backup officers who were responding to assist the officer, and occasionally by communication personnel and supervisors who were making behind-the-scenes decisions.

9. PSYCHOSOMATIC SYMPTOMS. There are a number of common psychosomatic symptoms that the officer may experience, including ulcers, high blood pressure, and chest palpitations.

10. Occasionally, there is TEMPORARY IMPOTENCE, loss of sexual drive, and/or virility. This may further traumatize the officer and should be seen as a not uncommon side effect of the syndrome.

11. There may be EATING PROBLEMS. Usually this is a lack of appetite, but in the case of individuals who tend to have eating problems, this may take the form of overeating.

12. ANNIVERSARY REACTION. Often the officer will experience a reaction on the anniversary of the traumatic event. One officer told the author that he would stop all conversation and have a moment of silence every year at the exact time that he had been involved in a shooting. Another officer indicated he still took the day off every year on the anniversary of the shooting that he had been involved in, the shooting having occurred 18 years previous.

PEER COUNSELING INTERVENTION

There are a number of things that the peer counselor can do to assist any officer, civilian employee, or citizen to better cope with a traumatic event. These activities on the part of the peer counselor can have a dramatic effect on the ultimate outcome of the situation and on the officer's well-being. Often a good opener for the peer counselor is something to the effect of: "I don't know exactly what you are going through, but I would just like to be here to listen to you."

Allow the person to ventilate. That is, you provide a safe, confidential, and nonjudgmental environment for the person to get in touch with the feelings and emotions. Encourage the officer to express any emotion that he/she is feeling, whether this be anger, regret, sorrow, etc. Encourage the officer by reassuring him/her that all of these emotions are normal and that it is much more healthy to deal with these feelings than to repress them.

Have the person tell the story frame by frame. This is an outstanding desensitization process. It also allows the person to realize that hindsight is 20/20 and that at each step of the event the very best possible decision was made based on the information at hand at that moment. Subsequent information might have caused the person to make a different decision but the decisions were governed by the information that he/she had at the time, and nothing more. If, for example, the officer had realized that the suspect was a juvenile, that it was the wrong person, or that the person was not armed, the officer might have taken a different course of action. Encourage the officer to tell the story more than one time; this can help him/her through the thoughts, feelings, and emotions.

Tell the person that what is being experienced is "normal for an abnormal situation." That is, the person is not crazy or not "not good enough" because he/she is experiencing these things.

Encourage the person to get some exercise. Exercise is an outstanding way of countering this tremendous buildup of stress.

If available, encourage the person to join an appropriate support group. This might be a group within the police department such as an officer-involved shooting group or it might be a group outside the department such as a support group for parents whose children have committed suicide.

With the approval of the officer, involve significant others. Usually the officer wants to be the one to tell this person about the situation that he/she was involved in. However, you can often provide some suggestions on how the officer might approach this person, especially if there is a lot of controversy surrounding the incident or where it has received wide news coverage.

A related area that the peer counselor may well be involved in is where the officer is shot or otherwise critically injured. The peer counselor could take responsibility for notifying the officer's family and then assisting them both psychologically and with such logistical things as picking up children from school and getting to the hospital.

Advise the officer as to the procedure that is followed by the department in this situation. This obviously means that you must be aware of what this procedure is and be able to accurately convey this to the officer. Paranoia runs rampant and there is often the tendency for the officer to look at every action on the part of the department as critical of his/her actions. Advise the officer: Who will be talking to him/her, in what order, what the purpose of their conversation will be, and who will be contacting him/her for follow-up, such as the district attorney's office. Also advise the officer if his/her weapon will be taken away (in the case of shootings) and what the purpose of this is.

The following is an example of needless trauma that officers can experience after a shooting just because they are not aware of the procedure that is followed. This trauma could easily have been avoided if the officer had just been told of the procedure.

> An officer was involved in a fatal shooting and everything was apparently handled in a satisfactory manner, as the officer had not heard anything for a week. During the second week after the shooting the officer received a letter from the district attorney's office. The officer was terrified to open it, feeling sure that they were advising him that criminal charges had been filed against him for murder. Finally he mustered up the courage to open the letter, only to find that they were simply advising him that they were investigating his shooting as they investigate all officer-involved shootings.

Depending on department policy, the peer counselor should be on the scene as soon as possible, and, in the case of a traumatic event in the field, remove the officer from the area as soon as practical. The peer counselor should stay with the officer for as long as he/she deems it necessary and should be prepared to see the officer on follow-up contacts. It is important to remember that if the emotions and feelings are not adequately dealt with in a timely manner, they will resurface if the officer is involved in another incident, especially if it is very similar in nature.

There are a number of symptoms that tend to indicate that the officer's condition is more severe than usual and the peer counselor should consider making a referral to a psychologist who is familiar with handling similar situations. If the symptoms continue for an extended period of time, a referral might be considered. This "extended period of time" is not easy to define. However, if there does not seem to be any improvement or if in doubt, either make a referral or at least consult with a mental health professional.

If the officer is having either visual or auditory hallucinations (that is, seeing or hearing things that are not there), there should be an immediate referral. Likewise, if the officer is suffering delusions (a false belief such as delusions of persecution, grandeur, etc.), an immediate referral should be made. If there is any disorganized thought process (as demonstrated by jumbled speech, etc.), if there are any signs of potential suicidal or homicidal thoughts or ideation, or if there is chronic depression, these people should be immediately referred.

The following example represents a critical role that the peer counselor can play in a posttraumatic incident:

> I was asked to assist the Sheriff's Department as they had just had two deputies shot; one was shot in the head and subsequently died, one was shot in the spine and was ultimately paralyzed. My role was to assist from a psychological, not a tactical, perspective.
>
> When I arrived at the scene, there was the usual confusion, and after a considerable delay, I followed the paramedics to the hospital with the officers. At the hospital all of the officers were crowding around the emergency room and hindering the efforts of the doctors.
>
> I arranged to have a special room set up for officers. This served to keep them all in one location, assisted the hospital personnel, facilitated the flow of information as to the condition of the officers, and provided a basic forum for beginning to deal with their frustrations. I arranged for a phone in the room, for coffee, and for regular updated information to be provided to the officers.
>
> This room also served to provide a sense of privacy for the officers from the rest of the people in the hospital. Additionally, one of the officers was taking his gun out, wanting to go for a walk alone, and stating that it was all his fault that it happened. Obviously he was dangerously suicidal and needed to be dealt with.

While there is obviously nothing medically that the peer counselors can do to assist an officer who is injured, there is a lot they can do to assist the other officers and the families of the injured officers.

The previous section has discussed the utilization of peer counselors to assist officers involved in traumatic incidents, primarily officer-involved shootings. It was pointed out that the peer counselor could substantially increase the prognosis of recovery from these events by timely intervention. The next section will examine the use of peer counselors to assist the rescue workers, including police officers, who must handle a major disaster.

DISASTER MANAGEMENT

The use of psychological services, including peer counseling, is relatively new in law enforcement. Even newer (since 1976) is the recognition that a major contribution can be made towards the psychological well-being of police officers and other emergency workers at the scene of a disaster. Until relatively recently it was generally believed that the rescue workers did not require any particular help to deal with their feelings during and after handling a major disaster. Recently we have made great strides in disaster planning from both a tactical and a psychological perspective. While this is a very new area in law enforcement, it is nevertheless a vital area and one in which peer counselors can do a great deal to ensure minimum adverse effects on the officer or other rescue workers. Peer counselors, usually under the direction of a psychologist, can, with some planning, be a vital force in assisting fellow officers to handle the adverse effects of a disaster.

The following example, while it certainly touches on some technical questions, reflects what can be done for officers when they are provided psychological (including peer counseling) assistance.

> The city of San Diego, California, has had the dubious distinction of having had at least two major disasters. The first was a PSA air crash. This was followed a few years later by the McDonald's massacre in which a lone gunman shot twenty-two people. In the case of the PSA air crash, where there were limited psychological services provided for the officers, six officers retired on stress. In the McDonald's massacre, where psychological services were provided for the officers, no officers retired on stress.

While it is recognized that there are some differences between these two disasters, the difference between officers who did or did not retire seems to be significant. The PSA air crash was more likely, from a psychological perspective, to be considered a technical disaster, whereas the McDonald's massacre was a human-induced kind of trauma. There is also a difference of several years between the two incidents during which there could potentially have been some changes in the psychological makeup of the personnel. However, the major difference seems to be the use of psychologists and peer counselors to aid the officers.

The peer counselors were used in a variety of manners. They were used to counsel rescue personnel and civilians--immediately after the disaster, during the time it was being handled, and in follow-up counseling after the incident was concluded.

Another use of counseling services to assist rescue workers, including the police officers, was in the city of Cerritos, California, where a commercial jetliner crashed on August 31, 1986, into a quiet residential area. The psychological services were utilized to assist several groups of individuals, including police officers, paramedics, fire fighters, coroners, residents and neighbors, and relatives of people who had been on the plane. Feedback from all of these groups was very positive. All of the groups felt that they benefitted greatly from the services provided. These services included immediate crisis intervention as well as follow-up counseling.

The crash of the commercial jetliner in Cerritos was very similar to the San Diego PSA crash. However, in the case of the Cerritos crash where there were more psychological services provided, no personnel retired on stress disabilities.

Psychological planning, in conjunction with tactical planning, can make a well-rounded disaster plan for a city. Every city of any size will have some type of disaster. It is only a matter of what type and when. Whether it be a major fire, earthquake, sniper, hazardous chemical spill, riot, flood, or plane crash, everyone involved can benefit from having the planning. While the tactical planning may vary greatly for the different types of disasters, there is virtually no difference in the psychological needs at different circumstances. The major difference is only in magnitude and duration.

Some understanding, from a psychological perspective, of what can be done may help the peer counselor and department psychologist to understand what needs to be done. This section will review some of the psychological ramifications of a disaster and will outline some of the procedures that can be instituted to assist the personnel.

Once the rescue operation is under way, a new danger arises: rescue workers may begin to suffer from signs of stress. If measures are not taken to relieve the stress immediately, rescue workers can become inefficient and, at worst, can become victims themselves.

Hafen and Karren (1985) list a number of considerations for the police administrator (and peer counselor) for reducing the adverse effects of a major disaster on the rescue worker. They state: "You can reduce the amount of stress on rescue workers, regardless of their capacity or function, by following these guidelines:" (p. 554)

1. As each rescue worker reports to the command post for an assignment, he should be instructed to rest at regular intervals, possibly once every thirty minutes. During rest periods, which may last as long as you decide, the worker should return to an area that preferably is away from the disaster, sit or lie down, have something to eat or drink, and relax as much as possible. If rest periods are effectively rotated, there will always be enough rescue workers to carry on disaster assistance, and the entire team will be rested and relieved periodically.

2. Make sure that each rescue worker is fully aware of his exact assignment. Have a well-designed plan that enables you to fully utilize your personnel, and fully explain to each worker what his responsibility is. It will help reduce stress if a worker has well-defined limits, and you will eliminate the problem of workers wandering aimlessly around wondering what to do.

3. Peer counselors can be utilized to circulate among the rescue workers and watch for signs of physical exhaustion or stress. If one of the workers appears to be having problems, he should immediately be required to return to the manpower area and rest for a longer period than usual. After resting, he should, if possible, be given a less stressful task, possibly in another area of the disaster site.

4. Make sure that rescue workers are assigned to tasks according to their skills and experience. If there is a question about whether a certain worker can handle a task, do not gamble--give him the task that you are sure he can handle. You will precipitate a personal crisis if the worker is asked to do something about which he is uncertain.

5. Provide plenty of nourishing drinks and food; encourage rescue workers to eat and drink whenever necessary so that they can keep up their strength.

6. Encourage the rescue workers to talk among themselves (this can often be moderated by a peer counselor); talking helps relieve stress. Discourage lighthearted conversation and joking, however--some victims as well as workers may be offended by this, increasing the stress level at the disaster scene.

7. Do whatever is necessary to keep the disaster scene well organized and running smoothly. A feeling of being overwhelmed results when you are faced with a disaster; conquer that by implementing a well-designed plan that breaks the responsibilities down into what people can easily handle.

These are the primary steps that can be followed by an administrator, possibly with input from a peer counselor, to assist the rescue workers at the scene of the disaster. This is the first step in maintaining the psychological well-being of the rescue worker. The next step is the critical incident stress debriefing. Jeffrey T. Mitchell, at the University of Maryland, has done a great deal of work in the refinement of the critical incident stress debriefing (CISD).

The CISD is an organized approach to the management of stress responses in emergencies. It entails either an individual or group meeting between the rescue worker and a caring individual (peer counselor) who is able to help the person talk about his/her feelings and reactions to the critical incident. This individual acts in the role of a facilitator and can be either a peer counselor or a psychologist.

The CISD has three parts. The first part allows for individual ventilation of feelings by the rescuer and an assessment by the facilitator of intensity of the stress response in the workers. Part two is a more detailed discussion of the signs and symptoms of the stress response and provides for support and reassurance. The third part is the closure stage, where resources are mobilized, information is provided, and referrals, if necessary, are made.

This section is not intended to be a complete thesis on the psychological handling of disasters, but rather a basic guide of some of the functions that the peer counselor can perform. It is also intended to point out the importance to the ultimate recovery of rescue personnel of the use of psychological services, including peer counselors.

SUMMARY

This paper has briefly examined the history of the peer counselor. It was pointed out that the peer counselors can perform an invaluable service due to their rapport and knowledge of the job to those individuals that they are counseling. There are a number of valuable services that can be performed and this paper has examined two of those: traumatic incidents and disaster management. The utilization of peer counselors is a win-win for all concerned: the officer [rescue worker], the department, the families, and the community.

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PREVENTION OF STRESS DISORDERS IN MILITARY AND POLICE ORGANIZATION

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SCOPE OF PROBLEM

Police and military occupations share the uniquely necessary capability for delivery of deadly force within an authoritarian command structure. Although these two distinctive organizational features vary greatly in execution from organization to organization, they nevertheless are essential determinants of illness and health within police and military personnel. It is the purpose of this paper, therefore, to demonstrate how police and military commands can reduce both the incidence and severity of stress disorders among their personnel through specific management techniques applied to the issues of both deadly force and chain of command.

Occupational stress disorders present in a variety of psychiatric syndromes including classic posttraumatic stress disorder; stress–induced dysthymic, somatoform, and impulse disorders, popularly referred to as burnout; panic, anxiety, and phobia disorders; or adjustment disorders. Personality traits and disorders are more significant determinants of psychopathology in adjustment disorders than in occupational burnout where the severity of chronic environmental stress overwhelms a broad spectrum of psychological defense patterns, both healthy and predisposed to morbidity. These psychiatric disorders are frequently associated with or complicated by other conditions as follows: Traumatic brain disorders, essential hypertension, headache, coronary artery disease, peptic ulcer disease, motility disturbances of the gastrointestinal tract, asthmatic bronchitis, and a variety of traumatic amputations and internal injuries.

Additionally there are a number of extremely important modifying factors, which, although not in and of themselves overwhelmingly traumatic, nevertheless modulate the degree of experienced trauma.

There are also factors unique to military and police occupations that enhance trauma. Radical shifts from passivity to overactivity overwhelm the ego. Unexpected danger from devastating booby traps, misinformation, and security breaches are just a few examples of unexpected trauma. Often personnel are in unique situations where they are exposed to brutality as a participant, victim, or third party. Military and police personnel cannot avoid situations where a backup unit or partner uses excessive or sadistic force, a brutalized victim needs attention, or they themselves are terrorized in riots or guerilla warfare.

Another important factor is the authority figures upon whom these personnel depend. If they are viewed as unreliable, unconcerned, inexperienced, or politically motivated, the essential structure of command and trust begins to break down. The ramifications of loss of trust are immense. An untrustworthy command structure enhances the development of poor morale, which eventually leads to a breakdown of individual values with resultant increased brutality, vigilantism, drug abuse, corruption, isolation, and guilt about sadistic acts committed.

Ambivalent situations, for example, where one has to make a decision to shoot or not to shoot, also enhance the trauma. Such situations become especially provocative when military or police personnel's split–second decisions are examined at length by their superiors or the public.

Personality traits and patterns result in marked variations of psychopathology, except in response to extreme trauma that would overwhelm any ego. Individuals with a background of childhood brutality and/or molestation can be especially susceptible to the development of grandiose rescue expectations and then become enraged and depressed as the defense of denial fails. At such a point, these individuals often recognize their own vulnerability and become extremely frightened and depressed.

B.T., a police officer, had been abandoned by her mother shortly after birth. She was moved frequently between relatives and foster homes. At one point she was tied to a stake in the back yard with the family dog. She was so poorly nourished that she developed a swollen abdomen and lightly colored hair, hallmarks of severe malnutrition. She was finally adopted at age five. Her duties as an officer often brought her into contact with traumatized children and adolescents. Often these individuals had suffered brutality at the hands of their parents or had been beaten and raped. As she began to recognize that she could not rescue such individuals, she began to overidentify with them, resulting in feelings of rage, helplessness, and despair. She eventually became totally disabled, as her emotions became so labile that she could not perform her duties reliably.

Those individuals who were treated cruelly or brutally as children can, of course, also become brutal.

Another police officer was brutally beaten by his father. As a young adolescent, he was hung by his hands from the cellar rafters and beaten with a hose. As a policeman, he became extremely distant and numb, and overreacted to threatening situations. As he became increasingly unable to suppress his rage, which was really directed toward his father, he eventually had to be removed from duty, as he became extremely brutal and seriously injured several civilians.

The age at which trauma occurs can also play an important role in continuing personality development. This was particularly true in Vietnam, where immature 18 year olds, who were completely unprepared for what they saw, became exceptionally sensitive to issues of overidealization and dependency upon authority figures. When expectations associated with such needs were not met, personality development arrested with consequent psychopathology.

A Vietnam veteran reported that he arrived in Vietnam terrified at age 18. He became very dependent upon authority figures and consequently very loyal. After several months, a reliable, consistent, and benevolent leader was killed and replaced by a "90-day Wonder." He then found himself in an unconscionable situation. He witnessed friends killed secondary to careless commands. He felt he was sent on needless missions that were suicidal. He was forced to dig up putrefying enemy soldiers who had been dead for several days, simply to increase the body count. He gradually lost all respect for authority and became homicidal. Since his return to the States, he has had chronic conflicts with authority figures, manifested by repeated altercations with police and an inability to maintain employment secondary to an attitude of "not taking any bullshit from anyone."

Symptomatology that appears to be secondary to personality disorders, particularly Borderline Personality Disorder, can actually be due to compensatory defenses mixed with continuing psychopathology secondary to trauma. For example, a pattern of pervasive depression with repeated suicide attempts, drug abuse, isolation, preoccupation with the meaninglessness of life, and an inability to form intimate relationships can appear to be secondary to Borderline Personality, but may actually be due to symptoms associated with Posttraumatic Stress Disorder. Such "adaptations" become fixed and endure and take on the appearance of a personality disorder.

The excessive demands for isolation of affect and control in the compulsive personality are particularly prone to the unexpected and uncontrollable threats to life and emotional dysregulation. Reaction formations against sadistic or violent impulses in these individuals leave them exceedingly vulnerable to ego disintegration.

Excessive uses of defenses such as grandiosity, projection, and splitting can be devastating, of course, when issues such as power, self-esteem, real helplessness, and arbitrary judgments of good and evil in association with aggression are omnipresent. Hypermasculinity and risk-taking behavior in defiance of castration anxiety can ultimately lead to personality disintegration in these occupations. Unfortunately,

individuals who possess these traits and defenses are often attracted to an occupation that may seductively promise omnipotent control, infinite sacrifice, and the ultimate in risk and aggression in the guise of grandiose ideals. In addition, there is always the imminent threat of annihilation by another human being.

TERTIARY PREVENTION

Efforts to reduce the number of psychiatric casualties in police and military organizations by denial or neglect of illness can lead to reckless and even negligent statistical challenges. Dr. Spragg, division psychiatrist for Australian forces in Vietnam, reported the resistance to evacuation implicit in the U.S. Army's plan of immediacy and expectancy. The Pentagon's one-year limit on minimum tours of duty in Vietnam led to a basic evacuation philosophy; young men can take anything for a year. Anything, perhaps, but the brutality, command ambiguities, corruption, and confusion of terrorism and counterterrorism in Southeast Asia. Certainly, a large percentage of the improvement in the psychiatric casualty rate of Vietnam compared to previous wars was accomplished at the cost of a high incidence of delayed stress disorders among Vietnam veterans today. Likewise, well-meaning police pension boards courageously buck the current trend towards increasing numbers of stress disability pensions by ordering sick and dangerous police officers back to duty. Police officers have been inappropriately and prematurely returned to duty while still suffering from the effects of postshooting traumatic stress disorder and myocardial infarction. The naivete of these boards and their medical consultants as to the psychological effects of police work, including its specific issues of extreme autonomic arousal, discretion to kill, and inevitably strenuous fights is astounding. Such statistical manipulations of police medical retirement statistics inevitably convert stress dysphoria into conduct disturbances, more amenable to the disciplinary dispositions of authoritarian administration than the politically sensitive exposure of police disability pensions. Again, resistance to treat stress disorders for fear of statistical exposure of an administrative failure, as in Vietnam, merely transfers the problem of stress disorders from command responsibility to civilian institutions such as public assistance, the Veterans Administration, probation services, and the private medical sector.

Acceptance of the fact of stress disorders within these occupations and referral for appropriate clinical services requires top-level command support for in-house clinical staff and line supervisors. If staff clinicians are afraid of top management's disapproval of regular and perhaps frequent referral for necessary psychiatric treatment, stress disorders jeopardize the entire organization. One has to only imagine the cost to Western security caused by the mental illness of West Germany's Chief of Counterintelligence who recently defected to East Germany for allegedly personal reasons. Seriously disturbed troops too frequently were returned to duty in Vietnam, jeopardizing the lives of comrades, civilians, and themselves, and compounding emotional conflicts in medical personnel responsible for their well-being.

Inappropriate dispositions can be as damaging as no dispositions. Ignoring autonomic hyperarousal problems, reliving, and survival guilt in recurrent drug and alcohol rehabilitation programs can dry out the kindling for a smoldering, underlying stress disorder and precipitate a fulminating illness.

In true stress disorders, an unbiased clinical judgment must be made about the relative importance of acute trauma or cumulative stress versus premorbid personality disorder in the emergence of dysphoria, impulsive behavior, social maladjustment, and cognitive dysfunction. If it is determined that the major contributor to aberrant behavior or dysphoria is the premorbid existence of a personality disorder and that a particular stress is a minor factor, then a medical disposition that might encourage secondary gain or even malingering is contraindicated. If, however, aberrant behavior develops insidiously or acutely following unique, chronic stress circumstances or acute trauma, then clinical attention must be timely and adequate, including in some cases removal from duty and even hospitalization to prevent potentially destructive behavior or further ego deterioration. Malingering and secondary gain are important considerations in the management of these patients, particularly in the noxious environment of combat and lucrative disability pensions, but the immediate problems of affective restriction or volatility, disabling depression, social withdrawal, impulse

dyscontrol, and hyperarousal are first priorities for the clinician. These issues may not be first priorities for pension adjudicators and commanders who are vigilant for pension abusers and cowards respectively.

Abreaction of intense affect accompanied by management of excessive swings in affect, autonomic arousal, and impulse behavior is central to psychotherapy and psychopharmacotherapy of these patients. Isolation from the environment that threatens to overwhelm the patient's ego may be necessary to prevent cognitive deterioration or destructive loss of impulse control. Isolation from the threatening environment must be balanced, however, against the patient's need for social support from peers and vulnerability to feelings of abandonment, guilt, and alienation if not returned to duty. The therapist's tolerance for the patient's intense affect and his fantasies of destruction or destructiveness are necessary as are skillful titrating of anxiolytic and antidepressant medications to suppress reliving, insomnia, autonomic hyperarousal, impulsive behavior, and dysphoria.

Inderal is effective for reliving and hyperarousal. Tofranil and MAOI's are useful for nightmares and dysphoria. Short-term use of Benzodiazopines for anxiety or panic are indicated as are neuroleptics for brief reactive psychoses. Gradual return to duty is indicated when the patient's status no longer jeopardizes either the patient or the organization's well-being and function. As obvious as the recommendation for gradual reentry seems in this complicated era of police and counterterrorist operations, there are oftentimes inadequate administrative controls for fitness determinations with the single exception of the Human Reliability Program for nuclear weapons handling in the United States Armed Forces.

SECONDARY PREVENTION

Early identification of stress disorders is the most promising area of prevention. Line supervisors can be taught to recognize personality changes in their subordinates that are early indicators of stress disorders. Withdrawal, loss of humor, and marital conflict often signal the development of a disturbance in intimacy leading ultimately to the numbing of full-blown Posttraumatic Stress Disorder or occupational burnout. Numbing and more subtle premonitory disturbances of intimacy are responsive to the patient's fear of emotional arousal and can result in the disruptive approach and avoidance behavior more typical of Borderline Personality Disorder psychopathology. Irritability, excessive stimulation, or depression can easily be observed by a supervisor. Impulsive behavior such as excessive force, sadism, substance abuse, and gambling can also be observed and may be early indicators of stress disorders. Insomnia and somatic complaints such as low-back pain, chest pain, concerns about blood pressure, gastrointestinal distress, and frequent respiratory infections are very common early warning indicators. When educated to these early warning indicators, front-line supervisors will refer their officers for clinical evaluation, either in-house or to an outside clinician, if they believe such referrals will not result in disapproval by upper-level command.

The varying cultures of police and military organizations demand a variety of early identification and referral procedures that minimize the threat to a person's career when labeled a psychiatric case; in some departments, these officers are labeled "220's" after the $2.20 fee the police were paid for transporting mental patients to the hospital. Gossip, mutual distrust, and suspicion of malingering and cowardice abound within police and military organizations and make the process of identification and clinical referral a sensitive one for line supervisors and clinical staff alike.

Some police departments require clinical evaluations and crisis oriented psychotherapy immediately following use of deadly force, and the subject officers welcome the opportunity to assimilate the abnormal experience of intentionally killing another human being at close range. The St. Louis Police Department has utilized a charge of resisting arrest to flag potential problem officers for clinical evaluations. The U.S. Air Force marks the medical files of all personnel handling nuclear weapons, as well as members of their family, with red triangles in order to alert physicians to potential medical and psychiatric problems that could lead to stress disorders in these critical personnel. The Human Reliability Program has been in effect for some years and was designed to reduce the risk of a nuclear accident; it appears to be working. Limitations to early

identification and referral come more from the culture of an organization and its definition by top command personnel than visibility of telltale symptoms. Standards for exposure to trauma could be developed that could profile high-risk individuals such as those who have experienced severe losses in line of duty, killed at close range, or witnessed extreme brutalization. Such standards could be developed in a fashion similar to the Holmes/Rahe Stress Assessment by interviewing a large number of police officers and combat veterans and asking them to rate the intensity of a variety of traumas from their own experience.

PRIMARY PREVENTION

The selection of top command personnel is where the entire process of prevention begins. The top command's attitude towards psychology, human beings, and psychiatric disability begins the process of prevention of stress disorders. Likewise, command personnel can end any hope of early recognition of stress disorders if they are threatened by psychological issues or helplessly prejudiced against them. There can be a potential built-in contradiction between the type of individual that is going to seek this type of position because of a need to control himself/herself and others and the opportunity to vicariously act out violent, antisocial impulses or omnipotent needs through the officers.

Achievement is difficult to assess in military and police organizations and difficult to reward because of the lack of financial incentives. Nonetheless, command personnel should be individuals with special qualifications as chief executive officers and must come from sound and competent chief executive backgrounds rather than "good ole boy" up through the ranks background. The successful Beirut terrorist act and many, but certainly not all, police and military fiascoes are preventable. It is essential to identify the good characteristics of top commanders, and it must be decided whether they need to come up through the ranks as police officers or military academy graduates or be selected strictly on the basis of personality criteria. Promotion policies need to address the preference for truly good leaders over those unfairly favored because of particular career routes in certain units and schools, such as military academies, submarine service, and major crimes investigations or proficiency in examinations sometimes gained while studying at the expense of buddies absorbing their workloads in the field. Affirmative action is a delicate and sensitive issue.

Upper command personnel must do what they can to avoid the "Catch 22" syndrome that puts their line personnel in irreconcilable conflicts. There is no way, for example, that a city can improve police-citizen relations at the same time it is pushing its officers to write seven traffic tickets a day. This policy is extremely widespread, ruins officers, and ruins organizational morale. Line personnel cannot be encouraged in unwritten orders to be excessively aggressive and then be penalized when they overreact. For example, if patrol officers are supposed to contain prostitution in a certain area, it must be directly communicated to them from top command, and top command must take equal responsibility for repercussions of this aggressive enforcement activity. Top command must be sensitive to the demoralization caused by black marketeering when its troops discover tons of their own most modern equipment, including the much-needed poncho liners in Vietnam, within enemy arms caches. To prevent public scandals in the military and police organizations, frequently these organizations are "scandalproofed" at the risk of creating increased distrust, paranoia, and suppression of innovation. Scandalproofing requires an increase in command personnel in order to avoid narrow channels required for upward directed payoff systems. Unfortunately, too much brass can cause too much bureaucracy with its consequent stifling of innovation and delegation of authority in a morass of internal political conflict.

Upper management must communicate goals to its personnel and front-line supervisors and not just react to crises; crisis-based management is inevitable in military and police organizations because of the nature of their operations--crises. Still, a strategy is required, and any strategy, if sensible, is better than none. For example, police departments could present a strategy of keeping murderers or vulnerable people such as street kids off the streets. Military commanders could formulate and execute unambiguous strategies of protracted war with limited goals to be fought with special forces or use of maximum fire power that denies refuge for the enemy. Top command personnel must be sensitive to the causes they are asked to delegate to their personnel. The value of protecting Central America or Southeast Asia from Communist insurgency must be

perceived by field personnel as a tangible ideal, or it should be delegated to other agencies. Too often Vietnam veterans become disillusioned, feeling like they were mercenaries. It must be decided in the complex counterinsurgency environment of the nuclear stalemate whether large units with maximum fire power or small scale counterinsurgency operations will be used. Strategic decisions need to be made instead of ambiguous commitments to multiple divergent strategies as was the case in Vietnam.

Tactics must be a constant subject of discussion within police and military organizations because there is no concrete answer to the ultimate issues of deadly force. Issues such as shoot/no shoot, visibility of shotguns in police cars, tactics of suppressing sniper fire in an urban environment or containing a fleeing felon must constantly be debated within the organization. This helps to create an honest environment for decisive action when it ultimately is needed; too often personnel in police and military actions are left alone to make their own decisions against a backdrop of unsupportive Monday morning quarterbacking, leading to a profound sense of abandonment.

Commanders must constantly be concerned about their personnel's safety, whether it is in the police or the military environment. Overly aggressive "high diddle diddle up the middle" operations in Vietnam were disastrous in terms of generating casualties and ultimately were probably responsible for the phenomenon of fragging in Vietnam. It may make good television to apprehend a bank robber redhanded in the course of a robbery, but it will preserve life and limb to apprehend him after the robbery. Commanders must decide on the basis of preserving human life in their own unit as to whether it is necessary to take a hill immediately or whether it can wait until resistance is reduced.

Control of one's self and the environment is an important issue in occupational mental health, but particularly important in police and military service. Training and recurrent training are certainly important mechanisms to provide personnel with confidence in their ability to control their environment. Clear, unambiguous, nonhypocritical statements regarding drug and alcohol abuse within police and military organizations, of course, is necessary. The hypocrisy regarding this issue is legion: Alcoholic commanders can hardly convey an appropriate model for their personnel. Similarly, physical health must be encouraged, and, therefore, police officers cannot be expected to safely participate in high-speed chases or engage in multiple street fights following triple bypass cardiac surgery. Maintenance of equipment is necessary in order to convey to personnel that top command cares about what happens to them. Brakes that fail, deadly weapons found in the back seats of police cars at shift changes, and inferior weapons convey devaluing messages of expendability to personnel who need to control their environment and do little to maintain their sense of security.

Line supervisors must not only be administrators, but must be willing to accompany their personnel in the field. In order for them to do this, they need to sense not only trust from their personnel, but also support from their command, and the command structure itself has to be validly perceived as being under control of itself. A military and police organization just cannot function properly if it is run by an alcoholic commander, and this is too often the case.

Information systems must provide timely and accurate information. Hoarding of information in internal power struggles, as well as breaching of security, can be devastating in these organizations when personnel need to know as much as possible about what they are expected to do and what to anticipate. If an officer divulges battle plans to an enemy prostitute or servant when intoxicated, he should be publicly tried for treason. Such breaches happened too often in Vietnam and cost a lot of lives and probably were rarely, if ever, prosecuted. If an administrator or officer blows a raid that jeopardizes lives and morale, the individual who breaches security should be prosecuted. Rumors and disinformation within organizations must be monitored; they frequently start with malicious leaks at the very top as well as in the locker room. Disinformation is a sophisticated military tactic today and appears to be emphasized by Eastern Block countries; countermeasures need constant development.

Another important factor in psychiatric morbidity within these occupations is that of chronic fear. There has to be a valid perception by line personnel that casualties are the number one concern of its command. This policy varied from commander to commander in Vietnam as the incidents of fragging and threatened fragging proved. It appeared that in many cases it was up to the troops to determine whether their lieutenants were going to be safe or not. The career lieutenant who needed combat experience in Vietnam following the beginning of winding down of operations was particularly suspect of leading suicidal missions and was frequently the victim of threatened or actual fragging. A police department whose line supervisors are afraid to back up their own personnel in the field are particularly suspect of inadequately dealing with the issue of fear and illegitimately holding down bulletproof jobs. Safety needs to be presented as the priority issue in police and military organizations, and this must be supported at the top in words and actions. An armed drunk can sleep it off overnight; the hill can be taken tomorrow in order to preserve human life. Inadequate communication of safety concerns at the very top conveys an impression of expendability to the personnel in the field; this expendability can lead to a sense of brutality in the command, and hence, to brutality in the field. Officers and soldiers who do not feel cared about or cared for are less likely to care about or for the civilians they interface with on a potentially belligerent basis. Command leadership has to be perceived as resolute and competent rather than motivated by politics, selfish career concerns, or fear of criticism.

Ambiguity of communications within police organizations needs to be maintained at a minimum. Again tactics and strategy need to be communicated and discussed internally. There are certain insoluble problems within police and military operations, but solutions can still be sought. The process of seeking solutions will lead to a more sane approach to the problem and heightened sense of security for officers having to execute deadly force or violate a citizen's privacy. Clear policy needs to be presented from the very top regarding the issues of deadly force and invasion of privacy. Management information systems must be the tool for improving communication rather than perverted into such abusive practices as body counts or inappropriate monitoring of police performance. It is not really understood what impact management information systems have on the performance of an officer. It is clear, however, that there are many things an officer does that are very constructive that cannot be recorded on a computer. Also, it is difficult to program a computer to take into consideration the variation of police tactics from one community to another community. Whereas it may be useful to aggressively enforce traffic in one area, it may be potentially disastrous to do so in another area. Body counts in Vietnam as a mechanism for judging performance of units were referred to as "the beginning of America's descent into evil" by Lifton.

Police and military personnel are frequently perceived as being invulnerable and consequently immune to threats to their dependency needs. This, of course, is only true of the psychopath who cannot emotionally bond, and it is this very individual who should be kept out of police and military operations. Also the numb, occupationally burned–out, or posttraumatic stress disorder survivor should be kept out of police and military operations. A command structure that can best balance the need for executive decision making by its personnel without conveying a sense of expendability to them will probably ultimately have the lowest incidence of stress disorders and misconduct at the interface of its personnel and civilians. Support for the troops is manifest in selection and maintenance of equipment, reasonable rotation policies and shifts, pay and financial benefits, fairness in discipline, social security for the individual and his/her family, and a valid perception by personnel that their management is there to support the mission of the field officer and not vice versa.

Today there needs to be special emphasis on the mental health needs of minority and female employees who experience special problems. Rapid promotion for black male officers can be associated with a high incidence of hypertension. Vindictive overreaction to the female police officer's desire for equality can result in accelerated field experience leading to abandonment; it might be equal to place a female officer in a single–person patrol car in a dangerous section of town at night, but it isn't very wise and guarantees failure.

Preemployment screening and routine reassessment of officers can reduce the incidence of stress disorders and misconduct by screening out severe personality disorders and vulnerable individuals with early

signs of stress disorders. Again, special attention must be paid to minority personnel and women who are relatively new to certain areas of police and military operations today. There needs to be more research in the area of polygraph, stress interviews, and personality assessment to determine efficacy of these procedures in predicting future behavior. It is our personal experience that stress interviews are probably underutilized as predictive measures, and too much faith is placed in polygraphs, which can be beaten by the skillful psychopath.

Special assignments such as counterinsurgency, narcotics, vice, undercover, and homicide need special attention because of personality vulnerabilities that predispose to psychiatric disorders. For example, the individual who is attracted to narcotics because of the legitimate antisocial life it promises is an accident waiting to happen. Efforts should be made to limit the length of assignment in these fields, because it is unlikely that any person can live a double life for very long unless he or she is a particularly asocial individual, again the type of individual not needed in police and military organizations.

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POLICE OFFICER SUICIDE OR HOMICIDE: TREATING THE AFFECTED DEPARTMENT

Walter W. Lippert, Ph.D.

ABSTRACT

The empirical work on the cognitive and emotional response of police officers to critical incidents has only now begun to catch up to the practical development of crisis intervention and management. Drawing from strategies used in several departments where officer homicides or suicides have occurred, approaches and techniques for observation, comparison, and intervention have been developed. Both constitute critical incidents and produce department-wide cognitive and emotional responses. The reactions of officers in the departments are compared with those in other departments where fatal shootings of suspects have occurred. Similar to Greenburg and Safran (1989) the emotional response is reviewed under three major headings: (a) the role of emotional expression in catharsis, (b) the role of emotional arousal in anxiety reduction, and (c) the role of emotion in experiencing. Intervention is based on cognitive behavioral theory where the meaning of an event determines the emotional response to it. Officers tend to have a high need for control and will usually try to suppress any emotional response to a critical incident. The critical intervention in the first 48 hours after the event may well determine the likelihood of a posttraumatic stress disorder developing.

INTRODUCTION

Police departments throughout the country have been developing various measures to respond to critical incidents. A critical incident is an occurrence where a sense of helplessness and trauma has occurred. The development of a critical incident response into a posttraumatic stress disorder is dependent upon the way the response is addressed. Critical incidents usually produce anxiety of a high level, depression, and frustration, with a sense of anger. The response may be solely that of an individual police officer or may involve a district, a peer group, or the entire police division. The critical incident response goes through fairly typical stages of denial, collection of facts as known, physical anxiety, peer group support wanted, moral self-questioning, and acceptance (Lippert & Ferrara, 1981).

CRITICAL INCIDENTS STUDIED

The critical incidents examined involved two incidents where a police officer was killed either by a suspect or by his fellow police officer, three incidents of a police officer or a fireman committing suicide, and some thirty-six incidents of police officers shooting (either wounding or killing) a suspect. It is usually perceived in police shooting episodes that the response to the shooting is limited to the individual officer, his partner, and the immediate families of these officers. This is in sharp contrast to a homicide or suicide of a police officer, wherein division-wide and sometimes multidepartment responses to the critical incident occur.

There was one incident where a K-9 dog was killed by a suspect subsequent to which the suspect was killed. The result initially was a profound reaction on the part of the K-9 handler and his family to the loss of their friend of some seven years (the K-9 dog). They felt guilt in relation to the loss of their dog. Also a fellow officer had been killed in this incident, to which they felt obligation but not as intensely as they did to their own K-9 animal. Treatment was initially helping but was not continued.

CRITICAL INCIDENTS AND OFFICER RESPONSE

The critical incident appears in many different kinds of situations. The shooting of a suspect by a police officer, for example, is a critical incident that tends to be an individual response rather than a group or divisional response (Appendix A). A natural or man-made disaster involving many injured people may result in the entire team developing depression and anxiety. The suicide of a police officer more frequently brings about a divisional response, where police officers throughout the agency are wanting an explanation as to the reason for the occurrence (Appendixes B1 & B2). The homicide of a police officer not only involves the immediate police department but also many surrounding department officers who experience frustration, sorrow, depression, anxiety, and anger (Appendix C). A very critical incident occurred in Newport, Kentucky, where a rookie police officer shot and killed his field training officer during a Saturday night look for "man with a gun" incident. This brought tremendous anguish to several police agencies in the tri-state area and a mixed response of anger, frustration, and sorrow.

The degree of response, from individual to interagency, determines who are the police survivors. The death of a police officer in homicide or suicide produces a guilt reaction wherein a person or persons who are alive feel that they should not have survived. There are incidents of police response to occurrences such as hostage taking wherein at the conclusion of the hostage taking event, a hostage taker commits suicide. In this case there is no question that the negotiator must be psychologically debriefed for his own sense of helplessness, anger, frustration, and depression.

CHAPLAIN'S ROLE

The chaplain is a vital part of the response. In the death of a police officer, the surviving spouse is best handled by a combination of the chief or district commander with a chaplain. The chaplain then participates in briefing with the captain of the district and the psychologist. The approach developed by our division involves the captain explaining to all officers on each relief the exact details surrounding the death of the police officer. The chaplain then notifies the same relief about benefits to the survivors, the paid education for the children, the burial arrangements, the funds due the spouse, etc. This is followed by the psychologist giving an explanation as to their own feelings, the possible anger and frustration, the need to express it (but not on the street), and cautions to avoid the unnecessary use of force. All techniques are aimed at eliminating the sense of helplessness and giving a sense of control. The chaplains are also very valuable in SWAT operations where, while the hostage taking demands the focus of the police officers, the chaplains can deal with the released hostages and with the hostage taker's family.

INDIVIDUAL RESPONSE

The immediate response by the police officer is one of denial and suppression of feelings. There is obvious anxiety, depression, and anger. As the police officer collects facts to present to the internal affairs, homicide division, or any other investigative agencies, he is quite detail-oriented, dealing with facts and not emotions. The emotional response is being suppressed. It is believed that the posttraumatic stress occurrence is primarily the result of lack of proper treatment following the critical incident. Where an individual officer is involved in a shooting, the officer is generally brought in alone; the spouse and children, if necessary, as well as immediate partner are integrated in the response to discuss feelings and responses. If emotional responses develop within the interview between the officer and the partner, they are encouraged to share these emotional responses--tears shared, physical hugging of one another to express open concern, and relief, and survival. In the shooting of a police officer, it is important that the paramedic who brought in the body and the injured to the emergency room also be given support. The death of a police officer in homicide produces division-wide multiagency response. The psychologist may well have to go to various departments and divisions and hold group exercises.

These group exercises are meant to bring out the emotional response, to have a cathartic effect, and to experience the sense of loss, frustration, anxiety, depression, and anger. There is a need on the part of the police officer to control and suppress emotions, which has a detrimental effect on long-term recovery from the critical incident. A group ventilation process is aimed at the officer giving up responsibility, control, and anger in relation to the critical incident. As he/she feels a sense of helplessness, expresses emotional depression and anger, and experiences fellow police officers doing the same, anxiety reduction usually occurs. Funerals also provide a place to display openly one's emotions and provide the activation of a cognitive-affective network of relating intellectual-emotional responses.

THE MODEL OF TREATMENT

The moving away from the initial choice of emotional repression (maladaptive method of psychological survival) to ensuing emotions as allies can lead to information processing, which leads to the appearance of new, more adaptive responses. To allow affective responses that were previously disallowed makes certain reactions and moods more understandable and paves the way for action and need satisfaction as stated by Greenburg and Safran (1989): "Without acknowledgement of feelings and desires, people feel empty, confused, and often fragmented, and they lack the impetus from action tendencies to motivate actions" (p. 21).

The therapeutic approach must take into account the stages of response. The denial stage is quickly followed by the "gathering of facts stage," which is a point where psychologists should avoid intervention. Let the police officer determine the facts. After their interrogation is complete, only then may we begin the activation of emotions. Their physical agitation reflects the level of emotional anxiety. The need for peer group support is the acknowledgement of feelings, the need to fill the emptiness and deal with the confusion. It is the lead into the moral self-questions wherein repression is weakened and emotions can be developed into therapeutic ally and information processing. The "acceptance" of the death of an officer is the end result of catharsis, anxiety reduction, and allowing the experiencing of emotions.

PHARMACEUTICAL APPROACH

It was found in some critical incidents of a particular personal nature that medications can be successfully used. The use of medication is to block the beginning of obsessive characteristics that quickly lead to intense self-criticism and inability to detach from the incident. An example involved a police officer striking and killing a six-year-old child while on routine patrol. Response of this police officer to this incident was a severe sense of helplessness, depression, and obsessiveness with his responsibility. He was immediately placed on Prozac, a Fluoxetine Hydrochloride, and antidepressant, which was quite successful in preventing a rapid development of obsessive characteristics very common to traumatic disorders. Medications found also to be useful are Nardil, and if this is not successful, Marplan. These are medications commonly used for "neurotic" symptoms of obsessive type characteristics. Medications are generally used briefly--approximately three to four weeks. One incident where an officer was involved in an off-duty accident wherein the passenger in the other car was killed where the officer was exonerated caused inability to sleep. Short-term use of Dalmane was helpful in bringing the anxiety level down to where sleep was possible for several days. Medication was then terminated.

CONCLUSION

The affective concept is one of encouraging the police officer to portray emotional response. Intervention is aimed at activating an intellectual-emotional network to the critical incident to relieve sense of responsibility, need for control, and potential for anger. If the crisis intervention is successful in the first 48 hours, there is a high likelihood that posttraumatic stress disorders may be avoided. Empirical research into

the averting of posttraumatic stress disorders through activating emotional response is being pursued by the author and follows Zelig's (1986) plea. Sometime usage of chemotherapy is a parallel study also being pursued.

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APPENDIX A

The following is an actual description by a police officer of fear, anger, and frustration following a shooting. This is a vivid illustration of human distress, humiliation, and outrage.

A. Part of the incident is nonrecallable

B. Nightmares

C. Lack of sleep and weight loss

D. Citizens' reactions, threats, crank calls, hate mail, suspicion felt from friends and family

E. Need to explain, so you don't think, and they don't think you are a murderer

F. Loneliness, need for friendships, concern and support needed from other officers and supervisors

G. Psychological problems developed by wife and children in fear of someone trying to kill their husband or father

H. A need for support more than ever before

I. Inability to concentrate; obsession with incident every waking moment

J. Swings of mood from anger to sorrow, to hate, loss of confidence in self and system

K. How you learn to live your life one day at a time

L. How your life is changed permanently

M. The anxiety and anger over the length of the investigation, and facing the Grand Jury

N. How you feel the first day back to work

APPENDIX B–1

Jean,

It's a difficult thing to realize that I no longer have your love and respect. I've become totally disgusted with life. Our relationship, my job, the cruelties of the world. On top of that I have the feeling about my physical health that all is not well. Besides the continuing and increasing pain from the arthritic spine and shrapnel, I still have this persistent bleeding from the bowels with much internal distress, and constant fatigue, even after a good night's sleep. I could probably contend with the physical problems if I still had your love and support. The added emotional distress makes the struggle for life seem not worth the effort. I find myself totally drained and tired of fighting. I guess Vietnam has warped my perspective on the value of life. Even my own. Since you said you'd be better off if I were to die, which I even have to agree with, I've decided to give you your wish. It's not a hasty decision. It has been decided over a long period of time, since July 1st. I've planned for it and even timed it for an advantageous period. That's why I had all three cars fixed up. I have just received my V.A. check on the 1st and my paycheck on the 2nd with uniform allowance. I've paid the mortgage. You have no current bills. I also put another $900.00 I had been holding back, with $680.00 household money. I don't want a funeral. Have me cremated and do it as cheaply as possible. I'm sorry you couldn't continue living with me as my wife. You know how I feel about divorce. That's why I've decided to make you a widow instead. Financially you'll be better off and should be able to take care of Jim well until he is 18.

Also I will have prices on all of my guns so you'll know about how much you can get out of them if you decide to sell. If you don't need the money, I'd like Jim to be able to have some or all of them. Also most of the accessories can be sold if you choose to do so.

Who knows? You may come out of this well enough off you may not even have to work, but I still work for Ace, for now. I have all of A.P.D.'s issued property together, except for the model 66 .357 I'll be using, but it will be tagged. The police will know it's A.P.D.'s gun. See that the equipment is turned over to A.P.D. Call Jake, he can probably take it.

Since I don't have a will, I will this last testament. Even though it's not notarized, it should help in Probate Court.

In making my last will and testament, I leave all my worldly goods, cash, and real estate property, including all monies, the savings account, residence, to my wife. I also make her beneficiary to all insurance policies and survivor's pension benefits. With which, I pray she will continue to provide for the material welfare of our minor son. I also leave with her my undying love. I also pray I will be forgiven for any pain, suffering, and inconvenience I may cause anyone. May God have mercy on me.

Al

APPENDIX B–2

I swear, to be fair,
As fair as any agent can be,
To stand tall, and through it all,
Be courageous, true, and free.

And when the proverbial shit hits the fan,
And the walls tremble and shake,
There I'll stand, with "Daisies" in hand,
And "sleep in the bed I make."

When trouble seems all around me,
And there's no place to cry,
I'll take it like a man,
The man from BCI.

And when it's time to say goodby,
They'll always say I tried,
To do my best, to stand the test,
To fight off suicide.

Pity the boy that's left behind,
Pity the boy that's late,
When it's time for reports, they always retort,
Do it in triplicate.

I swear, to be fair,
As fair as any agent could be,
To sweat and toil, to burn and boil,
And keep my sanity.

The psychologist was brought into the agency for a general discussion of suicide; 45 agents showed up voluntarily. It reflected their humanity for their fellow man, their own frustrations, angers, and fear, their wish for knowledge. Their feeling of helplessness and vulnerability. A poem is an intellectual–emotional response.

APPENDIX C

After the Shooting, What?

The goal of this outline is to provide a chronological reaction by psychologists, various supervisory police personnel, and the police clergy team to problems that arose after the shooting of a police officer. The participants including Steve Fromhold, Jerry Norton, and Barbara George (widow of Officer Cliff George) have given Dr. Lippert permission to use their names and the circumstances of their involvement in the tragedy.

April 16, 1987, Cincinnati Police Officer Cliff George was dead on arrival at 1:00 a.m. at the University Hospital. The suspect was shot and killed at 12:30 a.m.

Friday, April 16, 1987

I. 1:30 a.m. Dr. Lippert called to University Hospital Emergency Room.

A. On arrival--Rev. Mark Pruden, Captain Morgan of District 5, (Cliff George's District) and Cincinnati Police Chief Whalen have left Emergency Room to notify wife and children of Clifford George's death.

B. Meet with Cincinnati Fire Chief who is in Emergency Room.

1. See his paramedics who are devastated. See victims, bodies every day, but this is family. After counseling, they are sent home.

2. District 5--Lieutenant and Sergeant are present in Emergency Room, seen individually.

II. 5:00 a.m., Captain Morgan and Dr. Lippert go to Criminal Investigation Section to collect facts as are known at that point.

A. Meet with K-9 Patrolman Fromhold who shot and killed suspect.

1. He has concern that his partner, Jerry Norton, having been shot, may have been shot accidentally by Police Officer Fromhold. Also Jerry Norton's K-9 dog was killed and feared he may have shot him also. This was not true.

2. I usually do not see Police Officer until after he has been through internal investigation and homicide interrogation to avoid bringing emotions into facts.

3. He is in second stage of reaction to a fatal shooting (gathering of facts). I did give support to him.

III. 12:30 a.m., Officer Jerry Norton, upon shooting the suspect, retrieved his dog, and commanded a patrol car, and, with Police Officer Premm driving, rushed to a vet in an attempt to save the dog's life, checking into a hospital for his own wounds only after convinced his dog Bandit was dead.

A. Officer Fromhold is undergoing interrogation. Officer Norton is leaving the hospital AMA to retrieve his dog from the vet and proceeds to his farm, where he buries his dog at 6 a.m.., Thursday morning.

IV. 6:00 a.m. Dr. Lippert joined up with Captain Morgan and went to District 5 to meet with the 1st relief coming in and the last relief going off.

A. District 5 (Cliff George's district) was in a high state of tension, frustration, and anger.

1. Captain Morgan gave the facts, I followed and worked with the anger, attempting to keep it in the district building and trying to prevent it from getting on the street. They have a right to their feelings, but to prevent the possibility of judgment being clouded by emotions, I worked in getting them to ventilate. Police Clergyman Mark Pruden made facts known about the widow, funeral arrangements, and benefits.

2. Tension so high that when District 5 had a call of Police Officer needs assistance, the entire squad room rose in unison and only stopped by a second radio call which said disregard.

3. Every relief and power shift was met with for next 24 hours.

B. We have three major areas of emotional concern occurring at once.

1. The police division's response to the death of an officer.

2. Two officer who have shot and killed a suspect themselves are heading into turmoil.

3. One K-9 officer is shot and his K-9 dog has been killed.

V. 8:00 a.m. The Chief

A. Colonel Whalen went on the TV and gave initially a factual description of what has happened. He then gave a controlled, angry, emotional description of police officers' feelings when a fellow officer has been murdered. (Not only was Cliff George shot, he was dragged from under his car and executed with a shot to the back of the head.) The entire division felt some individual emotional venting at this point.

Saturday, April 17, 1987

VI. 1:00 p.m. The Widow

The widow and her children are being cared for by Police Clergyman Mark Pruden. Mrs. George calls for psychological assistance and possible medication. Psychologist responds to Mrs. George's home.

VII. 7:00 p.m., Officer Fromhold with his wife Trish, who is also a Police Officer, are met with as he moved through stages of shooting response having found out he had not shot either Police Officer Norton or K-9 dog Bandit. After discussion he spoke or next seeing a priest. He made sure I was going to see his partner, Police Officer Norton, as he continued to feel great concern for his partner.

Sunday, April 18, 1987 –– Easter Sunday

VIII. 8:00 A.M. Other officers not immediately involved in shooting called for appointments. As a family member is hurt and disturbed, an entire family is hurt and disturbed.

A. Officer examples

1. Radar man believing he could have saved Cliff George
2. Police officer whose family had experienced a suicide
3. Police officer who had previously been shot
4. Police officer who was burning out
5. Police officer who had been harboring problems and now they were exacerbated

B. 2 p.m. went to Police Officer Norton's home, spoke with officer and wife. They were in deep sorrow over loss of their dog (a friend and son of family for 7 years) but feeling guilty that they might be placing dog Bandit ahead of the death of Police Officer. Reassured, supported, told Jerry about how wife becomes more sexual attentive in these situations. He insisted on bringing his wife in and I tell these very important facts in a moment of levity and lessened tension.

Sunday, April 19, 1987, Easter Sunday

IX. Continued seeing Police Officers and hearing from Police Officers who told of their fellow officers' shakiness

A. Saw Officer Premm, who had driven Officer Norton to veterinary hospital. Feeling he may have not done enough, like not taking shortest route or not discovering immediately that Norton had been shot.

Monday, April 20

X. Laying out of body

A. Hundreds of officers in tears
B. Notes pinned to Police Officer George's vest "I want my Daddy" by his three children

Tuesday, April 21, 1987

XI. Funeral

A. 1500 Police Officers from Ohio, Indiana, Kentucky
B. Five miles of patrol cars
C. Jerry Norton, while driving his own car, is struck in the rear by a truck and the truck driver dies

Friday, April 24, 1987

XII. Saw Mrs. George. Had a female psychologist see her two daughters (15 and 12)

A. One daughter felt guilty over argument the night before father's death
B. One daughter refusing death as real
C. Son, age 7, in a daze

XIII. Increase in volume of Police Officers seeking help, seeking retirement, and seeking disability

Tuesday, April 28, 1987

XIV. 11:30 p.m., Returned to District 5 for evening and night of riding and talking with police officers on the street and in the District

XV. Continue to see Mrs. George and children

A. Two months later, oldest daughter is hospitalized following a suicide attempt. Recovering well and being seen individually.

B. Mrs. George's mother dies of cancer and the body is mistakenly buried in someone else's casket previous to her funeral.

THE MANAGEMENT AND TREATMENT OF POSTSHOOTING TRAUMA: ADMINISTRATION AND PROGRAMS

Michael J. McMains, Ph.D.

ABSTRACT

Both the support of management and the intervention of treatment professionals are necessary for the successful resolution of the psychological trauma associated with shooting incidents. This paper emphasizes the importance of both management by administration and treatment by counselors, and it outlines elements of both that are important if successful resolution of the trauma is to be accomplished. Administrative policies are suggested, principles of treatment are reviewed, and both peer and professional support programs are outlined.

INTRODUCTION

Ten years ago it was estimated that 95% of police officers involved in a shooting would leave police work within five years (Ayoob, 1981). By 1984, large departments had cut that rate to 3%, while small departments were losing two and one-half officers for every one involved in a shooting (McMains, 1986a). A major difference between the two outcomes seemed to be the degree to which larger departments formalized their support for officers involved in traumas. Departments with clearly defined policies and procedures gave their officers a clear message that the officer was important and that the department was going to manage incidents in a way that minimized the effects of trauma. Consequently, it is not only the providing of mental health support that fosters a successful resolution of traumatic stress, it is the support of management as well.

This paper focuses on the aspects of intervention that can keep officers involved in traumatic incidents from becoming psychological/emotional casualties. It assumes that it takes both the administration of a department and the service providers to effectively develop a program for the alleviation of traumatic stress. This paper will look at the elements of each necessary to support a program that supports officers in crisis due to traumatic events.

It is important to understand that even though the guidelines and the programs discussed are primarily focused on postshooting trauma, any situation that reminds an officer of his/her own limits and that overwhelms his/her ability to cope with that insight can be traumatic. This means that multiple-car accidents in which children are killed, taking the report of a death from the medical center, or having to make a death notification can be traumatic. Solomon (1984) has suggested that one of the things that makes an incident traumatic is that it brings home to an officer the fact that he is not in total **control** of every situation, and that it reminds an officer that he is not **invulnerable**. Many kinds of incidents have these qualities. So, traumatic stress can be seen as the emotional arousal that results from the failure of a person's ability to maintain the myth of his/her own omnipotence and immortality.

MANAGEMENT SUPPORT

The support of management in the resolution of traumatic stress generally falls in the realm of proactive intervention. It establishes a department-wide philosophy or attitude about how an officer is to act when confronted with an overwhelming situation. It recognizes that police officers are ordinary people doing an extraordinary job, not extraordinary people doing an ordinary job. The emphasis at the management level is on policies and procedures that recognize that officers are sometimes confronted with overwhelming

situations and that it is all right to feel fear, guilt, or shame about these situations. Generally, management-oriented interventions include policies on selection of applicants, on the content of both basic and in-service training, on the availability of professional and/or peer support, on the supervisor's responsibility during a potentially traumatic incident, and procedures for the management of officers involved in trauma.

Selection Policies

Selection policies need to reflect the knowledge that certain individuals are generally better capable of managing stress than others. Guidelines for selection should include an evaluation of such personality variables as A-B personality types (Jenkins, 1979), internal versus external locus of control (Strassborg, 1973), and/or hardiness (Kobasa, 1972). Research has shown that even in "normal" people these variables are important predictors of who can manage stress more effectively than others. By requiring the departmental psychologist or psychological consultant to screen for such "stress-resistant" personality, the department is taking a position that is preventive in nature. It is selecting for low impact and quick recovery--focusing on the most normal of the normal.

Academy Curriculum

Academy curriculum that requires classes in both stress management and postshooting trauma can prepare officers for the event when it occurs (Somodevilla, 1986). By presenting information on the symptoms of stress, on the phases of reaction to crisis (Tyhurst, 1958), and on postshooting trauma (Stratton, 1983; Solomon, 1984; Nielsen, 1986), departments can provide a clear message that the uncomfortable feelings often experienced by officers are legitimate, that it is all right to be human, that resources are available, and that it is not a fault to use the resources. In addition, if officers know what to expect and are familiar with modes of coping with their feelings, the traumatic incident is likely to be less of a crisis because they will have a broader array of options open to them, a strategy helpful in crisis intervention (Hoff, 1978).

Policies for Supervisors

Policies on supervisors' responsibilities in the recognition and management of officers in crisis are essential, since it has been found that there is an inverse correlation between supervisors' support and problems with authority and the impact of a trauma (Solomon & Horn, 1986). Supervisors can be key people if they recognize their role as a supporter of officers in crisis. Rather than being an administrative agent who is perceived as criticizing and persecuting, supervisors can be trained to reassure officers when appropriate, to be sure that investigators deal with officers after they have had a cooling-off period and in a private place, and to be sure that officers are not demeaned by such things as having their guns taken in public or not replaced, and by being "Mirandaed" in public.

Policies on Investigations

Clearly defined procedures for the management of investigations, for grand jury review, and for return to duty can minimize the uncertainty felt by officers after a traumatic incident. By designating such things as a shooting team that has responsibility for investigating police-involved shootings, an air of efficiency and control can be established from the first--helping the officer feel that not everything is out of control, even if his feelings are.

The issue of when and where the officer's gun will be secured if it is needed for evidence should be covered in this policy. As a general rule, the weapon should be taken in a private place that minimizes embarrassment to the officer. In addition, it should be replaced by the department immediately to minimize the message that the department is only concerned about the investigation.

Another critical issue involving the investigation is when and under what circumstances the Miranda warning is to be read to the officer. This act changes the officer's perception of the event from one in which

he is one of the good guys, doing his job, to one in which he is suspected of being one of the bad guys. The emotional impact can be devastating for an officer who is emotionally vulnerable due to the trauma.

Policies on Mental Health

By making it policy that the departmental psychologist or one of the peer support team is available to the officer at the time of the shooting, a clear message of concern and care can be sent that will minimize the officer's sense of being alienated from others. Rather than waiting for the officer to ask for help, the department needs to be active in its outreach to the officer. It needs to recognize and to formalize its understanding of the overwhelming nature of trauma. Rather than waiting to react to an officer's request for help, policy should specify that the interviewer take the initiative in reducing the impact of the crisis (Hoff, 1978).

Policies on Administrative Duty

Another policy important to the recovery of a traumatized officer is one covering administrative duties posttrauma. Departments vary on both extremes. Some put officers immediately back in the field and some keep them out until the grand jury has reviewed the case. The latter policy has been known to keep officers on desk duty for nine to twelve months. Though legally sound, such a policy has a problem in that it frequently keeps the officer in what he considers a nonproductive position for an excessive amount of time. A policy that allows the officer down time but facilitates the legal processing so that excessive time is not required for legal review is the most appropriate. Such a policy requires coordination between the district attorney's office and the police department.

TREATMENT TECHNIQUES

Before discussing the treatment techniques utilized in the management of traumatized officers, it is important to review some general principles applicable to intervention. The recurrence of "combat stress" or the Delayed Stress Syndrome (DSM-III) among combat troops has led to principles of intervention that have proven their effectiveness in minimizing the long-term impact of trauma on troops (Schultheis, 1982) and on officers (McMains, 1986b).

Principles of intervening in a variety of traumatic incidents (Mangelsdorf, 1985) include:

(1) **Brevity** – intervention should be short-term, focused on supporting officers during the time of crisis, and focused on returning them to the field at the earliest possible time.

(2) **Immediacy** – intervention should be begun as soon after the trauma as possible so as to provide officers a constructive way of understanding the experience before they solidify their thinking about the event in maladaptive and self-critical ways.

(3) **Expectancy** – intervention should convey to officers from the first interaction an expectation that the officer acted properly, can manage the situation, and will be returning to duty soon.

(4) **Proximity** – intervention should occur as close to the shooting as possible to maximize the desensitization of officers to any possible trauma.

Any intervention program, whether based on peer support or professional support, should be designed to utilize these principles.

Programs

Basically two types of treatment programs have been developed to deal with officers who have experienced traumatic episodes. They are the peer support system (peer counseling) and the professional intervention model. The former relies on fellow officers to provide emotional support, acceptance, and counseling to officers, while the latter relies on professional mental health support.

Peer Support: Peer support systems have been outlined and utilized by several authors talking about several departments (Nielsen, 1980; Klyver, 1986). All such systems make several assumptions, some of which are important to review.

(1) These systems assume and emphasize the fact that police officers are highly screened, highly trained, normal people who are faced with an extraordinary situation.

(2) These programs assume that peers have more credibility than do professionals because "they know what the job is like." This assumption states that you have to have had the experience of being a police officer to understand what a police officer has experienced. Taken to its logical extreme, it says you have to have been involved in a traumatic situation to understand the trauma.

(3) Basic to all peer counseling programs is the assumption that early intervention can prevent a situational problem from crystallizing into a chronic maladjustment. As such, peer counseling programs are assumed to be proactive and preventive in nature.

All peer counseling programs rely on volunteers (100%) who have a good work history and a good reputation in the department. About half the programs surveyed in the past (McMains, 1986) have used officers who were themselves involved in a traumatic incident. Some departments require a supervisor's recommendation while others do not. All departments that have active programs require a three- to five-day basic training program that includes: (1) an introduction to peer counseling, (2) counseling skills that include listening skills, problem-solving, and counselor characteristics, (3) material on specific psychological problems likely to be encountered by the counselor such as stress, traumatic stress, depression and suicide, and alcoholism, and (4) recognizing and referring problems that are beyond the scope of the peer counselor.

The majority (95%) of such programs emphasize the confidential nature of the program. However, all departments make exceptions to this policy if the person being counseled is a threat to himself/herself or to others (homicidal or suicidal). A few departments (15%) clearly state that serious violations of departmental policy or state law are also exceptions to the confidentiality policy. It is interesting to note that these departments report a steady growth in the use of their peer counseling programs, even with these exceptions (Phoenix, 1986).

Most departments (95%) provide professional backup of their peer counseling program, and they require continuing education and supervision of their counselors. Even the departments that have no professional staff involvement in the program have consultation agreements with local mental health professionals.

Record keeping in peer counseling is minimal. Most departments state that only the records necessary for the efficient management of the program are kept. These usually are statistical in nature and do not identify officers in order to protect the confidentiality of the program.

Professional Support: Many departments recognize the need for professional support of their traumatized officers. One hundred percent (100%) of large departments and 69% of small departments have been found to provide professional support for traumatized officers (McMains, 1986a). The effectiveness of

such programs is demonstrated by the rated effectiveness of such programs in larger departments as well as the few officers who have resigned from departments with such programs.

Professional support is generally provided by a psychologist who sees the officer(s) involved in a traumatic incident within 24 hours of the incident for an initial evaluation. By being immediately available, the professional demonstrates concern and builds rapport. The principles of immediacy and proximity mentioned above suggest that the professional would do well to respond to the officer(s) at the time of the incident, in the field. Though there are no systematic data comparing the effectiveness of immediate response, it has enhanced the credibility of the professional and led to self-referrals on the part of officers who have met the professional under these circumstances.

The professional's role is fivefold upon initial contact:

(1) review the facts
(2) review the feelings of the officer(s)
(3) give the officers information on the common reactions to trauma
(4) provide immediate service in the form of a chance for the officer to **ventilate** and in the form of **supportive services** such as notifying family, protecting the officer from news media, an explaning the procedures
(5) provide for follow-up services

At the minimum, a 48- to 72-hour follow-up needs to be scheduled, because it is during this period of time that the officer moves through the **impact** phase to the **recoil** phase of reaction to trauma (Nielsen, 1984). During this period, the officer needs to know that the emotional reactions he/she is experiencing are normal, and this message is best sent by a professional who is in a position to speak with authority. Officers are frequently in a highly suggestible state during recoil and the opinions of others have a powerful impact. Consequently, their expectations about their feelings and about their eventual outcome can be influenced in a powerful way. In addition, the professional can evaluate the need for additional intervention such as relaxation training and biblio-therapy at this time.

After the 48-hour follow-up, most programs leave any further contact up to the individual officer. This is done to help give officers a sense of control over their lives and to establish the idea that they are not disturbed enough to justify regular emotional support--it complies with the requirements of **expectancy** and **brevity**.

After six to eight weeks, most officers will settle into a new routine--they will move into the post-trauma phase of the incident. They may have established a new equilibrium in their life and may not be constructive (both anxiety attacks and depressive episodes have been noted in officers who have not successfully accepted their mortality, their responsibility, and their limits as a human being). The professional needs to be available for follow-up at this time. The request usually needs to come from the officer's supervisor or family, since the officer that has not made a successful adjustment is not likely to recognize it. He/she may be drinking more to cope with the trauma or may become irritable, withdrawn, and uncooperative. It is here that the departments need to be clear about the supervisors' responsibility for making an adequate referral.

Overall, the impact of traumatic situations on the effectiveness and morale of officers has been recognized and managed effectively by most departments. The management and treatment of postshooting trauma serves as a model of a constructive interplay between police managers and mental health professionals, and it has served to reduce the turnover rate and disability of ordinary people doing an extraordinary job.

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A CHECKLIST FOR CRITICAL INCIDENT RESPONSE TEAMS

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ABSTRACT

The scene of a critical incident is often somewhat distracting. In such an environment a written guide can serve to help a Critical Incident Response Team member recall actions and priorities for responding effectively.

INTRODUCTION

In September 1986, the eight members of the Tulsa Police Department's Critical Incident Response Team developed a checklist of actions that might be performed in response to an officer involved in a critical incident. This list has been reduced to fit on an easily carried card and has been effectively used for the last three years.

The purpose of the checklist is to serve as a set of reminders regarding helpful actions that a team member could consider taking according to the situation. It is not meant as an exhaustive list or as a policy statement. Other teams are encouraged to tailor their own methods to fit their unique circumstances.

Tulsa Police Department
Critical Incident Response Team Checklist

IMMEDIATELY

Who is the main "customer"?
Situation Assessment: Who are secondary "customers"?
How many CIRT members needed?

ID self and purpose
Insulation from scene
Physical needs met?
Phone contacts?
Transport from scene?
Care for equipment?
Replace firearm?
Preview Detective/Investigator activities.
Preview potential physical, emotional reactions with emphasis on normalcy.
Suggest "balancing" SNS arousal with relaxation or breathing techniques.

AS THE TIME ALLOWS

Continue preview of potential physical, emotional reactions with emphasis on normalcy as situation warrants or seems appropriate.
Inform officer to expect call from department psychologist--routine.
Consideration of continued insulation (i.e., someone at home to screen calls?)
Notify psychologist of incident.

Consider officer resources:

1) other people:
   a) family support system?
   b) social support system?
   c) departmental support system?
   d) friends?

2) psychological:
   a) current attitude?
   b) mood (stable or erratic)
   c) verbal and nonverbal behavior
   d) thinking (clear? loose? attention span? ability to focus?)
   e) memory
   f) impact on you?

3) physical: preexisting "stress-related" disorder (ulcer, high blood pressure, diabetes, etc.?)

Arrange a "staff meeting" within 48 hours with two other CIRT members (invite psychologist if appropriate)

TECHNIQUES

1. Divide person from behavior (officer from incident).
2. Active listening - paraphrase, label emotions, "feedback" questions to clarify feelings.
3. Self disclosure when appropriate (usually when asked).
4. Tolerate silence.
5. Remind yourself to see the officer as an adult, provide menu if necessary, avoid making his/her choices.

LAW ENFORCEMENT APPLICATIONS OF CRITICAL INCIDENT STRESS TEAMS

Jeffrey T. Mitchell, Ph.D.

INTRODUCTION

Although police departments have been utilizing peer support teams for shooting incidents for a number of years, it is only recently that law enforcement agencies are joining with their counterparts in fire and emergency medical services to develop multiagency critical incident teams. The critical incident stress teams do not replace the postshooting trauma teams, nor do they replace the services of police psychologists. Instead they incorporate those support services or work in very close association with them. In addition, critical incident stress teams more closely utilize specially trained mental health professionals in direct group services to emergency personnel than peer support shooting teams have, in general, utilized in the past. Another factor that differentiates critical incident stress teams from postshooting trauma teams is that a broader scope of distressing events beyond shootings have been identified as being stressful. In addition, critical incident stress teams have shifted the emphasis from posttrauma intervention to pretrauma prevention programs. This paper will explore the recent utilization of critical incident stress teams in the law enforcement arena.

BACKGROUND

Wittrup (1986) and Blau (1986) report marital and family disruption and an increased use of alcohol and drugs after a shooting incident. Mantell's work with police officers involved in shooting episodes certainly supports the concept that this particular critical incident has significant negative short- and long-range impact on the officers (1986).

Recent experience with a variety of distressing events has clearly indicated that shootings are only one of a variety of situations that have the potential to disrupt the police officer's life and happiness (Lippert & Ferrara, 1981). Pierson (1988) points out that a critical incident is one in which "the coping mechanisms are overwhelmed by what is experienced" (p. 26). He goes on to list co-worker deaths, child victims of violence, victims of traumatic events who are known to or who remind the officer of a loved one, disasters, prolonged rescues, or events in which there are extreme dangers to the officers at the scene.

Fowler (1986) states that a significant critical incident for law enforcement is a situation in which the officer's expectations of perfect performance are suddenly tempered by fallibility, imperfection, and crude reality. For example, when a prolonged negotiation with a suicidal person breaks down and the intention to die becomes a harsh reality, the officer's expectation of success becomes crushed and a loss of self-confidence and increased self-doubt ensues.

Wagner (1986) further indicates that serious injury to an officer, which might be caused by a vehicular accident or a fall, can be a critical incident that may need intervention. Other critical incidents might be a situation in which an officer's life is in danger. Hostage taking and hazardous material incidents come to mind as life-threatening circumstances.

This author has identified traumatic deaths to children, significant child abuse cases, witnessing a person's traumatic death, disasters, accidental death or serious injury to a civilian as a result of police action, intensive media interest in a particular event, or virtually any event that has sufficient power to overwhelm

the usually effective coping mechanisms of the officers involved as critical incidents (Mitchell, 1982, 1983, 1988a, and 1988b; Mitchell and Donahue, 1985).

THE CRITICAL INCIDENT STRESS TEAM

The seeds of critical incident stress teams were actually planted during combat situations in World Wars I and II. Brown and Williams (1918), Salmon (1919), Appel, Beebe, and Hilger (1946), Pittsburgh Post Gazette Staff (1984) found that the soldiers in the great wars were more prone to return to combat when given immediate psychological support after combat than when managed later in hospitals where they were well behind the combat lines.

More recently, the Israeli Defense Forces began to utilize group and individual psychological support after fire fights in the Middle East. They concluded that the incidence of psychiatric disturbance was trimmed by as much as sixty percent since the inception of their support services (Breznitz, 1980; Solomon and Horn, 1986; Pughiese, 1988).

Many emergency services personnel, including law enforcement officers, were initiated into critical incident stress teams after such horrific events as airplane crashes, tornadoes, floods, and large fires. It was through these types of events that police frequently learned that there was something very positive to be said for immediate support from teams of specially trained mental health professionals and peer support personnel (McMains, 1986; Somodevilla, 1986).

Many critical incident stress teams were begun in fire and emergency medical services units and these organizations experienced great benefits from the teams (Mitchell, 1988). However, police were initially slow to accept the potential benefits of such teams despite the fact that they saw the benefits of postshooting trauma teams for police officers. For some unknown reason, it was more difficult for law enforcement to accept the fact that more than one type of event (namely shootings) could be highly stressful for law enforcement personnel. Perhaps experiences coming out of other emergency service organizations were not easily accepted by police departments because they thought that no other experience compares to law enforcement. Perhaps some resistance was founded in the "macho" image that many police have developed (Baruth, 1986).

In any case, disasters and other major events such as line-of-duty deaths, serious injuries to emergency workers and very traumatic deaths to children tend to strip away the usual defenses and equalize emergency service providers. What remains then is a realization that they are all very much the same regardless of the uniforms or the equipment. They are human beings first and they are vulnerable to being hurt by their jobs.

TEAM COMPONENTS

Critical incident stress teams are in actuality a partnership between mental health professionals and emergency workers who are interested in preventing and mitigating the negative impact of acute stress on themselves and their fellow workers. They are also interested in accelerating the recovery process once an emergency person or a group has been seriously stressed.

Mental health professionals who serve on the teams have at least a masters degree in psychology, social work, psychiatric nursing, psychiatry, or mental health counseling. They are specially trained in crisis intervention, stress, posttraumatic stress disorder, the personality of emergency workers, and the critical incident stress debriefing process.

Peer support personnel are drawn from emergency service organizations--police, fire, emergency medical services, dispatch, disaster response personnel and nurses (especially those in emergency or critical care centers). Both the mental health professionals and peer support personnel form a pool of critical incident team members from which a response team is developed. An incident that is predominantly police oriented

is worked by police peers with the support of mental health professionals who are familiar with police activities and procedures. Likewise an incident that is predominantly fire in nature will have fire peers who provide the support services. If an incident involves various response agencies, then a mixed cadre of peers is developed to provide support services (Mitchell, 1988a, 1988b).

There are currently 175 teams in 34 states around the United States. There are also teams serving emergency personnel in five foreign nations. Since the first multiagency, multijurisdictional teams were developed in 1983, over 8,000 critical incident stress debriefings have been provided (Mitchell, 1990).

PREINCIDENT STRESS EDUCATION

Perhaps the most important element of a critical incident stress team is preincident stress education. From inception of the critical incident stress team concept, stress and crisis intervention programs formed a base from which most other support services were established (Mitchell, 1987; 1990).

Providing stress education before the crisis event strikes helps to reduce the impact of traumatic events on the personnel. There is some truth to the statement, "forewarned is forearmed." Personnel involved in distressing situations generally are better able to avoid stress reactions or they are able to better control their reactions should they occur. It has been found that they are usually better able to recover from acute stress reactions because they recognize the symptoms and call for assistance sooner (Miller and Birnbaum, 1988; Bandura, 1985; Meichenbaum, 1974).

Stress training should begin with new recruits (Ellison and Geny, 1978). New police recruits are generally more open to hearing the message that they are vulnerable too and need to take precautions to control their stress. In Howard County, Maryland, every police recruit class receives a minimum of six hours of stress control training. Anecdotal reports from participants encourage the continuation of the stress program because it is "useful," "practical," "interesting," and designed to give information that protects the officer from excessive stress. The majority of attendees believe that the program was personally helpful to them. In addition, all police officers in the county are given three hours of stress training when they cycle through the academy for required in-service programs. Command personnel are also given stress training to enhance their skills in picking out officers with symptoms of distress.

The stress training, which is a potent part of stress prevention (Jeremko, Hadfield, and Walker, 1980), includes an overview of general stress theory, some differentiation between routine stress and the stress encountered during police operations, the signs and symptoms of distress, stress survival skills, referral strategies for additional help, and methods of dealing with cumulative stress (Mitchell, 1990). It should be noted that peer support personnel and mental health professionals on critical incident stress teams provide the stress education programs in between their activities related to crisis events.

FAMILY SUPPORT

There are incidents in the careers of police officers that leave a profound effect not only on the involved officers but upon their family members as well. With police work, it is virtually impossible to "leave it all at the job." Side effects of traumatic events tend to have a way of making it home in the form of anger, depression, frustration, grief, insecurity, confusion, and disillusionment. Family members frequently become the convenient target of displaced emotions.

A significant other stress course is helpful when officers first enter the department and periodically during the course of their career. In this way spouses feel less left out. They also gain valuable insights into the behaviors and reactions of their loved ones.

When a major event occurs that distresses those at home, debriefings are provided to significant others as well as the affected personnel. However, significant others and the emergency personnel are never mixed together since the issues encountered by significant others are markedly different from the issues encountered by emergency personnel.

On occasion, critical incident stress teams may need to provide support services to the children of officers. Critical incident stress team members have also provided assistance by means of general support and counsel to bereaved family members after a line-of-duty death (Mitchell, 1990).

ON-SCENE SUPPORT SERVICES

Some police events are powerful enough to produce virtually immediate, noticeable stress reactions at the scene of an incident. Delayed assistance in such cases almost assures difficulties in both maintaining one's function at the scene and in achieving a full recovery in a timely fashion.

Several police departments around the country are sending police peer support members of a critical incident stress team to actual or potentially disruptive incidents such as barricaded subjects, hostage takings, and major SWAT operations. Although the team members are not always utilized in such incidents, their mere presence has been favorably accepted by police because the officers feel positive about the support given by fellow police officers. If a situation goes bad, peer support personnel can go into action immediately and provide support to officers during the height of the crisis. Maintenance of the officer's on-scene function or a quick restoration to duty are the goals of on-scene support services (Dean, Taber, Collier, 1989).

Peers who are present at the scene provide three general areas of support.

1. They assist individual officers who may be seriously stressed by an event. They may, for example, move a distressed officer a short distance away from the scene to cut down auditory, visual, and olfactory stimuli. Group work is not provided since officers are at various emotional levels during operations.

2. They provide suggestions and advise commanding officers. For example, they may recommend that certain tactical units be given a break to enhance their overall performance.

3. They may assist actual victims of the event or their family members. For example, if an hysterical person is interfering with a police operation, critical incident stress team members may intervene to free up operational officers.

INDIVIDUAL CONSULTATION

Many services of critical incident stress teams are provided to groups. However, individuals frequently need to talk to someone. Peer support and mental health professionals therefore make themselves available for one-to-one consultations. Several police officer suicides across the nation were averted because of the support rendered by fellow officers trained as critical incident stress support personnel or peer counselors. The group on the critical incident stress team which, as a whole, appears to have the greatest success with law enforcement personnel is the peer support group. Several authors have praised the success of peer support programs (Klyver, 1986; Linden & Klein, 1986). Peers are certainly vital to the critical incident stress team functions in every aspect from education to debriefings.

SMALL GROUP MEETINGS AND DEFUSINGS

After a distressing incident, police personnel frequently get together and talk things over among themselves. These meetings are usually helpful as a ventilation mechanism and are encouraged. On occasion, trained peer support personnel are present and may informally assist their fellow officers. When properly trained, police peer support officers are knowledgeable about telltale signs that indicate that a group meeting is going sour. They are advised to change the topic or otherwise divert the conversation when members of the group are being personally attacked or when the humor is forced and no longer spontaneous and natural.

A more structured meeting is called a defusing. These meetings usually take place within twenty minutes or up to a few hours after the incident. Eight to twelve hours after the incident is about the limit of the window of intervention. After that time, emergency personnel have managed to seal over their distress and their defense system is fully mobilized.

The defusing takes place away from the scene. Police frequently gather at someone's home or in some other area with limited interruptions. A defusing lasts between twenty minutes and one hour and has three main parts. They are:

1. A brief introduction that sets the ground rules for the defusing. Confidentiality is emphasized. Defusings are not an operations critique and should not be mixed with one.

2. Personnel are asked to describe what happened. They are reminded that a defusing is not part of an investigation, but instead is a meeting designed to assist police officers in recovery from a distressing event.

3. Police officers are then given information that may be helpful to them during the next 24 to 72 hours as they return to routines.

The defusing meeting is typically led by peer support personnel but it may also be led by mental health professionals or a combined team of peers and mental health personnel (Mitchell, 1990).

DE-ESCALATION PROGRAM

A de-escalation is a process of transition from a major event, such as a disaster, back into the usual routine. It is sometimes called a "demobilization" although police officers generally do not appreciate that term because "demobilized" has certain negative connotations of being incapacitated.

The de-escalation is reserved for large-scale incidents only. A great many emergency personnel must be involved in a single event for a considerable period of time before a de-escalation center is established. The usual criteria call for 40% to 60% of available emergency resources to be committed to a single action for longer than eight hours.

In the de-escalation, personnel are brought to a large meeting room by a working unit such as a tactical unit, a perimeter control team, or a K-9 unit. They are seated with their own unit and given a ten-minute talk on critical incident stress, the signs and symptoms they may encounter, and the techniques they may use to control and reduce their stress. Police officers or any other emergency personnel do not have to talk if they do not want to. They are given an opportunity to ask questions or to make comments if they wish at the end of the ten-minute talk, but no pressure is exerted on them for any discussion.

Once the ten-minute stress survival talk is completed, they are given a handout that outlines the general signs and symptoms of distress and offers numerous suggestions that the officers might utilize to reduce

and control stress. There are phone numbers at the bottom of the handout that may be used to obtain additional assistance should that be necessary.

Officers are then given twenty minutes to eat and rest before they are given instructions regarding a return to their usual routines. The entire de-escalation process takes a total of thirty minutes and only ten minutes spent on the stress information talk (commonly given by a mental health professional) and the remainder is dedicated to eating and rest (Mitchell, 1990).

CRITICAL INCIDENT STRESS DEBRIEFINGS (CISD)

Another service of the critical incident stress team is debriefings. Debriefings are group meetings that have been designed with two major goals in mind. First, they mitigate the impact of a critical incident. Second, they accelerate the recovery process in normal personnel who are experiencing normal reactions to abnormal events.

The debriefing process has both psychological and educational elements, but it should not be considered psychotherapy. Instead, it is a structured group meeting or discussion in which personnel are given the opportunity to discuss their thoughts and emotions about a distressing event in a controlled and rational manner. They also get the opportunity to see that they are not alone in their reactions but that many others are experiencing the same reactions.

There is always some question as to whether a debriefing should be made mandatory. The answer is a command decision and not one to be made by the critical incident stress team. However, it should be recommended as a mandatory process because many who could benefit from the debriefing will not show up unless it is mandated. If an organization decides to mandate the debriefing, it must also be willing to provide either release time or pay to the officers.

The manner in which a debriefing opportunity is presented to the personnel is crucial. If the leadership downplays the importance of a debriefing, or if it criticizes the process, command staff may, in effect, be denying their personnel the opportunity for rapid recovery from trauma. They may be setting their officers up for longer term distress than would occur if they encouraged a positive involvement in the debriefing process.

The debriefing is structured with seven major phases. It has been carefully structured to move in a nonthreatening manner from the usual cognitive-oriented processing of human experience, which is common to law enforcement personnel, through a somewhat more emotionally oriented processing of their experiences. The debriefing ends up by returning the personnel to the cognitive-oriented processing of their experiences where they started.

The first segment of the seven-phase process is the **Introduction**. The trained critical incident stress team lays out the ground rules of the debriefing process, describes an overview of how a debriefing works, and encourages active involvement on the part of the participants. Confidentiality is emphasized throughout the process. Space available for this paper does not permit a full discussion of the introductory remarks that are made to the participants. Additional details of the process can be found in Mitchell (1990).

The second phase of the debriefing is the **Fact** phase. Officers are asked to discuss the general facts of the incident (not aspects that would jeopardize an investigation or cause them difficulties with their supervisors). The usual questions that begin this discussion are "Who are you? What was your job during the incident? and What happened?" If the group is small enough (below 35) the team leader simply has everyone in the room answer the same questions one after the other around the room. If the group is larger than 35, then a different technique may be utilized. The leader may then ask "Who arrived first, what

happened?" then "Who arrived next and what happened?" until enough people have spoken to recreate the incident for the purposes of the debriefing.

The third phase is the **Thought** phase. Officers are asked what their first thoughts were about the incident once they got off the "auto pilot" mode. This phase personalizes the experience for the officers. It makes it part of themselves rather than a collection of facts outside of themselves.

The fourth phase, **Reaction**, is the phase in which the debriefing participants discuss emotions by means of answering the question "What was the worst part of the event for you personally?" This segment may last between thirty minutes and an hour depending on the intensity of the event.

The fifth phase is the **Symptom** phase in which the participants describe the signs and symptoms of distress. Usually three occurrences of signs and symptoms are discussed. Those symptoms that appeared immediately during the event, those that arose during the next few days, and those that are left over and still being experienced at the time of the debriefing.

The sixth phase is the **Teaching** phase. In it, the critical incident stress team teaches a great deal of practical, useful information that can be utilized to reduce one's stress at work and/or at home.

The seventh and final phase of the debriefing process is the **Reentry** phase. In it, officers may ask whatever questions they may have. They may repeat certain portions of the incident and review those aspects that still bother them. They may also bring up new pieces of information that were not brought out earlier in the debriefing. Advice, encouragement, and support are offered by the critical incident stress team members. Participants are given referral resources should they need additional assistance. Handouts including resource phone numbers are also distributed.

CAVEATS FOR CRITICAL INCIDENT STRESS TEAMS

Reading an article or chapter on stress teams does not constitute appropriate training to perform the work associated with a critical incident stress team. There are too many details that are too lengthy to include in a single chapter or article. People who wish to function on a stress team should receive appropriate training in crisis intervention, stress, posttraumatic stress disorder, stress survival strategies, disaster psychology, human communications, conducting a debriefing, and other related topics. The minimum time frame for training to become even barely adequate for critical incident stress debriefing team functions is two days.

The services of a critical incident stress team have to be relatively comprehensive. Teams should include education of their personnel, defusings, de-escalations, debriefings, follow-up services, significant other services, individual consultation, on-scene support services, and referral services as a part of their general activities.

A debriefing may not be necessary if a defusing is performed immediately after a distressing incident. A debriefing, if it still needs to be provided after a defusing has been given, is enhanced by the discussion that took place in the defusing when the intensity of the incident that was still vivid in the minds of the officers.

Debriefings are not therapy per se in spite of the fact that they have therapeutic elements. They should never be used as a substitute for therapy. They can also not be expected to be equally effective for all people under all circumstances. Some police personnel will need referrals for therapy after debriefings have been completed. Provisions for additional help such as that provided by the department's psychologist should always be made when a debriefing is planned (Mitchell, 1983, 1990).

Personnel may be mandated by their commanders to come to a debriefing but they can never be mandated to speak if they choose not to. The right of refusal to disclose one's reactions to an event is always respected.

PRELIMINARY STUDIES

Preliminary studies in the United States and Australia are pointing to considerable benefits that are being derived from the critical incident stress teams (Kennedy-Ewing, 1989; Robinson, 1989). In her study of those who participated in crisis debriefings, Robinson (1989) indicated three main benefits of critical incident stress teams. They are:

1. The chance to learn from others how to mobilize one's own resources and coping behaviors.

2. The ability to gain a greater understanding of critical incident stress, its ramifications, and the methods to deal with it.

3. The opportunity to express oneself and be reassured that one's reactions are normal.

Robinson reported that 75% of the personnel involved in a debriefing felt that it was between moderately and extremely helpful. No one reported negative effects of the debriefing process.

More research will be necessary in the future but the preliminary results are quite encouraging for continuation of the work of critical stress teams.

CONCLUSION

Police critical incidents are likely to occur with regular frequency. The choice facing police departments is to either make believe that police officers are never affected by their work or to take the more realistic stance of recognizing the need for critical incident stress teams and the valuable services they can perform. The key to success for police departments is to maintain a healthy and satisfied working force. One way to achieve that task is to provide support to them when the situations they face become bad enough to hurt. Critical incident stress teams make the tasks easier to accomplish.

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FACTORS INFLUENCING THE NATURE OF POSTTRAUMATIC STRESS DISORDERS

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ABSTRACT

Police are frequently exposed to traumatic events. In recent years more attention has been paid to the occurrence of posttraumatic stress disorders in officers who have been exposed to traumatic incidents. One of the questions frequently posed is "Why do some officers experience severe reactions whereas others seem to adjust without major disruption to their functioning?" This paper examines the prognostic factors that may influence the direction and degree of the reaction. The factors that most frequently affect or predispose the reaction include: Adequacy of social support, degree of warning available, coping style, prior mastery experience, concurrent stresses, nature of the incident, and physical and psychological proximity to the event.

INTRODUCTION

A review of the literature regarding trauma incidences, as well as clinical experience in working with many individuals who have been exposed to trauma, leads one to the inescapable conclusion that few people who are exposed to natural disasters or specific traumatic events in their lives remain untouched. Certainly, it is the case that not everyone exposed to a traumatic incident necessarily develops a posttraumatic stress disorder. Stratton, Parker, and Snibbe (1987), in a study regarding police officers who had been involved in a shooting, reported that approximately 35% of those officers indicated that the event apparently had little long-term impact upon them. Of equal or greater importance was the fact that approximately 60% of the officers they studied indicated it had a substantial impact on their subsequent lives.

In another study (Nielsen, 1980) regarding police shootings, approximately 20% of the officers interviewed reported little or no significant emotional symptoms following the shooting incident. As with the Stratton et al. study, it is also important to note that approximately 80% of the involved officers indicated some level of emotional distress or complicating problems developing after the incident.

This variability of reaction is one of the characteristics frequently noted by critics of the diagnosis of posttraumatic stress disorder. Many clinicians and researchers suggest that because there is no consistent symptom constellation, and because there is no predictable outcome to traumatic events, it should not be considered a viable diagnostic category. While it may be true that there is no consistent symptom constellation or a clear predictable path for traumatic reactions, there is a wealth of information that suggests that there is a high probability for most individuals who are exposed to traumatic incidents to experience some level of emotional or psychological distress in their lives, either in the short-term or long-term view of their history.

Hearst, Newman, and Hulley (1986) completed an interesting study examining the long-term effects of military service in a combat environment. In their study they sampled a group of Vietnam veterans who were demographically similar to another group of individuals who did not experience any military service or subsequent combat. In the 12-year follow up to the end of the Vietnam war, the Hearst et al. study determined that those individuals who had had military service (as compared with those who had not) had higher subsequent death rates from motor vehicle accidents and suicide. On its face, this study would seem to indicate that exposure to the rigors and stresses of a war environment results in some long-term negative effects not experienced by those who were not exposed to that environment.

We know from a wealth of research on law enforcement stress that police officers as a group are at higher risk for exposure to traumatic type incidents. Officers are routinely exposed to various forms of trauma in the sense of viewing maimed and decomposed bodies, exposure to physical assault, and involvement in numerous disaster situations. In addition, law enforcement officers, due to a more chronic form of stress, often suffer from a range of other stress-related disorders, including relationship problems, gastrointestinal ills, and substance abuse (Dunning & Silva, 1980). Obviously, an officer who is already laboring under the burden of some stress-related disorder and who is then exposed to a traumatic incident is at even higher risk for more negative outcome than would be the individual who is not currently impaired or struggling to resolve some issue in his life.

MODELS OF STRESS REACTIONS

Some of the factors that influence reactions may be gleaned from models that are proffered to describe stress disorders. The first of these is best characterized as an illness model. In this model, latent or potentially present intrapsychic conflicts are activated by the traumatic event. There may or may not have been prior neurotic symptoms, but the impact of the traumatic event is viewed as tapping into a latent neurosis that surfaces in response to the incident.

The second is the endurance model. This, perhaps, represents a more pragmatic view of how stress and stress-related events impact individuals. This is often summarized by the statement, "everyone has his breaking point." This particular model is often extolled since it has the virtue of exonerating the individual, suggesting that he has neither an illness nor any lapse or defect of character. Endurance is the salient principle. Such a model, of course, is predicated on the notion that the longer and more intense the nature of the stressor, the more likely one is to experience clear emotional disintegration. Recent studies regarding Israeli combat veterans suggest that recurrent exposure to the stress of combat seems to have a differential effect. Some seem to become stress inoculated while others tend to deteriorate progressively (Solomon, 1989).

The third is the "voluntaristic" model, which tends to be focused around a large number of fully conscious motives that the individual may employ in dealing with a given situation. This model tends to suggest that unconscious processes are largely unimportant and that an individual chooses a course of action. Application of this model often leads to a determination that the functional person has adapted while the dysfunctional person is somehow malingering.

The fourth is an environmental or external induction model. This model pays particular attention to settings and combinations of events to which the person is exposed. Such external factors include physical exhaustion, interpersonal relationships, climactic extremes, lack of sleep, and inadequate training of the person involved. This is a somewhat more complex model, obviously emphasizing the role of various factors in the outcome of the event. This particular model also has the advantage of offering a more useful clinical insight, both in terms of assessment and treatment.

It seems an inherent assumption in all models that people are different in terms of character structure and style. This results in different reactions among differing styles.

Dorn (1984) developed a model for assessing the traumatized person's ability to return to his premorbid state. It recognized individual differences. As a result of his work, he identified four probe areas: (1) play life, (2) work life, (3) interpersonal life, and (4) religious and ethical life. This model, while useful in that it provides an overview of both prior history and social support networks, tends to leave out the nature and impact of the given traumatic event. From a clinical point of view, the most important question that we can answer is, "Why do some officers experience severe reactions whereas other officers seem to adjust without major disruption to their functioning?" There appear to be a number of factors from each of the theories that become important when considering the outcome.

INFLUENCING FACTORS

Research and clinical experience reveal certain factors that influence both the nature and extent of an individual's reaction, as well as contributing to the prognosis for a favorable outcome.

The first of these factors is the nature of the event. It has long been recognized that the presence of children as victims in disasters has more impact than when victims are adults. Exposure to dismembered bodies seems to have more impact than burned bodies (Dunning & Silva, 1980). These two examples serve to illustrate that the nature of the incident carries with it a differential effect. It is also the case that the nature of the incident interplays with the officer's past experiences and own psychological sets.

Case Example:

> Officer Jones had been assigned to the Traffic Division for approximately five years. During that time he had investigated several auto-pedestrian accidents resulting in death. In the last two years he had personally responded to four fatalities involving young children. The precipitating incident was an accident in which a seven-year-old girl had been hit and run over by a pickup truck. The scene was particularly difficult in that the child's brain was exposed and there was a considerable amount of blood. Complicating the picture was the fact that Officer Jones had a daughter the same age with similar hair color and skin tone. The accident precipitated anxiety symptoms, ruminations, and recurrent nightmares about past accidents and his own children.

In the example, Officer Jones had apparently been managing the trauma attendant to accidents until he was confronted with a particularly "messy" accident that also had unique meaning for him in that the victim resembled his own daughter. His usual methods of isolation and objectifying the trauma into an "accident scene" failed, and he was flooded with intrusive thoughts and anxiety.

A second factor influencing the nature and extent of an individual's reaction has to do with coping style or ego strength. Individuals who function with pervasive ego weakness are obviously at more risk to regress or fragment under the impact of a traumatic event. Likewise, the coping style of the individual may also contribute significantly to the development of post-incident symptoms. This is an area where clinicians typically devote much of their effort.

Case Example:

> Officer Smith had been involved in a police shooting incident a few years before. His general style was that of an hysterical male. He enjoyed and sought out the limelight. His attention style was global and he tended to use a broad view and perspective to protect himself from specific facts or information that might be disconcerting to him. After his first shooting, he had developed a good deal of secondary gain using the shooting as a "badge of courage" to impress others. This tactic had worn thin on his comrades in the department, who had increasingly come to view him as superficial. Officer Smith became involved in a shooting incident that was outside prescribed conditions for the use of deadly force. As a consequence, his continued employment as a police officer was in jeopardy. Officer Smith was unable to grasp the significance of his behavior. He initially relished the attention from the department and media, even though much of it was negative. He showed up at press conferences that had nothing to do with him and seemed to behave as if he were a local hero. Efforts on the part of his supervisors to tone down his attempts to gain narcissistic mirroring were met with globalizations about the department's policies and continued ostentatious behavior. He ultimately sought psychological assistance because of his feelings of social isolation.

In the above, the officer's hysterical style prevented him from appreciating his precarious position and propelled him into further behaviors that exacerbated his situation. Rather than experiencing appropriate anxiety, the officer was avoiding a clear cognitive appraisal of his situation while feeding his narcissism.

The third factor is prior experience that the person has mastered. The military has long been aware that in combat, new troops are more likely to "crack" and disintegrate than are veterans. This is simply due to the fact that the veterans are more likely to know what to expect and have already confronted their fears and mastered them. A considerable amount of training is based on this premise. In field training exercises, new police cadets are gradually exposed to increasingly complex situation such that their skills and personal confidence grow.

Case Example:

> Trooper Brown was hit by a truck while issuing a citation to another motorist. He was badly hurt, with a broken hip and two broken legs. Because he had been hit while outside his car on a previous occasion, plus had been injured when a truck hit his parked car, supervisors feared that he might deteriorate emotionally and requested mental health intervention. Trooper Brown was seen in the hospital where he was recovering. During the first meeting he was cooperative and his affect was appropriate. He smiled readily and engaged in a discussion of the medical procedures that he had recently undergone. He was knowledgeable of the course of his recovery and frequently mentioned his past injuries and treatment. Rather than being overwhelmed by his medical predicament, he had extracted recovery estimates from the treating physicians and was determined to return to duty before his estimated recovery period. In fact, Trooper Brown did return to light duty four months before he had been predicted to be fit for duty.

In the Brown case, the Trooper clearly had an expectation that he would not only recover but that he would do so sooner than expected. This optimistic attitude was born of his past positive experience. He knew he would heal and based on past experience, he expected to return to duty. His attitude no doubt contributed significantly to his early return to duty.

Another factor that seems to act as an influencing agent is the degree of warning available to the individual. Traumatic incidents typically are sudden, are largely unexpected, contain an element of loss or threat, and alter the person's view of the environment. The extent to which an individual is alerted to an impending event allows him to mobilize his resources and cognitively rehearse potential outcomes. Perhaps this explains why SWAT team members rarely seem to have negative reactions to traumas arising out of their operations. On one level of awareness there is the rather constant threat that a member of the entry team could be hurt or killed. Additionally, in most operations, the SWAT team members have physically rehearsed their roles and have a good deal of time to cognitively envision potential situations. In a sense, they have a good deal of warning, which allows them to mobilize their resources, consider outcomes, and adjust their attitudes and expectations.

Proximity is another important variable. The literature on disasters is replete with examples of how inner perimeter workers (those with most direct exposure to carnage) are more at risk to develop subsequent symptoms. Jones (1985) points out in a study of Air Force personnel involved in transporting and identifying the bodies of the 1,000 persons who died in Jonestown that relative youth and degree of exposure to bodies during the evacuation correlated with emotional distress.

In addition to physical proximity, psychological proximity must be considered. Often living victims of a disaster or traumatic incident are not the only injured. Relatives and friends are also at risk.

Case Example:

> During routine mental assessments of new SWAT candidates, an officer from the Utah Department of Corrections was identified as having inordinate amounts of anxiety, being overly hostile and angry, and having a potential for moderate levels of depression. The report was distressing to the director of the enforcement division. The officer had long been considered solid material, was skilled, and had a vast positive experience within the prison. The supervisors were shocked at the report results and requested a follow up. In subsequent interviews, Officer Green acknowledged depressive symptoms, which he felt had been in place for about two months. Upon further interview, he revealed that he had been "best friends" with another enforcement officer who had been killed in a siege about two months previously. This officer's death had been traumatic for many in the enforcement division since he was well-liked and the lieutenant of the K-9 team. After his death, several officers under his command had sought assistance, so a general debriefing and preventative group sessions were held with the K-9 squad. Officer Green had not been included because his current assignment was not in that division and his long-standing friendship and past partner status with the deceased officer went undetected until his SWAT evaluation.

In this example, Officer Green, while having nothing physically to do with the incident that killed his friend, was very emotionally and psychologically involved. His reaction was similar to what would be expected by a family member. Since he was not in the unit and not involved in the incident, neither he nor his supervisors realized the extent of the impact that the death had upon Officer Green.

Concurrent stresses will complicate the situation for anyone. If an individual's psychological resources and energy are already taxed, a sudden, unexpected loss or threat may well prove overwhelming. Breslau and Davis (1987) point out that in addition to the person's personal characteristics (coping style), the nature of his/her social environment (concurrent stresses) will enhance or otherwise modify the likelihood and form of responses to all types of stressors.

Case Example:

> Officer White was a deputy sheriff who had been in psychotherapy for two years. She was being treated for chronic depression and was further afflicted with a series of losses in her life. She had been married twice and because of her chronic depression, had been unable to contend with her last husband over custody of her children, resulting in the loss of those three relationships. After a mid-air collision involving a commuter airliner and a private airplane, Officer White was detailed to assist in body recovery. The planes did not burn and the bodies were torn apart and scattered over a four-square-mile area. After the accident, a snow storm covered the scene. Body parts were recovered for the next several days as citizens called in, reporting discoveries in their yards. Officer White was detailed to pick up these pieces of human tissue. After about two weeks, she became very depressed, with marked anxiety symptoms. She was unable to sleep and was overwhelmed by routine duties.

In this case, Officer White may well have managed the stress of body recovery were it not for the presence of other losses and her own depression. Her resources were already taxed to the limit, and the additional trauma proved overwhelming to her.

The nature and degree of social support is yet another, and perhaps one of the most important, factors influencing posttraumatic reactions. James Titchner and Donald Ross (1974) note that:

> Reorganization after the impact of a trauma or during chronic stress is very much along the lines of the form and strength of relations with all those persons significant to the victim. Meaningful communication with other humans restores structure and redefines the self. The

> connection between fragmented parts of the self is restored in the renewal of social relations, and functions of adaptation are revitalized by the warmth, assurance, and orienting power of personal interchange. Resuming meaningful relations during or after stress is a giant resource of reorganization.

Maintenance of a sense of self and anchoring in reality are both facilitated through relationships. Thus, the officer who is socially isolated or is the "new guy" may be at more risk for deleterious reactions to trauma.

Case Example:

> A new officer had recently completed the police academy and joined his department in a small rural police agency. Within two weeks he was involved in a shooting incident with a drunk driver. The officer was shot three times, but managed to return fire, which killed his assailant. He was subsequently hospitalized for about four months at a regional medical center some 60 miles from his agency. During that time, he had virtually no contact with his fellow officers, including his chief. Further complicating the situation was the fact that he was a quiet, stoic man and the hospital staff made no attempt to discuss the shooting with him. As a consequence, he came to believe that he had handled the situation unsatisfactorily and would probably be discharged and his incident would be used by the academy staff to illustrate how not to effect a traffic stop.

Ultimately, to his relief, he was returned to duty, but continued to experience pain in his wound areas. Medical examinations, including exploratory surgery, revealed no medical explanations, although one neurologist did note that the officer appeared quite depressed and may not be fit for duty as an officer. Ultimately, the officer sought mental health intervention, acknowledging that "Maybe this is in my head." In addition to psychotherapy, this man was introduced to several other officers who had been involved in shooting incidents. In these relationships, he discovered common ground and this tended to "normalize" his own experience. Ultimately his symptoms disappeared and he was able to return to a full-duty status.

The isolation of the officer in this example resulted from his hospitalization, insensitivity of his own department, and his own socially cautious style. Once he was able to socially connect with officers who had similar experiences, he began to improve. One wonders what the outcome might have been had he had a more responsive social network when he experienced the trauma.

SUMMARY

In summary, there appear to be several factors that influence the nature and degree of reactions to traumatic events. These factors include: The nature of the traumatic incident; the coping style or ego strength of the involved person; similar prior experience in which the person mastered the stressful event; the degree of warning prior to the traumatic event; physical and psychological proximity to the traumatic event; concurrent stresses or losses in the victim's life; and the extent and nature of the victim's social support.

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TRAUMATIC INCIDENT CORPS: LESSONS LEARNED

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ABSTRACT

In the latter 1970s the Salt Lake City Police Department became concerned about traumatic incidents and the impact they had on individual police officers. As a result of this concern, a study of shooting incidents and officer reactions was completed. Certain of the findings indicated that officers involved in such incidents frequently experienced repetitive psychiatric symptoms. Additionally, involved officers reported that they preferred to talk with other officers about the experience, but that frequently other officers proved to be a significant source of stress and aggravation. Relying upon these findings, as well as past experiences with officers, the department established a Traumatic Incident Corps composed of police officers who were charged with providing emotional and social support to traumatized officers and their families. The Corps was established in 1980 to serve the Salt Lake City Police Department and has frequently been requested by outside agencies. While the concept has proven worthwhile, many lessons have been learned and incorporated into the operation of the Corps. These lessons include suggestions regarding selection of members, administrative support, training, operation of the members, and some unforeseen problems.

Since 1980 the Salt Lake City Police Department has employed a Traumatic Incident Corps (TIC) for the purpose of ameliorating and reducing the impact of traumatic events such as shootings and assaults on individual officers. This team of individuals came into being after a study was completed in 1980 regarding the deleterious effects traumatic events can have on some officers (Nielsen, 1980). In this study officers who had been involved in shootings routinely indicated that other officers were often a major source of subsequent stress as they were relatively insensitive in their comments and behavior towards the involved officer. In addition, the study revealed that officers routinely talked most frequently with other officers about the shooting incident, as opposed to speaking with clinicians or clergy.

In response to these findings, the Salt Lake City Police Department created a Traumatic Incident Corps composed of officers who had previously been involved in some traumatic incident, who had adequate social skills and ability to empathize with other individuals, and who were generally seen as acceptable people within the rank and file of the police department. These officers were then trained through the psychological services unit of the department in techniques of crisis intervention, recognition and understanding of traumatic events, and techniques of social support and referral for further psychological service when indicated.

In addition, a general order was established within the department (Eskridge & Nielsen, 1982) that detailed the conditions under which the team might be used. In essence, this order required that the field commander contact one of the sergeants in charge of TIC whenever there was a shooting incident involving a Salt Lake City police officer and/or any other incident such as severe accident or assault in which he deemed the services of the team to be useful. In early traumatic incidents, when no standing general order was in place, field commanders occasionally failed to call out or notify the TIC commander. Consequently, there were occasions when team members had not been called out but were aware of an incident and showed personal initiative by interjecting themselves into the situation. As a result of these types of problems, a general order was developed that required the Corps commander to be notified any time there was a shooting incident. Since the inception of this standing general order, no incidents have occurred in which the involved officer was not provided with the assistance of a Corps member. This has become so routinized that oftentimes investigators from the homicide division (officers who investigate each and every shooting) are typically so

sensitized to the presence of TIC counselors that they request or require that one be present before they will take statements from or investigate the officer in any way. Typically, TIC officers arrive at the scene of the incident and remain with the officer through any investigative period and maintain ongoing contact with him through the following days and weeks. In addition, TIC officers are frequently sent to assist families and provide an overview to spouses of what might be expected and what the typical procedures within the police department are.

Since its inception, the TIC has responded to around 30 incidents, some of which were in neighboring police jurisdictions. Because of TIC's usefulness and positive reputation among line officers, neighboring police departments have frequently requested the assistance of team members when an incident has occurred within their own department. New members have been added over the years as original TIC members have been promoted and moved into administrative responsibilities. One of the original tenets of TIC was that it would be in the best interest of the team and provide a more effective approach for individual officers if team members were primarily officers working patrol assignments. As a consequence, when an officer moves into plainclothes assignments, such as detectives or administrative positions, his slot on the team is filled by another officer currently assigned to patrol activities. Generally, this has proved most useful in that whenever incidents occur, some TIC members are on duty performing routine patrol functions and can quickly be dispatched to the location.

In the operation of the team, lines of command are such that TIC members report to the psychological services unit. In this sense, they are not responsive in any way to the involved officer's division commander or to the investigators. Their primary concern has always been defined as the well being of the individual officer.

In 1984 an officer who was involved in a shooting was subsequently charged criminally. This came as a surprise to the department since the charges developed out of the county attorney's investigation. As a consequence of these charges, the police department administration intended to use the TIC counselor as a conduit of information to the officer, which included informing him that he was going to be charged criminally and relieved from duty without pay pending trial.

As a result of this incident, efforts have been focused upon removing the peer counselors from the position of being conduits of information from the department to the individual officer. In the aforementioned example, the division commander was ultimately assigned the responsibility of informing the officer, although the team member assigned to the officer was likewise informed and available at the time the officer was told of his suspension To allow the peer counselors to become embroiled in these types of communications seriously jeopardizes their usefulness as a social support to the individual officer and in a sense makes them an extension of the administrative process. Since that incident, the TIC members have assiduously avoided becoming a conduit of information from the administration to the individual officer. They have, however, worked to arrange resources to assist individual officers that sometimes include the resources of the police department and police union.

In the aforementioned example, the officer was suspended for the better part of three months with no income. His family included two small children, and during the time he was suspended, TIC counselors spent time arranging union resources to assist him and developing part-time jobs that would assist him in financially supporting his family until the trial. The officer was ultimately acquitted and restored to full duty status.

When the original TIC was formed, the ten members were selected from a cross section of the police department with the notion that from within this group, an individual peer counselor could be matched with the officer involved in the traumatic incident based on compatibility. We knew there may well be occasions when an officer involved in a traumatic incident may have had a negative past experience with some members of the team or be someone who could not relate in a particularly positive fashion with certain team members. Under these conditions, the TIC member would be able to assess the extent to which another team member

might have had a more positive relationship with an officer in times past or have had no negative past history, thereby facilitating the development of a relationship that could be supportive to the officer. On at least one occasion since the team came into operation, an officer who was involved in a shooting incident was largely regarded within the department as an inadequate officer who was socially without any relationships. In fact, every member of the team reported no favorable experience with the officer. Ultimately, the peer counselor selected was the person who had had the least to do with the officer, anticipating that under these circumstances there was less past negative history that would have to be overcome to be of some assistance to the officer. This incident, however, points out that there are probably individuals in every police agency who are largely socially isolated and/or have personalities that do not engender positive reactions on the part of their fellow officers. When these officers become involved in a traumatic incident, it becomes a very difficult task to find someone who has the ability to relate to this individual in an accepting fashion.

As mentioned earlier, TIC members have occasionally been used in neighboring police jurisdictions. Unfortunately, when this has been the case, the pitfalls and problems that have slowly been addressed over the years within the Salt Lake City jurisdiction often manifest themselves. Neighboring departments have had little or no experience in dealing with such a service, and typically the chief administrative officers see themselves as being privy to the peer counselor's contacts with the involved officer. As a result, whenever team members are sent to adjoining jurisdictions, we now endeavor to send a copy of the general order to the police administration outlining the methods of confidentiality and the general operation of the peer counselors so they understand the nature and function of the team.

In smaller jurisdictions, team members have had the experience of being expected to perform functions outside the role of peer support. In one incident in a rural part of Utah, a small sheriff's office had an incident wherein one deputy sheriff accidentally shot and killed another deputy. Although initial peer support was offered to the involved officer and other members of the agency, the family of the slain officer began to see the peer counselors as potential family therapists. Unfortunately, the family was fraught with a good deal of pathology and it was necessary to extricate the peer counselors from the situation and refer the family to local mental health resources. Again, this is an example of the types of problems that can occur when the Corps (which is quite unique in function and operation) is lent to another jurisdiction that has neither a base of experience nor any operational procedures to govern their use.

On another occasion, the team members were sent to an adjoining jurisdiction where the requesting agency had experienced the death of an officer due to a training accident in which one officer had accidentally killed a fellow officer. It was a relatively small agency and the incident touched virtually everyone employed in the department. Perhaps because of the tremendous impact it had on the department, their chief requested that all members of Salt Lake City's Traumatic Incident Corps be sent, since he concluded that virtually all members of his department were somehow suffering or could have been touched by the event. In addition, the department's psychological services unit was mobilized to be of assistance. The result was a rather chaotic beginning in which the better part of eight TIC members, plus one clinician from the psychological services unit, arrived simultaneously at the police department. No provisions had been made for any kind of debriefing situation, with the exception that the officer who had pulled the trigger was available for interview at that time. What followed as a chaotic and rushed set of experiences in which the department endeavored to find uses for this large number of peer counselors. After approximately four hours of this situation, it was suggested by the psychological services unit that only one officer be detailed to be of assistance to the involved officer and that a meeting for other officers and spouses be established in order to facilitate a more general level of debriefing that included some information sharing.

In this example, the chief of the requesting department had reacted in such a fashion as to let his own anxiety and distress influence his request, and as a result, he asked for far more resources than could be effectively utilized within the agency. Since there was no attempt to screen over the telephone the exact nature of what had happened, how the event had occurred, and how team members might be deployed and used, too many people were sent to perform too few tasks.

Lessons have been learned regarding selection and training over the years. As mentioned previously, team members were originally selected based on their past participation in a traumatic event, their social skills and ability to relate effectively with others, and their acceptability throughout the rank and file of the police department. In subsequent personnel selections, officers were chosen for the team who had not specifically been involved in a police shooting (as had the original 10), but had had other types of trauma in their lives such as the traumatic death of a child and/or severe accidents. It has generally been felt that by expanding the nature of the traumatic event, the department has gotten away from having a "shooter's club" to having an actual team of individuals who have, in fact, experienced a range of traumatic events.

Since the TIC has been established, it has become prestigious to be involved as a member of the Corps, and, therefore, it is not uncommon for people within the agency to aspire to become team members. Oftentimes this motivation is because of the uniqueness and importance of the team rather than a sincere desire or interest in the nature of the task to be done. It has been the experience of the Salt Lake City Police Department that officers who have this type of motivation usually become clearly identifiable during training processes. For instance, those officers who typically are really not interested or who do not have much psychological mindedness tend to become preoccupied with details of shooting incidents rather than the emotional impact that the event has on the individual officer. As a consequence, during training sessions when specific examples are used, this group of officers often becomes concerned about the "rightness" of the shooting or about the potential of becoming a witness in a civil suit. Experience has shown that when this is the case, these officers typically lack empathy or are largely indifferent to the emotional state of fellow officers and tend to become preoccupied in the technical aspects of the police situation; i.e., conditions for the use of force and/or police tactics, etc. Obviously, people with this type of orientation will be largely ineffective in a peer counseling role and this has been borne out through subsequent events.

One of the major problems confronting the operation of the TIC was the ability to continue with some level of training. Traumatic incidents in very large police departments are probably fairly common; however, in a medium-size department like Salt Lake City, such events may be relatively uncommon, at least to the extent that they do not occur on a weekly basis. As a consequence, all team members are not routinely involved in these incidents, and it is conceivable that sometimes months go by before a team member may find himself called upon to provide his valuable service. Efforts have been made over the years to do bimonthly training in blocks of four hours. Such training typically has been focused upon reviewing specific case examples that have occurred within the department to ascertain where and how the peer counselors had been helpful and to discern areas of improvement.

As with other types of special function teams within the police department such as SWAT and Hostage Negotiation, the skills of the individual officers need to be used with some regularity lest they fall into some disuse and officers themselves find a lowered level of motivation. As a consequence, TIC has developed an unwritten policy that some type of training and general team meeting will be conducted on at least an every-other-month basis. This continues to keep the tasks in the minds of the individual officers and gives the officers an opportunity to review some materials (either case studies or other material) that may be helpful when they are called upon to assume their peer counseling role.

CONCLUSIONS

Over the last nine years the Traumatic Incident Corps concept has proven useful to a medium-size police department such as Salt Lake City. Based on its operation over this period of time, certain lessons and suggestions have been learned that may prove useful in the establishment of similar programs in other agencies.

The first of these lessons is that a clear policy and procedure must be established that activates the team. This policy also legitimizes the involvement of team members. In the absence of such a policy, the team is likely to flounder.

The second lesson is that the concept is one designed to be a preventative program. Since it is a mental health program, it should logically be an extension of the department's psychological services unit. As such, it is possible that a degree of confidentiality and privileged communication may be extended.

The selection of peer counselors is of primary importance. They should be officers who are acceptable to the rank and file of the department, and ideally, they have successfully mastered a traumatic incident themselves. Officers with limited social skills and empathy will not work out. Officers who have a narrow range of interests and thus become preoccupied with tactics or the adequacy of the victim officer's police response are, likewise, ill suited to the task.

The fourth lesson is that there will be times when the peer counselor may not be able to effect a supportive relationship. Some people simply do not relate well and the peer counselors will undoubtedly meet examples of avoidant or abrasive officers. Additionally, there are limits to what peer support can do and peer counselors must be prepared to effect referral when signs of disintegration appear.

When TIC personnel are "loaned out" to other agencies, it should be done cautiously and with adequate preparation of the host agency. This should include briefing chief/executive officers. Perhaps including a supervisor from the Corps to represent the philosophy and maintain the integrity of the program would help to avoid the potential pitfalls.

The last suggestion has to do with maintaining a regular training schedule. Because traumatic incidents are infrequent, not all Corps members will be continually involved. To maintain interest and to learn from past experience, it is a good idea to meet regularly. Such meetings can focus on discussions of past cases or reviews of relevant skills.

Since the Traumatic Incident Corps' inception, the author has had many requests from other agencies regarding the development and maintenance of such a team. Interestingly, few of these departments seem to have actually implemented the program. Many of those who began programs saw them fall into disuse. Some attention to the lessons learned in the Salt Lake City Police Department may preclude problems for other agencies.

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POSTTRAUMATIC THERAPY

Frank M. Ochberg, M.D.

ABSTRACT

Posttraumatic therapy (PTT) has as its foundation principles and techniques that assist the survivors of trauma in post-event readjustment. The basic tenet of PTT rests upon the premise that certain reactions are normal following abnormal life experiences, yet require, in some cases, the assistance of therapeutic intervention to achieve recovery. The therapist acts as a collaborator in the recovery process, pointing out guideposts that seem to appear universally after traumatic incidents and leading the survivor to a sense of empowerment over the feeling of loss of control occasioned by the trauma. The author presents techniques of posttraumatic therapy useful in the readjustment process that focuses on ventilation, education, and tenets of wholistic health.

INTRODUCTION

Most victims of violence never seek professional therapy to deal with the emotional impact of traumatic events. If they did, they would be sorely disappointed. There are not enough therapists in the world to treat the millions of men, women, and children who have been assaulted, abused, and violated as a result of war, tyranny, crime, disaster, and family violence. When people do seek help, suffering with posttraumatic symptoms, they may find therapists who are ill equipped to provide assistance. The credentialed clinicians in psychiatry, psychology, nursing, social work, and allied professions are only recently learning to catalogue, evaluate, and refine a therapeutic armamentarium to serve traumatized clients. There are, however, a cadre of clinicians who have shared insights and approaches, face to face and through written works, defining principles and techniques that address the world-wide problem of posttraumatic readjustment. Recently, I assembled a sampling of those clinical insights (Ochberg, 1988) and attempted to define the commonalities in assumptions and approaches to therapy. The common ground is the foundation of Posttraumatic Therapy (PTT). The individual distinctions that separate clinicians who share this common ground are the inevitable difference of creative minds.

My purpose in this paper is to enlarge upon the foundation of PTT and clarify some of the clinical techniques that stand upon this foundation.

THE FOUNDATION OF POSTTRAUMATIC THERAPY

Several principles are fundamental to PTT and discussing these at the outset of therapy is usually advisable. Since traumatized and victimized individuals are, by definition, reacting to abnormal events, they may confuse the abnormality of the trauma with abnormality of themselves. The first principle of PTT is therefore the normalization principle: **There is a general pattern of posttraumatic adjustment and the thoughts and feelings that comprise this pattern are normal, although they may be painful and perplexing.** The word normal can mean many things. Offer and Sabshin (1966) described, among other connotations, the use of the term normal to designate health, an ideal, and a statistical mode. When a doctor says, "This is a normal reaction," he or she could imply any or all of those three possibilities. For example, after breaking a bone, a patient has the fracture examined and set. A few days later there is pain and swelling, some itching under the cast, but good circulation and no sign of infection or nerve damage. The doctor has seen this pattern may times before and knows the physiological reasons for discomfort and the danger signals of disease. His or her

reassurance, "This is normal," means that a healthy healing process is under way. Further explanation of the healing pattern allows the patient to participate actively in the recovery process, understanding the reasons for symptoms, the time course of reequilibration, and the signs of abnormal interference, such as a wound infection. The emotional healing process often includes reexperiencing, avoidance, sensitivity, and self-blame. These symptoms are easily described, explained, and set in a context of adaptation and eventual mastery.

By sharing such information, the second principle of PTT, the collaborative and empowering principle, is recognized: **The therapeutic relationship must be collaborative, leading to empowerment of one who has been diminished in dignity and security.** This principle is particularly important in work with victims of violent crime. The exposure to human cruelty, the feeling of dehumanization, the experience of powerlessness creates a diminished sense of self. This diminution is normal when it is proportional to the victimization. Survivors of natural disasters experience powerlessness, too, although they are not subjected to cruelty and subjugation. They benefit greatly from a therapeutic alliance that is experienced as collegial and empowering.

A third principle is the individuality principle: **Every individual has a unique pathway to recovery after traumatic stress.** Cannon (1939) and Selye (1956) may have identified common physiological and psychological reactions in states of extreme stress, but Weybrew (1967) and others note the complexity of the human stress response and the fact that one's pattern is as singular as a fingerprint. This principle suggests that a unique pathway of posttraumatic adjustment is to be anticipated and valued, not to be feared or disparaged. Therapist and client will walk the path together, aware of a general direction, of predictable pitfalls, but ready to discover new truths at every turn.

These three principles can be expressed in various ways and supplemented with other important tenets. For example, an appreciation of coping skills rather than personality limitations allows therapy to proceed without undue emphasis on negative characteristics, and the devastating implication that victimization is deserved. PTT begins with the assumption that a normal individual encountered an abnormal event. To ameliorate the painful consequences, one must mobilize coping mechanisms. How different this is from the hypothesis that PTSD and victimization symptoms are products of personality flaws and neurotic defenses that must be identified and treated according to traditional paradigms! Furthermore, an interdisciplinary approach, recognizing the contributions of biology, psychology, and social dynamics, stimulates clinician and client to see beyond any singular explanation for posttraumatic suffering and to search for remedies in many different fields. The contributions of pharmacology, education, nutrition, social work, law, and history are recognized and valued. Interventions may include introduction to a self-help network, exposure to inspirational literature, explanation of the victims' rights movement, establishment of an exercise regimen, or prescription of anxiolytics. PTT is interdisciplinary. The practitioner should, therefore, be aware of community resources that are of potential benefit and be willing to assess the merit of these adjuncts to his or her direct clinical intervention. Often this requires personal meetings with colleagues from disparate fields.

TECHNIQUES OF POSTTRAUMATIC THERAPY

Many techniques have been used effectively to help survivors readjust after traumatic events. I have found it useful to group the various methods in four categories. The first is educational and includes sharing books and articles, teaching the basic concepts of physiology to allow an appreciation of the stress response, discussing civil and criminal law with new participants in the process, and introducing the fundamentals of wholistic health. The educational process is a two-way street. The client may have resources that he or she finds helpful and wants to share with the clinician.

The second grouping of techniques falls within the category of wholistic health. Although the term wholistic health has its critics as well as its supporters, I offer it in the spirit of Merwin and Smith-Kurtz (1988) who note how physical activity, nutrition, spirituality, and humor contribute to the healing of the whole person. The clinician who promotes these aspects of healing serves as a teacher and a coach, offering concepts that might be new to the client, and shaping abilities that may be latent.

The third category includes methods that enhance social support and social integration. Family and group therapy could be included here. Exposure to self-help and support groups in the community is another example. But most important is the sensitive assessment of social skills, the enhancement of these skills, the reduction of irrational fears, and the expert timing of encouragement to risk new relationships. Traditional analytic tools and traditional social work skills are employed to promote healing in supportive human groups.

Finally, there are clinical techniques that are best categorized as therapy. These include working through grief, extinguishing the fear response that accompanies traumatic imagery, judicious use of medication for target symptoms, the telling of the trauma story, role play, hypnotherapy, and many individualized methods that are consistent with the principles of PTT.

These four clusters of techniques are not comprehensive. There are innovations that defy categorization, such as the Native American sweat lodge technique, discussed by Dr. Wilson (1988) and testimony of political repression, used as a therapeutic instrument (Cienfuegos & Monelli, 1983). But it is not my purpose here to prepare an exhaustive catalogue of techniques. My intent is to explain those approaches that I have employed, in residential (Ochberg & Fojtik, 1984) and outpatient settings, with victimized, traumatized clients.

EDUCATION

Reading the DSM together

I will never forget the first time I brought out my green, hardbound copy of DSM III (APA, 1980), moved my chair next to Mrs. M, and showed her the chapter on PTSD. She is a thin, soft-spoken woman in her thirties who was assaulted and raped in south Lansing. She was referred by a colleague and had just finished telling me her symptoms, eight or nine weeks after the traumatic event. She was frightened, guarded, perplexed, and sad. She had no basis for trusting me. But after she saw the words in the book, as I read them aloud, she brightened, sat up tall, and said, "You mean, that's me, in that book! I never thought this could be real."

Seldom have I found such a reversal of mood and such a sudden establishment of trust and rapport since Mrs. M., but I have never missed an opportunity to read the criteria list with a client, when it seemed appropriate.

The responses vary, from satisfaction that the symptoms are officially recognized, to surprise that anybody else has a similar syndrome. Some patients take pride in making their own diagnosis, pointing out exactly which symptoms apply. Few show any interest in other sections of the book. Most seem to enjoy hearing my explanation of the trouble we had formulating the diagnostic category--how some of us argued for placing the description in the "V Code" section, with other "normal" reactions such as "uncomplicated bereavement," but others prevailed and the practical consequence of placing this normal reaction to abnormal events in the chapter on anxiety is that insurance companies pay their fair share of the bill!

Reading DSM-III (APA, 1980) or DSM-III-R (APA, 1987) together begins the educative and collaborative process. It opens the door to further education about the physiology of stress and the range of human responses to adversity. DSM-IV is scheduled for production in 1993, and the architects are considering a "Victim Sequelae Disorder," in addition to PTSD (Spitzer, Kaplan, and Pelcovitz, 1989). This should help clinicians and clients, since the list of potential criteria supplements the PTSD symptoms and includes those common features that affect **victimized** rather than **traumatized** individuals. I have long considered the distinction important (Ochberg, 1984, 1986, 1988, 1989) and am delighted to see it considered in DSM-IV (see Table 1).

TABLE I

Proposed Diagnostic Criteria for Victimization Sequelae Disorder (Spitzer, et al., 1989: Draft for DSM-IV)

A. The experience, or witnessing, of one or more episodes of physical violence or psychological abuse or of being coerced into sexual activity by another person.

B. The development of at least [???] of the following symptoms (not present before the victimization experiences):

1. A generalized sense of being ineffective in dealing with one's environment that is not limited to the victimization experience (e.g., generalized passivity, lack of assertiveness, or lack of confidence in one's own judgment)

2. The belief that one has been permanently damaged by the victimization experience (e.g., a sexually abused child or rape victim believing that he or she will never be attractive to others)

3. Feeling isolated or unable to trust or to be intimate with others

4. Overinhibition of anger or excessive expression of anger

5. Inappropriate minimizing of the injuries that were inflicted

6. Amnesia for the victimization experiences

7. Belief that one deserved to be victimized, rather than blaming the perpetrator

8. Vulnerability to being revictimized

9. Adopting the distorted beliefs of the perpetrator with regard to interpersonal behavior (e.g., believing that it is OK for parents to have sex with their children, or that it is OK for a husband to beat his wife to keep her obedient)

10. Inappropriate idealization of the perpetrator

C. Duration of the disturbance of at least one month

Introducing civil and criminal law

A therapist need not be a lawyer to know about the law. When our clients face the criminal justice system for the first time, they may be understandably concerned, confused, and overwhelmed.

Mr. A was shot in the abdomen at close range by an intruder and almost killed. After heroic surgery, he awoke to the hubbub of an intensive care unit. Between hallucinations, he learned what occurred, received family visits, and began looking at mug shots. His introduction to the world of detectives, prosecutors, and judges was better than most. They appreciated his condition and worked slowly and sensitively, after realizing the futility of expecting a positive identification. He appreciated their professional responsibilities and their regard for him. Would it were always so!

Victims of violent crime are often treated like pawns in an impersonal bureaucracy (Young, 1988). President Reagan realized this in commissioning the President's Task Force on Crime Victims (1982), and the U.S. Congress followed suit by passing the Victims of Crime Act of 1984.

I usually offer clients who are victims of violent crime several articles and brochures that explain their rights under state law and the role of the victim–witness in the American justice system. Michigan is blessed with a model victims' rights law (Van Regenmorter, 1989; Ochberg, 1988, pp. 315–317) and a Crime Victim's Compensation Board that provides financial aid. Clinicians who counsel victims could easily find resources and references in their own states. I find that many clinicians, even in Michigan, are unaware of these resources, but are pleased to know that a portion of their bills can be paid by the state, if their clients report their victimization within a year of the crime.

A patient who is in the middle of a trial, cooperating fully with the prosecutor, may know nothing of his or her right to sue the assailant, to have a court injunction against harassment, to receive workers compensation, and, in some instances, to receive representation from the *pro bono* committee of the county bar association. Finding the right lawyer is as difficult as finding the right clinician, so I pay close attention to my patients' experiences with attorneys and maintain an up–to–date referral roster. Sharing information about legal resources is part of the education process.

Discussing psychobiology

Few clients are interested in reading about autonomic nervous system activation, but some read voraciously. To understand the physiology of mammalian arousal during stress is to begin mobilizing the mind in pursuit of recovery. It is relatively easy to impart a basic understanding of the fight–flight mechanism (Cannon, 1939) and the General Adaptation Syndrome (Selye, 1956). Merwin and Smith–Kurtz explain the concepts clearly (1988) and Roth (1988) and van der Kolk (1988) discuss more complex implications in the same volume. Without turning therapy into a didactic exercise, without burdening the client with unsolicited instruction, one can convey the fact that lethal threat has a powerful impact on body chemistry; that our adrenal glands are stimulated; that we are prepared to fight or to flee as if we were facing a wild beast, millennia ago; that all this circuitry is out of date and usually destructive when we face threats in modern society; that PTSD is the predictable outcome in general after extraordinary stress; that everyone's individual pattern is different. Furthermore, vigorous use of the large muscles is the intended result of adrenal activation, and physical activity is an advisable measure to ameliorate the effects of PTSD. This point leads to the next educational objective.

Reviewing concepts of fitness and wholistic health

In designing the milieu and program of the Dimondale Stress Reduction Center (Ochberg & Fojtik, 1984), I hoped for a blend of a health spa, a community college, and a hospital. We maintained this balance for several years, but eventually the hospital bureaucracy crowded out the other elements. I was disappointed, but not surprised. American medicine, particularly hospital–based medicine, places the patient in a passive

role and ignores the power of health promotion. We used to call health promotion "hygiene" in elementary school. Gym teachers, not doctors, got the points across.

Now, in an office-based, part-time practice, I do what I can to educate patients about the benefits of exercise and nutrition. The syllabus is in the Merwin and Smith-Kurtz chapter of Posttraumatic Therapy (1988). My approach includes nagging, begging, and heartfelt approval when interest is shown. Since the general category of wholistic health promotion includes this education goal, let us move there now.

PROMOTING WHOLISTIC HEALTH

Physical activity

Writing about the development of a healthy fitness routine for PTT clients, Merwin and Smith-Kurtz (1988) observe that "Techniques of physical training have changed in recent years as the maxim 'no pain, no gain' has been discarded. Exercising past the pain threshold risks injury to muscles, joints, or tendons. The watchwords today are 'balance,' 'moderation,' and 'listen to your body.'" They go on to describe the three elements of a balanced program: strength, cardiovascular efficiency, and flexibility, and they note the generally accepted activities that provide these elements. I find few clients nowadays who are unfamiliar with these principles, but many who lack the motivation to begin or to resume an interrupted routine. Some fear social interaction. Some have injuries that limit activity. Some are generally lacking in initiative, evidencing criterion C.(4) of PTSD (APA, 1987), "markedly diminished interest in significant activities." Relatively early in therapy I will evaluate the client's potential for supervised physical activity. I want to know that a recent medical examination has been performed and there are no limitations or restrictions. If there are limitations, I may still promote allowable activity, but only after consultation with the examining physician.

Often the client and I develop an exercise plan, with goals and methods listed in the record. This process usually occurs after a preliminary discussion of stress physiology and before agreement on overall treatment objectives. (The client may be ready to take daily walks, but not ready to discuss the details of the victimization.) Agreeing on an exercise plan and fulfilling the agreement are separate issues.

When there is resistance to exercise, the resistance itself must be confronted. The therapist should not assume to know an individual's underlying motive for avoiding healthy activity. A gentle, collaborative search for the obstacles and the construction of a path around these obstacles comprise an important chapter of PTT. Having said this, I must admit that I find it very difficult to avoid the methods that ultimately motivated me to undertake a fitness routine: the unremitting urging of well-meaning friends.

Therapists are advised to become familiar with supervised, structured fitness programs in their communities. A referral to a specific YMCA, health club, or aerobic instructor can assure that the milieu is appropriate, the regimen is reasonable, and the opportunity for reinforcement is available.

I am delighted when clients adopt a healthy exercise routine, and they know it.

Nutrition

We never learned much about nutrition in medical school (outside of infant formulae in pediatrics). I am still baffled by conflicting professional and lay advice on the value of various "healthy" diets. But it makes sense to evaluate a client's eating habits and look for the common mistakes that contribute to anxiety, irritability, and depression. This is part of good clinical work, in general, but particularly important for posttraumatic patients who are vulnerable to mood swings and who may have neglected their nutrition.

Caffeine intoxication. DSM-III-R (APA, 1987) requires 5 out of 12 signs, plus the presence of recent excessive caffeine ingestion and the absence of other causes, to make the diagnosis of caffeine

intoxication (or "caffeinism"). The 12 signs overlap with the hallmarks of panic, generalized anxiety, and aspects of PTSD: restlessness, nervousness, excitement, insomnia, flushed face, diuresis, gastrointestinal disturbance, muscle twitching, rambling flow of thought and speech, tachycardia or cardiac arrhythmia, periods of inexhaustibility, and psychomotor agitation. Clients who experience numbing may consciously or unconsciously increase their coffee consumption. A demoralized indifference to preparing and consuming adequate meals may result in excessive drinking of tea or coffee. And caffeine is found in soft drinks, candy, and certain desserts as well as coffee and tea. The incidence of true caffeine intoxication is relatively rare, but good clinical practice requires that we rule out the diagnosis when anxiety symptoms are present. Furthermore, a discussion of caffeine effects leads to the broader issues of diet, appetite, and meal rituals.

The meaning of healthy eating. Food gathering, preparation, and consumption has ritual significance in most cultures. Full participation in the family or tribe requires the equivalent of "bringing home the bacon" or "fixin' dinner" or "getting to the table on time." Food sharing is a critical aspect of nurturing and of family cohesion. When a traumatic event interferes with one's desire to eat, one's ability to face the ordeal of shopping, and one's participation in shared meals, more than nutrition is at stake. There is disruption of biochemistry, interpersonal relations, self-esteem, and connection to culture. PTT requires attention to all of these issues, agreement on desired objectives in the short-term and long-term future, and a collaborative search for remedies.

Mrs. A developed agoraphobia in addition to PTSD after being held hostage and surviving a sexual assault. Her therapy was prolonged, involving residential and outpatient treatment. She read every book she could find about coping with stress and understood the significance of reestablishing her role in her family and community. But a major obstacle was her fear of meeting people who knew about her assault and who felt compelled to make well-intentioned remarks about her recovery. We discussed this situation at length. As she learned to respond to the sympathetic comments of friends and acquaintances without feeling invaded, she overcame her fear of the marketplace. The later phases of PTT were supportive and nondirective. She resumed her functions in the family and meals became a source of pleasure rather than pain.

Referral to nutrition experts. My community has a state university with a department of food science, four hospitals with dietitians, and a professional association of dietitians that holds regular educational conferences. It is relatively easy to identify competent colleagues. Several expressed interest in counseling clients on the fundamentals of food selection and diet. They are experienced in working with eating disorder patients, but not with victims of violence. In those few instances where I made referrals, the outcome was generally good. The clients learned new facts and experienced a feeling of mastery. Those therapists who do not have colleagues close by to assist with nutritional counseling are advised to review the basic facts and the supplementary reference list provided in Chapter 4 of Posttraumatic Therapy and Victims of Violence (Ochberg, 1988).

Humor

Following the advice of my colleague who write the section on humor in the chapter just mentioned (Smith-Kurtz, 1988), I asked Mrs. R, an adult survivor of incest, to tell me about her ability to laugh. "Do you think my life is funny?" she fumed, casting a look at me that could wither an oak tree. My timing was awful. But usually I can succeed in initiating a discussion about humor, its salutary effect, and ways that we can improve our ability to laugh at ourselves. Ms. Smith-Kurtz cites the remarkable example of Norman Cousins (1979), a genius in marshalling humor as a coping mechanism for critical illness. Furthermore, she provides techniques and references to enhance the therapist's sense of humor.

The goal in adding humor to PTT is not for the therapist to be witty, but for the client to have the capacity to laugh. A clinician can facilitate the recovery and the improvement of a client's sense of humor by setting an example, by searching for instances when the client used humor well, and by providing a good audience when spontaneous humor arises.

A week after Mrs. R cut me down to size, I told her how clumsy a therapist can feel, trying to uncover humor and failing completely. She laughed. Now we can talk freely about her tendency toward sanctimoniousness and her neglect of humor as a healing art. She is interested in elevating her capacity for laughter, and that is a step in the right direction.

Spirituality

Long before psychology and psychiatry were invented, before medicine was a science, there were healers who treated the sick and the wounded. They sometimes used remedies with a chemical basis for efficacy, unknown at the time (e.g., belladonna for diarrhea). But invariably there was a sacred, ritual dimension to the treatment. The medicine man invoked spiritual assistance. Sacrifices were required to the gods. Prayers were said, individually and collectively. There is abundant evidence that healing was facilitated.

The power of prayer in surviving captivity and torture is well known (Fly, 1973; Jackson, 1973), although the mechanism of action is subject to debate.

Although I once felt that religion and spirituality had no place in the clinical sciences, I am now convinced that clinicians must evaluate every client's spiritual potential. By this I mean their ability to benefit from their own beliefs, particularly a sense of participation in universal, timeless events. For adherents to the major religions, this spiritual dimension may be conceptualized as feeling God's love. For others, spirituality may be described as a transcendent feeling of harmony and communion with humanity or nature or the unknown reaches of space.

Dr. Merwin (1988) explains, "spirituality is a state of being fully alive and open to the moment. It includes a sense of belonging and of having a place in the universe. A deep appreciation of the natural world, an openness for surprise, a gratefulness for the gratuity of everything, joy and wonderment are all a part of spirituality. Although spiritual growth is a type of healing from which most of us could benefit, a victim's sense of spirit may be acutely dimmed for a period after victimization.

"Over time, however, as the victim heals in all areas, the potential for spiritual growth may become greater than ever before and greater than for many people who have not faced the reality of their individual death."

I usually avoid these issues early in therapy. Many patients have complained to me about clergy who focused on their own method of spiritual healing after a trauma, ignoring the feelings of the victimized individual. On the other hand, many clients have been helped by sensitive pastoral counselors, and continue seeing them while seeing me. My role is not to promote any specific spiritual approach. But after a relationship is established, after some progress has been made, I express interest in the client's experience of spirituality. Often I am surprised by the strength of religious conviction that coexists with pessimism and helplessness. The issue in therapy then is not creating, *de novo*, a spiritual capacity, but identifying and overcoming the obstacles to feeling the embrace of one's faith.

An excellent example of personal triumph over childhood sexual assault, and the effects of racism and sexism, can be found in the autobiographical prose and poetry of Maya Angelou (1978). Her faith in her own indomitable spirit inspires others. I have referred her works to clients and students, when the spiritual dimension of overcoming adversity was relevant. Here is a powerful poem of hers that can reach the right client at the right time:

And Still I Rise

You may write me down in history
With your bitter, twisted lies,
You may trod me in the very dirt
But still, like dust, I'll rise.
Does my sassiness upset you?
Why are you beset with gloom?
'Cause I walk like I've got oil wells
Pumping in my living room.
Just like moons and like suns,
With the certainty of tides,
Just like hopes springing high,
Still I'll rise.
Did you want to see me broken?
Bowed head and lowered eyes?
Shoulders falling down like teardrops,
Weakened by my soulful cries.
Does my haughtiness offend you?
Don't you take it awful hard
'Cause I laugh like I've got gold mines
Diggin' in my own backyard.
You may shoot me with your words,
You may cut me with your eyes,
You may kill me with your hatefulness,
But still, like air, I'll rise. . .
Out of the huts of history's shame I rise.
Up from a past that's rooted in pain I rise. . .
Leaving behind night of terror and fear
I rise
Into a daybreak that's wondrously clear
I rise.
Bringing the gifts that my ancestors gave
I am the dream and the hope of the slave.
I rise.
I rise.
I rise.

Wholistic health recognizes that the healing process is more than chemical reequilibration. Attention to exercise, nutrition, humor, and spirituality are important elements of the wholistic approach. Beyond these elements is the human group, whether it is a family, a support network, or a community. The individual who is victimized cannot recover in isolation. Therefore the clinician must attend to the demands of social integration.

SOCIAL INTEGRATION

A supportive family is the ideal social group for healthy posttraumatic healing. Figley (1988) describes how such families promote recovery by "(1) detecting traumatic stress; (2) confronting the trauma; (3) urging recapitulation of the catastrophe; and (4) facilitating resolution of the trauma–inducing conflicts." After reviewing the first 50 admissions to the Dimondale victims' assistance program, a residential treatment facility with an average stay of two weeks, I was surprised to find that less than 10% of the patients had supportive families. My conclusion is that victimized individuals with loving, effective families would rather recover at home than be separated from their primary source of nourishment. However, even the ideal family

can be sorely strained after one or more members are seriously traumatized. There is an important role for the posttraumatic therapist in assessing family strengths and weaknesses and assisting in the design and implementation of strategies for optimum recovery. Referral to support groups and self-help networks may complement or supplement the healing function of the family.

Posttraumatic family therapy

Figley's formula for posttraumatic family therapy includes an assessment phase and four distinct treatment phases (1988). Before summarizing these, I must emphasize that family therapy is not necessarily the best approach, particularly when violation occurs within the family. For example, Judith Herman (1988) cautions, "Following the crisis of disclosure, the incestuous family is generally so divided and fragmented that family treatment is not the modality of choice. Experienced practitioners who have begun programs with a family therapy orientation have almost uniformly abandoned this method except in late stages of treatment (Giarretto et al., 1978)." Stark and Flitcraft (1988) minimize family therapy and emphasize the shelter movement and individual, empowering therapy for battered women: "Assuming that violence has stopped, principal treatment objectives are to overcome the sense of physical and psychological violation and restore a sense of autonomy and separateness."

Family assessment. Eleven criteria distinguish functional from dysfunctional families, according to McCubbin and Figley (1983): The traumatic stressor is clear, rather than denied; the problem is family-centered rather than assigned completely to the victim; the approach is solution-oriented rather than blame-oriented; there is tolerance; there is commitment to and affection among family members; communication is open; cohesion is high; family roles are flexible rather than rigid; resources outside of the family are utilized; violence is absent; drug use is infrequent. Standardized protocols can supplement clinical judgment, but ultimately the clinician and client together must decide whether family therapy is feasible.

Treatment phase I: Building commitment to therapeutic objectives. When the clinician and the client agree that family therapy is indicated, the first phase of treatment requires that as many family members as possible disclose their individual ordeals, and the therapist demonstrate recognition of their suffering. Figley (1988) suggests that the therapist's sense of respect for each family member's reaction, coupled with optimism and expertise, promotes trust and commitment to therapy. Highlighting differences in individual responses leads to the next phase.

Treatment phase II: Framing the problem. Now each family member is encouraged to tell his or her view of the traumatic event and to understand how each member was affected. The therapist reinforces discussion that shifts the focus away from the victimized individual toward the impact on the family as a whole. This is the time to recognize, explore, and overcome feelings of "victim blame." When positive consequences of the ordeal are mentioned (e.g., a greater appreciation of life after a close brush with death) they are duly noted.

Treatment phase III: Reframing the problem. After individual experiences, assumptions, and reactions are expressed and understood, the critical work of melding these viewpoints into a coherent whole begins. ". . . The therapist must help the family reframe the various family member experiences and insights to make them compatible in the process of constructing their healing theory," notes Figley (1988), illustrating this principle with an example from his work with Vietnam veterans. A combat veteran felt rejected by his wife, who avoided talking with him. She felt like a failure as a spouse because she couldn't help him overcome PTSD symptoms. In this treatment phase, "he began to reframe his perception of her behavior from a sign of rejection to a sign of love." Eventually, the whole family rallied, seeing obstacles as challenges to overcome.

Treatment phase IV: Developing a healing theory. The goal of posttraumatic family therapy is consensus regarding what happened in the past and optimism regarding future capacity to cope. An appraisal that is shared by all family members, that accounts for the reactions of each, that contributes to a sense of family cohesion, is a healing theory. Figley (1988) suggests a fifth phase that builds upon this consummation,

emphasizing accomplishment and preparedness. However the therapist chooses to clarify the closure of successful therapy, the family will know that they have fulfilled their potential as a healing, nurturing human group.

Alternatives to family therapy

Self-help groups. Lieberman and his colleagues (1979) described and evaluated self-help groups, noting how effective they are, particularly in those countries and cultures that do not rely upon the extended family for support. Self-help and mutual support groups tend to be specific, rather than generic. It is unusual to find a group for all victims of violent crime, but common to have groups for parents of murdered children, adult survivors of incest, and victims of domestic assault. Groups that endure tend to have extraordinary leaders, compatible members, and an optimum blend of ritual and flexibility. Often, professionals are in the background, available for consultation and referrals, but not intruding upon the autonomy of the group.

Therapists who work with victims of violence should become familiar with community groups that offer opportunities to share experiences, promote normalization, combat victim blame, and provide a nonthreatening social experience. Some groups will complement individual therapy. Some provide unique opportunities to help others, restoring a sense of purpose and potency. But some groups do more harm than good, encouraging premature ventilation, allowing self-styled "experts" to dominate, confusing and demoralizing the new participant.

Dyadic support. I have found several ex-patients who were willing to meet with current clients to share experiences. This usually worked best one-on-one, at the ex-patient's home or a restaurant. Since I knew both individuals, I could arrange the meeting, giving a bit of background information on each. I would choose the pairs carefully, thinking about compatible personalities, common traumatic events, and timing with respect to each. For example, Mrs. L, a 35-year-old mother of two children, a survivor of rape by a man eventually convicted of serial rape and murder, told me, after therapy, that she would be pleased to help other women with similar terrifying experiences. Mrs. L was of considerable help to Mrs. A, the woman mentioned earlier who was held hostage and assaulted. Both were mothers, career women, and articulate and assertive. Mrs. A did not want sympathy from strangers, had difficulty returning to work, feared entering a supermarket, but rallied as therapy and self-help efforts progressed.

Later, Mrs. L assisted other clients. But when she went through a separation and divorce from an abusive husband, she was not available to help. I therefore recommend that any attempt to promote contact between ex-clients and current clients be made with caution, knowing the current status of each, and protecting confidentiality by withholding names and personal information until each has been consulted, each agrees, and the timing seems appropriate. However, a carefully screened dyadic "support group" can be extremely beneficial, and is well worth the effort on the part of the therapist. Most of my clients tell me they would appreciate an opportunity to assist others, and I believe them.

Support services for victims. Social integration refers to the use of sensitive, supportive companions in the course of recovery from traumatic events, and also to the goal of reentering society without fear. Victims of violent crime who participate in the criminal justice system have little choice about the timing of some very stressful social experiences. They are questioned, cross-examined, brought to crowded courtrooms, and sometimes forced to share a waiting room with the perpetrator. For them, social integration can be sudden and traumatic. Fortunately, efforts are under way in most states to provide specialized services for victims facing these stressful ordeals. Marlene Young, Director of the National Organization for Victim Assistance, describes these efforts and the generic model of ideal victim services in her chapter, "Support Services for Victims" (1988). Dr. Young points out the need for advocacy and assistance at every stage of the process, including the precourt appearance, the trial, and the sentencing hearing.

There are victim-witness specialists who are trained to support an individual throughout the criminal justice gauntlet, but caseloads are overcrowded, budgets are tight, and too often, the victim-witness is ignored.

I have not hesitated to meet with prosecutors and to attend court hearings when my clients felt it would help. PTT objectives are advanced, particularly the objective of sensitive facilitation of social contact. Moreover, court personnel take more interest in the client, and I learn about the wheels of justice in my home town. Some colleagues argue that this type of intervention fosters dependency and interferes with the therapeutic relationship. They would be correct if psychoanalysis were the modality. But PTT recognizes the reality of revictimization by busy bureaucrats and officious officials. Partnership between clinician and client in the pursuit of justice is both ethical and professional.

PSYCHOTHERAPY

When I concluded a dozen years in federal and state government to return to full-time practice of psychiatry, Perry Ottenberg, M.D., congratulated me and said, "It's a great occupation. You've got your tools in your *tuchas* (Yiddish for backside)--right here!" and he pointed to his head. Wherever the tools of the trade are located, most therapists rely on their own stock of intervention methods, sharpened by years of use. Good therapists establish rapport easily, facilitate discussion of painful material gently, and help their clients or patients make informed choices about critical decisions, such as use of medication. PTT requires and employs these basic skills. There are several additional psychotherapy tools, specialized tools, that deserve mention. These are the timing of the telling of the trauma story; symptom suppression; the search for meaning; and the handling of coexisting problems.

Telling the trauma story

PTT is never complete if the client has not told the details of traumatization. This does not mean that a person who has seen several therapists must tell every detail to every clinician. Nor does it mean that one unemotional synopsis will suffice. Persons who suffer PTSD and victimization symptoms are still captured by their trauma histories. They are unable to recollect without fear of overpowering emotion. And they recollect what they do not want to recollect, when they are unprepared to remember. The purpose of hearing the details of the trauma story, as a therapist, is to revisit the scene of terror and horror and in so doing, remove the grip of terror and horror. The client should feel your presence at that moment. The purpose is more than catharsis. It is partnership in survival. It is painful.

There is no sense in exploring these corridors before a bond of mutual trust is established. I usually know some details from a referral source before beginning my first session with a client, and I will mention them in a matter-of-fact manner, but I make it clear from the beginning that there will be a time for sharing the details, and that will come later.

I believe that highly charged events are filed in the brain's special filing system according to emotional tone, not chronologically, certainly not alphabetically. My objective with respect to the traumatic memory is to file a memory of the two of us, client and clinician, revisiting the trauma, right next to the original file. The co-location of this experience of controlled, shared recollection, with the original, terrifying event, allows mastery and respect to permeate the experience of lonely dehumanization.

Obviously, a mechanical retelling of events will not produce a memory file that ends up in that "special" drawer reserved for extreme emotion. And an uncontrolled, unanticipated abreaction lacks the healing quality of guided, collegial reexploration. There is an optimal emotional intensity, strong enough to assure association with the original trauma, but not so strong as to obliterate the recognition of mastery and respect.

I have employed hypnosis and guided imagery to facilitate recall of trauma scenes, but always with continual reassurance that we are proceeding together, that safety is assured. With female sexual assault survivors I have always used a female co-therapist during hypnotic revisiting of trauma scenes.

Occasionally, the properly timed telling of the trauma story is the dramatic crux of therapy. Mrs. M, a 60-year-old woman married to a man with advanced senile dementia, was driving with her lover on a snowy night. There was a crash and he died in her arms. She could not share her horror with her daughters, and she had PTSD symptoms for over a year. My colleague, Alice Williams, M.S.W., worked with her on an outpatient basis, and I consulted once or twice. Symptoms remained. But after three days in a residential unit, we revisited the terrible snowy night together, with Mrs. M in a light hypnotic trance. She cried and screamed as she narrated the events, then blurted out, "Alice, why didn't I do this before?" then cried some more. But now they were clearly tears of relief. The lonely terror was welded to the reenactment experience with a respected therapist. Symptoms abated completely. Telephone follow-up two years later confirmed enduring relief.

More frequently, the telling of the trauma store is not curative. One reenactment with a trusted clinician is not enough. Aspects of the trauma are still hidden. Implications of victimization are profound. Symptoms remain entrenched. PTT continues, with all applicable tools applied.

Symptom suppression

Walton Roth, M.D. asks the pertinent question in his chapter on the role of medication in posttraumatic therapy (1988): "Is the treatment of a psychological disorder by biological means a short-sighted suppression of symptoms that robs the patient of the motivation and resources to solve his or her true underlying psychological problems?" He then provides an "integrated psychobiological viewpoint" of posttraumatic stress, justifying the temporary suppression of symptoms that interfere with adaptation. Whether medication, biofeedback, or behavior modification are offered to suppress symptoms, the client should have the opportunity to make an informed choice among effective options. Common posttraumatic symptoms that can be suppressed at any stage of PTT include insomnia, panic, and generalized anxiety. Medication can help with each of these, but there are pitfalls and contraindications. Roth (1988) and van der Kolk (1988) discuss these issues well.

I have found that judicious use of sedatives (e.g., Triazolam, 0.125 mg every other night) often restores a normal sleep pattern without creating dependency. The dosage may be increased, but the client avoids using medication nightly, and discontinues the drug within a month. Some sleep disorders are very difficult to treat, however, with or without drugs.

Similarly, moderate use of tricyclics for panic and benzodiazepines for anxiety have allowed many of my patients to accelerate recovery, reenter social groups, and restore self-esteem. Both of us know that symptoms are being suppressed to facilitate PTT, not to replace it.

The individual search for meaning

Catastrophic stress, by definition, shakes one's equilibrium, breaks one's attachments, removes a sense of security. Confrontation with deliberate human cruelty inevitably strains one's sense of justice, shatters assumptions of civility, and evokes alien, sometimes bestial, instincts. Those clinicians who describe therapy with Holocaust victims and refugee survivors of violence and torture (Danieli, 1988; Mollica, 1988) recognize these profound effects, often transmitted to a second generation, cast in the shadow of cruelty.

Viktor Frankl, the famous Viennese psychiatrist, pondered the profound questions about life's meaning as he endured the Nazi concentration camp, and afterward, as he provided therapy to fellow survivors. "Woe to him who saw no more sense in his life, no aim, no purpose, and therefore no point in carrying on," states Frankl, recalling the death camp (1959). "What was really needed was a fundamental change in our attitude toward life. We had to learn ourselves, and, furthermore, we had to teach the despairing men, that it did not really matter what we expected from life, but rather what life expected from us. We needed to stop asking about the meaning of life and instead to think of ourselves as those who were being question by life--daily

and hourly. . . Life ultimately means taking the responsibility to find the right answer to its problems and to fulfill the tasks which it constantly sets for each individual."

It is a rare privilege to work with a client who reaches the philosophic stage of PTT, consciously formulating a new attitude toward life. But when patients are overwhelmed with symptoms, discussion of life's meaning has little relevance. However, as **normalization** restores a sense of dignity, as **empowerment** restores a will to endure, and as **individuality** restores a sense of self, the client does take "responsibility to find the right answer" for himself. His behavior demonstrates his fulfillment of Frankl's ideal, even if he lacks the ability or inclination to formulate a philosophy of life.

The therapist, however, should have the aptitude to guide a search for meaning, to recognize existential despair, to confront self-pity, to reinforce recognition of one's responsibility for one's own life. A final phase of PTT includes articulation of the meaning of life in terms that are specific to the individual, not general or abstract.

Coexisting problems

PTSD may mimic personality and anxiety disorders. It may precipitate physical and psychiatric conditions. It may exacerbate preexisting disorders. It may be confounded by coexisting problems, including normal stages of life adjustment (Wilson, 1988; Mowbray, 1988). To illustrate this point, Wilson (1988) cites the remarkable findings of Green, Lindy, and Grace (1984) who found "that only 13% of a treatment seeking population of Vietnam veterans manifest a single diagnosis of PTSD." Therefore it is important for posttraumatic therapists to recognize coexisting problems and to clarify these in therapy.

Certain coexisting disorders, particularly borderline personality, may be impossible for the posttraumatic therapist to manage according to the principles of PTT. For example, collegiality may be misinterpreted as intimate friendship, and a willingness to intervene with criminal justice officials may lead to insatiable requests for help with personal affairs. Unfortunately, abused children may evidence combinations of borderline personality, multiple personality, and PTSD. This presents enormous challenges to the therapist. A treatment strategy must be individualized and may involve several therapists, concurrently or in sequence. Recently, I served as a consultant to a therapist treating a client with borderline personality disorder and PTSD. I provided educational material to the client and his spouse, and shared my clinical hunches with the therapist. The client made several attempts to enlist my aid in undercutting therapy, calling me at home, complaining that his therapist never saw him after the therapy hour, citing previous papers of mine to "prove" how insensitive his therapist was to the needs of traumatized patients. His therapist confronted him respectfully, maintained appropriate therapeutic boundaries, and continued undeterred. I am grateful for therapists with the maturity and stamina to treat borderline patients. And I am thankful for lessons in the limitations of PTT.

It is not unusual for a traumatized patient to request help with psychological issues that antedate the trauma. Several clients have embarked upon long-term therapy for dysthymia, avoidant personality disorder, or dependent personality disorder, after achieving mastery of PTSD and victimization symptoms. In these cases I continually clarified the contract and the objectives, to avoid self-blame when working with victimization issues, and to promote self-reliance when treating the preexisting condition. There is no way to completely untangle PTSD and a personality disorder, treating one first and then the other. But the therapist can maintain the fundamental principles of PTT and use tools in the general armamentarium of techniques, as long as there is no contraindication due to coexisting problems.

CONCLUSION

The clinician and the client have no difficulty realizing when posttraumatic therapy approaches its conclusion. Symptoms subside, although they may be present to some degree. There is an understanding of

the causes and significance of autonomic echoes. There is a sense of mastery and control. But most significantly, there is a shift from victim status to survivor status. To clarify this change of self-perception, I wrote the Survivor Psalm and use it with clients to gauge progress and to mark termination:

I have been victimized.
I was in a fight that was not a fair fight.
I did not ask for the fight. I lost.
There is no shame in losing such fights, only in winning.
I have reached the stage of survivor and am no longer a slave of victim status.
I look back with sadness rather than hate.
I look forward with hope rather than despair.
I may never forget, but I need not constantly remember.
I was a victim.
I am a survivor.

With every client who travels that painful path from victim to survivor, I feel a surge of hope for all of us who are engaged in the larger struggle for survival.

It is no accident that many of the same principles that guided the Community Mental Health movement in the 1960s are rediscovered in the victims' rights movement of the 1980s. There is a vast, underserved population. There is a need to mobilize help from separate disciplines. There is a crescendo of attention that cuts across ideology. There is a scientific basis for humanitarian aid. There are atavistic approaches that do more harm than good, and that beg for reform. Treating rape victims on the same psychiatric unit as chronic schizophrenics is the modern equivalent of institutionalizing the mentally ill. Removing sexually abused children from their mothers rather than removing the abusive father is reminiscent of persecuting psychotic individuals as demons. And denying that thousands of Vietnam veterans and millions of refugees can benefit from clinical attention is tragically similar to the national myopia that culminated in President Kennedy's call for Action for Mental Health (1963).

Participation in any aspect of the healing arts and sciences is a source of gratification and humility. The rewards are great; the problems are never ending.

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TEAM APPROACH TO CRITICAL INCIDENTS IN VICTORIA, AUSTRALIA

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ABSTRACT

The Victoria Police (9,500 members) are responsible for policing the State of Victoria, Australia. There is a comprehensive, integrated health service within the Police Department delivering a range of psychological, welfare, and medical services. The wider community has a disaster recovery plan that provides crisis care for ordinary citizens. A mass murder and the ambush murder of two constables are used as examples of the integrated response.

THE STATE OF VICTORIA

Victoria is the state in the southeast corner of the vast continent of Australia. It has a population of 4.5 million people and generates a third of the country's gross national product although it only forms 3% of the land surface of the country. More than half the population live in Melbourne in a diverse multicultural society that represents almost every cultural heritage in the world.

Southeastern Australia is one of the most fire-prone areas of the world. Long hot summers dry the native eucalypt forests and their natural oils provide a flammable fuel. On days of gusty north winds, large fires are a part of life for rural communities.

The state government has developed a well-organized Disaster Plan (DISPLAN), which is the basis of the communities' ability to combat, control, and nullify the effects of natural and man-made disasters using "all available resources." DISPLAN cuts across the organizational boundaries of government departments and receives the cooperation of all levels of government--local, state, and federal--in working towards common community goals. In the acute phase of a disaster the emphasis is on combating the event and on the management of physical injury; however, DISPLAN recognizes that "psychological effects of disaster can occur in all phases of disaster."

On Ash Wednesday 1983 communities in two states were devastated by wild fires that destroyed thousands of hectares of forest and hundreds of homes and claimed the lives of 57 people. The Victorian Premier stated afterwards, "Every one of us has, in some way, experienced the bushfires, and, as a community we must be prepared to learn from that experience and build upon it." It highlighted for the politicians that the effects of emergencies on individuals, families, and communities can be so great that recovery is not possible without assistance; that the process of recovery is complex and protracted, requiring the coordinated interaction of a wide range of agencies. Out of the experience of Ash Wednesday grew the State Disaster Recovery Plan, which aims to provide a flexible, resilient framework around which all sections of a community can marshal resources and work together to attain their normal level of functioning after an emergency. Recovery plans are coordinated at state, regional, and municipal levels.

This paper focuses on the mental health aspects of the recovery plan, but there are programs for emergency housing, provision of clothing and medical attention, assistance with finance, and other resources that are outside the scope of this paper.

In Australia policing is predominantly a state responsibility. The Victoria Police is a force of 9,500 sworn members supported by 2,500 public servants, covering the whole range of policing duties in settings varying from metropolitan and semi-urban areas to isolated one-man stations. It is a diverse and complex organization with more than 400 job descriptions.

The Police Health Service has been evolving since 1852 when the Colonial Surgeon suggested that he could reduce malingering if he had his own hospital into which he could admit sick members under his personal supervision. The Police Hospital has known several sites, but the current 30-bed facility attached to a major university hospital allows police the security and privacy of their own modern hospital with the advantages of tertiary medical technology close at hand. The emphasis is on the promotion of occupational health in the widest sense, not limited to the medical model but coordinates the services of psychology, chaplaincy, and welfare to produce an integrated approach to the total needs of the work force.

Slightly removed from the clinical activities of the Health Service is the Department of Forensic Medicine, which provides a whole range of forensic services to the police. These services include the assessment of injury, the health care of police prisoners, and the interpretation of medical evidence in courts.

This paper illustrates how these services responded in two separate incidents.

THE MASS MURDER OF HODDLE STREET

On Sunday, the 9th of August 1987, a 19-year-old man, recently resigned from the Australian Army after being charged with violent civilian offenses, fired without warning on motorists in a quiet inner urban residential area. He had no criminal history, but as an adopted child with a father in the Armed Forces, he was obsessed with the military. Slightly intoxicated (blood alcohol 0.08%) after a quiet day with family and friends, Julian Knight went home, armed himself with a shotgun and two rifles, then went out on a shooting spree, firing on passing cars, killing 7 people and wounding a further 17. He later told investigators that he wanted to experience the feel of combat. He shot and hit the police helicopter, which was forced to land. He later wounded a police officer but gave up without further struggle after the police returned his fire.

Approximately 100 police were involved in the incident. Some were directly in the line of fire--seeking cover on the roadway with the dead and dying; others arrived after the arrest and were obliged to protect the crime scene for long hours; some accompanied the injured to hospitals; some had to deal with the victims' families; many spent time reassuring and comforting local residents.

The Police Psychology Unit started formal debriefings the following day and continued seeing new referrals for three months after the incident. Ideally all the participants would have been seen within the first three or four days, but the magnitude of the operation involved police from widely dispersed stations, which compounded the usual difficulty contacting some individuals.

The initial debriefings were structured and formal but as time passed this was less appropriate, and later sessions were conducted individually focusing on symptom recognition and stress management. Of the original 100 police personnel involved, about 60 were seen in the psychology unit.

Those facts of the incident that were identified as traumatic for the participants were:

1. Threat to life--most police perceived themselves to have been in grave personal danger.
2. Loss of life around them.
3. Loss of control.
4. Feeling they were unable to function adequately because they were also victimized.
5. The horrifying nature of the injuries seen.

An array of personal responses were reported. Many stated that they had fears of returning to work in case they were confronted by a similar situation--they had an increased sense of personal vulnerability and awareness of danger sometimes translated into fears not of their own safety but that for their families; some had doubts about their careers--questioning if they really joined the police force to be confronted with this sort of trauma; some individuals reported reliving the traumatic event of the night over and over, not because of their own prolonged periods of personal danger, but because of the emotive nature of their experience.

Several members had lain in a gutter for more than half an hour with a critically injured victim discussing life in general and supporting her until it was safe to bring in medical assistance. They formed a special bond with her and had difficulty coping with her 10-day illness and eventual death. These sorts of experiences led to reports of nightmares that were either symbolic or realistic representations of the scene.

The strongest psychological reactions related to the emotional impact of some of the deaths.

The following day the State Disaster Recovery Plan was invoked to coordinate support service. Local health clinics, church groups, and voluntary relief agencies were contacted. Meetings of survivors and debriefings of local residents were held. The community came to life in its expression of grief and horror. Several groups became outspokenly politically active, promoting gun control, which gave purpose to their anger. A successful amnesty at which police collected illegal weapons for disposal allowed a real sense of achievement. No accurate records were kept but many hundreds of people were involved in the recovery activities and at least 40 people received formal mental health assistance. Two years later a memorial was formally erected in a nearby park signaling that the healing process was over.

THE EXECUTION IN WALSH STREET

Walsh Street is a leafy tree-lined street in an affluent area of Melbourne just a few kilometers south of the city. During the early hours of Wednesday, the 12th of October 1989, a number of offenders stole a car, which they parked in Walsh Street in an obvious position to attract attention and lure police to investigate an abandoned vehicle. The offenders are believed to have then placed themselves in wait for police to arrive.

They became frustrated with the lack of action and called a taxi at 03.45 hours. The driver, unable to find his fare, noticed the abandoned vehicle but although he investigated the car himself, he left the scene without notifying the police. At 04.15 two men leaving for work noticed the car and they notified the police.

The local police station notified the communications center and a car was dispatched at 04.38. The two young police constables arrived at 04.46 and examined the car. At 04.48 one policeman was seated in the suspect vehicle examining the contents when he was shot at close range with a pump action shotgun. His partner moved to his assistance and was also shot at point-blank range with a shotgun before being shot with his own service revolver.

Immediately a number of calls were received that shots had been fired in the area. Police attended and found the two young constables critically wounded. Both died at the scene.

The on-call psychologist was contacted shortly after the shootings. He attended at the local police station with a member of the welfare staff and held an informal debriefing of the crew last in touch with the deceased members and those who first discovered the scene. They talked about their feelings of shock, horror, and outrage, as well as their stunned disbelief. All of them wanted to continue their duties the next evening. Informal discussions were also held with other members of the station as they arrived for work and heard the news.

An intensive investigation followed. To date, four offenders have been charged with the double murder. One suspect was shot dead by police attempting his arrest; a few weeks later another suspect was seriously injured when police attended at his home and he later died. This sparked a community protest about "revenge killings," increasing the pressure on the investigators.

The Director of Health Services attended the scene of the shootings and the postmortem examinations in order to ensure an accurate flow of information to other members of the health service team. He arranged for health professionals to make visits to surrounding stations not directly involved in the shootings or the formal debriefings.

Family and close friends of the deceased constables were able to view the bodies and be reassured that they were intact and that the deaths had been sudden and painless.

Later that day the resources of the psychology unit were allocated so that the psychologist who was first contacted would continue the work with the members' station and one of the families, another psychologist was available for the other family, and the third psychologist was available to other members not linked to the station and seeking assistance.

The State Recovery Plan was less obvious in this event, but worked quietly behind the scenes to ensure that adequate support was available from the local community. A memorial plaque erected in the street soon after the shootings proved too emotive for some local residents who publicly objected.

In the following six months, over 200 members made contact with health services as a direct result of the shootings. Ten who missed the early debriefings required long-term psychology or psychiatry. There have been no admissions to the hospital directly as a result. After six months there have been some presentations of depressive illness in which the Walsh Street killings have played a symbolic if not a causative role.

POLICE HEALTH SERVICES

In 1986 one of the authors was charged with developing a blueprint for the development of a comprehensive occupational health program for the Victoria Police. A Churchill Memorial Fellowship allowed a review of health service in 44 police forces around the world. It was recommended that all health and welfare services be integrated into a functional unit. Force command has fostered this development, which has been a vital part of the response to these two recent events.

Members of the team are free to cross refer to other professions and individual professionals. There is a sense of working together with common purpose for the good of the police community. Not only does this give the police member looking for assistance the choice of a variety of professional styles, but also a diversity of personalities, to meet his or her individual needs. Force policy dictates that all members involved in shootings or other critical incidents must attend health services for debriefing. This task is usually undertaken by a psychologist, but the individual can utilize the services of other members of the health services team if desired.

About half the members that assisted in these two events have sought no other help than the formal and informal support offered by the psychology unit, about a third have sought medical advice about general medical or psychiatric concerns, and about fifteen percent have sought assistance outside the department. This flexibility of approach acknowledges the individual's right to choose the person and profession most suited to his/her perceived needs and is seen as an important aspect of the healing process--restoring self-confidence and empowering the individual.

CONCLUSIONS

The evolution of services, not only within the Victoria Police but for the whole population, has established a degree of teamwork and sophistication not usually experienced in government departments. Individuals and communities can now rely on a refined, sensitive, coordinated response to disaster on an appropriate scale aimed at alleviating the impact of critical incidents and encouraging recovery.

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CRITICAL INCIDENT PSYCHOLOGICAL CASUALTIES AMONG POLICE OFFICERS: A CLINICAL REVIEW

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ABSTRACT

This paper uses case examples to elucidate several points regarding post-critical-incident reactions among police officers. The points elucidated include the role of police culture and personality in post-critical-incident reactions and the role of unique personal experiences including multiple cumulative trauma in shaping reactions to critical events. They also include a focus on the course of untreated and/or severe post-critical-incident reactions, which, it will be pointed out, can be so severe or surprising as to lead to mislabeling as psychosis or, conversely, as malingering.

The role of stress in police work has been recognized for many years (see, for example, Ellison & Genz, 1983). There is a long history of psychiatric description of reactions to trauma, particularly in a military context (Andreasen, 1985). The role the specific type of trauma called critical incidents plays in leading to police officer symptomatology was extensively explored in Reese and Goldstein (1986).

The following cases were selected from among over 300 law enforcement officer fitness-for-duty evaluations surveyed to illustrate various points about post-critical-incident reactions among police officers.

Case 1: This police officer had a good record for the first six years of his career. In his seventh year he was working a police van with a primary assignment of transporting prisoners and bodies to their appropriate destinations. He received what appeared to be a routine call involving suspicion of a dead body in an apartment. When the officer entered the apartment, he was shot at and narrowly missed being killed by an old woman, who, unknown to him, had barricaded herself in her bedroom. The officer was able to call for help and the old woman was apprehended and sent to a nursing home, where several weeks later she committed suicide. A year later, the officer put himself on the sick roll after he confronted a citizen with a knife and saw the old woman instead of the citizen. Thereafter, the officer was sent for an evaluation.

In the evaluation the officer was pleasant and cooperative, but his hands were shaking and his voice quavered. He had, he said, come "within a hair's breadth" of killing the citizen.

The officer related that he had no problem dealing with the incident for the first few months. Thereafter, he began thinking of the old woman while he was at work. Moreover, the officer related, he began to have nightmares about her. The nightmares became progressively more intense, with him reliving the incident over and over again and dreaming the old woman was in the street laughing at him.

As time went on, the officer explained, he began having the thought that the old woman was still alive, even though he knew she was not. He began to think that the only way to get rid of her was to kill her. To do so, he felt, he might have to kill himself. His reasoning was that since he knew that in actuality the old woman was not alive, she must only exist in his own mind; as a result, to kill her, he would have to eliminate himself. In addition, the officer described increasing irritability at work as well as having a great deal of energy and being unable to sleep. He became increasingly preoccupied with the incident. About eight months later, while on duty, he confronted a man with a gun, with the result that his thoughts about the old woman became more intense. The incident with the citizen with the knife followed.

A follow-up evaluation performed nine months later showed that the officer's symptoms were largely in remission, probably as a result of counseling he had obtained. He had, however, in the interim shoplifted and been caught, an event that he described as the last vestige of the reactions he suffered as a result of the incident.

Several aspects of this case as described by the officer are important to the understanding sought in this paper. The officer related that part of his reaction to the incident involved, as might be expected, fear connected with coming so close to dying. His feeling was that the old woman should not have missed because she was so close to him when she fired. "I don't know why I'm alive today." But part of his reaction also was self-critical in that, as he looked back at it, there were "little signs" that he "should have picked up on" that would have told him that this was not a routine case, that someone was alive and dangerous in that apartment. He explained that the incident also violated his sense of the way the world should be. "Little old ladies are not supposed to be trying to kill you when you are trying to help them." Moreover, the very intensity of his reactions seems to have violated his self-concept. Before, he said, he was carefree, whereas now he was preoccupied and disturbed. The officer's history as related by him also seems connected to the intensity of his reactions. The officer related that when he was two or three years old, his mother gave up major responsibility for his upbringing to her parents. When he was ten years old the grandmother who had raised him died. The fact that an old woman was involved in this incident appears to have been a central feature of his reactions.

It is of interest, given the purpose of this paper, that many of the officer's supervisors, when interviewed, expressed doubt that he had been traumatized by the incident. Instead they emphasized the possibility that he was using the story about his alleged reactions to abuse the medical roll or lay a foundation for an early retirement. Conversely, it is possible that the officer's "seeing" the old woman instead of the citizen just before he went on the medical roll could be viewed as an hallucination and a symptom of psychotic functioning. This view is not being endorsed, but is only pointed out to emphasize the possibility of diagnostic confusion.

Case 2: This officer joined the police force 15 years earlier. He presented a history of multiple trauma beginning with his being injured by shrapnel in Vietnam, which led to his being brought home on a stretcher. About a year after he joined the police force he was shot, with injuries to his lung, diaphragm, spleen, and stomach. Due to this injury, he stayed on the medical roll for eight months. He continues to suffer pain, he related, due to adhesions on his lungs caused by that injury. About a year and a half before the evaluation, the officer had been injured in the course of attempting to apprehend an inebriated person in the basement of his home. During the ensuing altercation, the officer sustained multiple bite wounds to the forearm and thumb. He lost a large clump of hair that was pulled from his head by the individual's teeth. After the injury, the officer had six drinks and then went to the emergency room. There, it was noted, he admitted to unprescribed Valium use.

About ten months later (about six months before the evaluation), the officer admitted himself to a psychiatric ward, describing a lack of energy and motivation as well as difficulty sleeping. He related that he went to the hospital because some time earlier he had hit a citizen and broken his jaw. He had acted that way, he said, because "I saw teeth" (related back to the injury he had sustained earlier that year). He had hit the citizen, he said, quite deliberately, thinking to himself that he was not going to allow himself to get bitten any more. At the same time, he felt that hitting a citizen like that was not his way of working, and he was scared by it. Less emphasized by the officer was a divorce he had experienced that year. He did describe chronic alcoholism, which he used to cope with feelings such as anger that he now felt toward his ex-wife.

When seen for evaluation, the officer manifested extreme anger, pressured speech, and emotional liability. He described "bouncing" moods and confused feelings. He described difficulty concentrating. The day before the evaluation, he said, while typing a paper, tears came to his eyes as he thought about having been shot in the past. He also thought about "this animal with his f___ing teeth. . ." According to the officer, despite being wounded in Vietnam and despite having been critically injured by a gunshot wound, being bitten

was the worst experience he had ever had. He said, "I couldn't stop this f___ing man from biting me." He related that he felt blood running down "when I tried to rip his head off. . ." In the course of conversation, he revealed intense feelings about the divorce he experienced a year earlier.

Despite treatment with lithium and psychotherapy, this officer continued to relate severe emotional symptoms when seen in follow-up examinations six months and one year later. One experience he described was driving down the highway past an area where he used to work, hearing a noise, and feeling that people were shooting at him. "It scared the hell out of me." He described continuing manic symptoms. He maintained, however, that his alcoholism was under control.

This case illustrates the role of multiple, probably cumulative, trauma in leading to severe post-critical-incident reactions. A special meaning of the type of incident--biting--is possible although unexplained by the available data. Multiple concurrent psychiatric problems--such as Bipolar Disorder and Substance Abuse--almost certainly played a role in the post-critical-incident reactions manifested.

Case 3: This officer was highly regarded during his first 13 years of active duty. He was referred for evaluation after a series of events that culminated in his initiating an apparent suicide attempt resulting in his being hospitalized.

In the evaluation, it was learned that during this officer's eighth year of active duty he was involved in an incident during the course of which he shot a perpetrator who was endangering the life of another officer. After shooting the perpetrator, the officer was highly praised and commended. What happened next is a matter of dispute. The officer claimed that he felt very good after the incident and functioned well for the next four years. His wife maintained that he became irritable after the incident with sleep difficulty and deep feelings of apprehension.

In any event, it is undisputed that about four years later he began to experience increasing anxiety to the point of eventual incapacitation. That increase in anxiety occurred, it was later learned, at the time of the one-year anniversary of the death of a family member, a family member with whom he still had many unresolved issues. With the increase in his anxiety, he began to believe that people were trying to break into his house and that he was continually being watched. He became intensely afraid to be alone. Eventually, the officer began to perceive what he thought were voices of persons, who he thought were trying to break into his house, having a discussion. He thought he saw people lurking in shadows waiting to get him. His feelings became increasingly intolerable and he began to believe that the only way to relieve himself of his emotional pain was to kill himself. He took steps to do so but decided that he could not do that to his family. He then asked for help with eventual hospitalization. In the hospital, he was given a provisional admitting diagnosis of schizophrenia.

With treatment through psychotherapy and medication, this officer achieved good symptom remission. One aspect of his treatment concerned his being able to admit that despite the praise he received at the time of the incident, he had felt he did poorly, that for one thing he had reacted much too slowly to the events that were taking place.

This case suggests that officers themselves may not realize or be in touch with the extent of their reactions to traumatic experiences. This officer, like many police officers, was invested in believing he could master and control almost any experience. From an outside point of view, he had performed very well, even heroically. As a result, he "should have" felt good about what occurred. He was able to deny adverse responses and negative feelings (that his wife noticed) until his feelings all but overwhelmed him. When he began to feel overwhelmed, he was unable to ask for help, until he reached the point of near-suicide. The complicating role of personal issues is also shown by this case--in this case the role of the loss of a family member with whom he had unresolved issues may have increased his sense of helplessness and vulnerability.

DISCUSSION

These cases raise several points about post-critical-incident reactions among police officers. One point concerns the effect post-critical-incident reactions themselves have on officers. A coping mechanism commonly used by police officers to cope with the dangers of police work is maintaining a sense of invulnerability and competence that may belie the hazards they actually face. This sense of invulnerability and competence may be a positive coping mechanism in the same sense that research (Alloy and Abramson, 1979) shows that some exaggeration of self-confidence characterizes the coping of normal as opposed to depressed persons. One aspect of the reactions suffered by these officers was an undermining of their sense of invulnerability and competence. In the first case, the officer could not deny that he came close to dying. In his mind the incident was cause to doubt his own abilities, since the old woman took him by surprise despite the view he had of himself as able to detect danger if it were nearby. The third officer handled the incident very well, but he nonetheless was later highly critical of his own behavior. It is of interest that one of his criticisms--that he reacted too slowly--probably was a function of a common occurrence during trauma, namely the slowing of the sense of time. This officer had high standards, and since he perceived himself as reacting slowly, questioned his own ability, in particular his ability to survive or be helpful to a partner in a situation involving another fatal shooting. Apparently, for the first four years after the incident, he perceived himself as functioning well, despite his wife's attestations to the contrary. He was able to "fence out" his reactions until they started becoming overwhelming and began to dominate his life. When he realized that he could not control or deny his reactions any longer, he experienced almost utter despair and a wish to end his own life.

Another point brought out by these cases is the cumulative nature of the trauma suffered by the officers. While the critical incident literature tends to focus on the immediate precipitant of critical incident reactions, the cases show that, particularly among police officers, the incident does more than stand along, and, in fact, might be the culmination of a long series of traumatic events. For the second officer, in particular, the precipitating trauma was the culmination of many wounds suffered in the past, both physically and psychologically. If the cumulative nature of the trauma was not considered, the reactions of the officer might appear out of proportion and therefore suspect. This officer's experience indicates that each subsequent trauma can occur in the context of the previous ones, with the person exhibiting increasing sensitivity each time. To express the matter concretely, the second officer's reaction to having been bitten might have been much less severe had he not been wounded in Vietnam, had he not been shot while on active duty, and had he not been divorced a year earlier.

A related point is that the trauma may occur in the context of other psychiatric problems shown by the officer. The second officer was an alcoholic and had a Bipolar Disorder. It is arguable and probably indeterminate whether his alcoholism added to his problems or was a product of the multiple trauma he had faced, representing an attempt to self-medicate chronic depression and anxiety. The etiology of his Bipolar Disorder is unclear. At any rate, his alcoholism and Bipolar Disorder cannot be considered apart from his trauma. The trauma and his other, more chronic psychological problems all contributed to his sense of being overwhelmed and hopeless.

These cases also indicate that the intensity of the post-critical-incident reaction may be a function of the special meaning the critical event has for the officer who experiences it. The first officer may not have reacted as strongly if an old man had tried to kill him and then committed suicide as he did to an old woman taking these actions. Being bitten appears to have had special meaning to the third officer. It was as if in his view of the world being shot was expectable and could be coped with; being bitten appeared to have violated some of his fundamental expectations about the world.

The intensity of these officers' reactions raises another point. All three officers related perceptual distortions that could be labeled hallucinations. The first officer said he saw the old woman instead of a citizen on the street. The third officer said he saw people and heard voices when in fact no people or voices were present. Even the second officer, who did not emphasize perceptual distortions, stated that he "saw teeth"

and as a result reacted in a violent way. These reported distortions engendered very different reactions from different persons. In the case of the first officer, his supervisors were skeptical that his attestations were genuine and correspondingly, they suspected him of malingering. In the case of the third officer, when initially hospitalized, a diagnosis of schizophrenia was entertained. Neither conclusion seems warranted. The first officer was treated extensively by a counselor who confirmed the genuineness of his reactions based on her frequent interactions with him and based on her wide-ranging experience with post-critical-incident reactions. There was no indication that the third officer was schizophrenic, and, unlike the usual progressive deterioration of the schizophrenic, when seen about a year later, the officer had made a significant recovery. Close exploration of his experiences showed that what could superficially be termed hallucinations were, in fact, intensely experienced and misinterpreted perceptual experiences. Thus the voices he heard turned out to be actual sounds generated by machinery, which, in his high state of agitation and anxiety, he misinterpreted as voices. It is notable that when he discovered that the noises emanated from the machinery, he was able to recognize that and realize that they were not voices. Similarly, the people he saw were distortions of shadows and lights rather than hallucinations without any basis in reality at all. These diagnostic points are important because they point to significant treatment implications. Clearly, treating the first officer as a malingerer would only add to his sense of being overwhelmed and to his sense of inadequacy. Treating any of the officers as psychotic would miss the point, which is the need to work through the critical incident traumatic experience.

In short, critical incident reactions are more complex than a model that simply emphasizes trauma and expectable reactions to that trauma would suggest. The trauma impinges on aspects of police culture and police personality such as a sense of invulnerability and a wish to control the situation. Often the critical incident occurs in the context of many other traumas experienced by the officer in the past. The incident may have a special meaning to the officer based on idiosyncratic aspects of his biography or idiosyncratic interpretations of it made by the officer. The incident occurs in the context of other problems the officer may have such as emotional disturbance and substance abuse. An officer who is unaware of expectable reactions to the incident and who tries to resist them as a way to keep control and maintain a sense of invulnerability may eventually develop extremely dramatic reactions that can be misinterpreted on the one hand as malingering and on the other hand as a part of a psychotic process. These results underline the importance of appropriate and timely intervention after critical incidents occur. Exploring with an officer his reactions to the critical incident is particularly important.

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THE ROLE OF THE LAW ENFORCEMENT CHAPLAIN

Reverend Anthony Palmese

The role of chaplain has many different proving grounds. The role of chaplain requires, first of all, a definite ecumenical perspective. The chaplain enters a world which in no way is *oikos*. *Oikos* is a Greek word meaning family or close knit group like team players or the people working in your office. They are out of their field and in all cases must prove themselves to the officers. The chaplain enters the role usually with a set of tenets or doctrines, with a knowledge of theology, and with a guess as to where he/she is going to stand. With everyone being so nice, a new chaplain usually thinks he/she has it made. They soon find out it is the same niceness the person on the street perceives when they receive the citation for a traffic offense.

In our city, the Chaplain Division has from the beginning held to the norms of the ICPC (International Conference of Police Chaplains) for qualifying persons wishing to be chaplains. One of the other requirements is that the person work as a civilian ride-along for a period of six months to one year, at which time the person aspiring to be a chaplain will be presented to a minimum of three senior chaplains. We have found that, after riding with the officers, those who have the officers at heart and have a dedication to law enforcement work are recommended by the officers with whom they have ridden over those months as well as the supervisors. When chaplain candidates don't trust someone or have made wrong moves, officers tend to say they don't want them around or riding with them anymore. After the name presentation, the senior chaplain submits the person's name to the chief of police, who invites the person into the police department and the Chaplain Division. It is at this time they receive their letter and equipment.

No one cares who you are, although they are polite enough to ask, "Are you Catholic, Methodist, etc.? It's nice to have you here." After that you sort of ease into the fact that you are now 'chaplain.' That is your new identity. You begin to meet with other chaplains and see what you have in common, and it is usually the Lord. This active interest in meeting with and joining positive discussion and possibilities of services, retreat and spiritual worship, not only draws chaplains together, but it demonstrates to the men and women we serve a special bond in their chaplains.

This truly brings about collegial achievement. No jealousy here. What one can't do, the others are happy to do as long as the job gets done. Law enforcement people have a habit of picking the people they want to help them. A good chaplain lets that happen. What is a success for one is a success for all.

If a Catholic wants to see the Protestant or Jewish Chaplain, that is fine. If the Protestant or Jew wants to see the Catholic Chaplain, that is fine. We are after results. It is not a matter of religious sect that counts. What counts is that the chaplain has walked in the way of the Lord and it has been seen and is now being sought by another. The making of the Lord present to all is what is important. Preaching and evangelizing through preaching cannot be tolerated. The chaplain must be God-centered in his life. If he is, he will be sought out and worn out, but will be nourished through the understanding of his brothers and sisters in ministry as well as those who are served.

There is a certain pastoral presence that goes beyond the normal presence. One normally sees their minister on their own terms, when they are ready and willing. It is seldom that the scene is anything but neatly prepared. Chaplains in law enforcement see the men and women in the work place. There is no chance to neatly arrange everything or predispose ourselves to what will occur. What happens, happens. The chaplain must discipline himself/herself to toleration and understanding. This is the key to being able to enter a world few are invited to see. The glamour, clamor, boredom, and novelty soon wear off as reality hits us. This is the world these people live in day after day; the stress and strain of ordinary living is nothing compared to what these men and women are ready to bear each and every day. Thus begins the tension.

Education is certainly the most important clue to being able to cope with the ordinary stresses of life and those added by law enforcement conditions. The challenge is great, but the chaplain has an edge. He is present; he is where the action is. The chaplain can open doors that no one else can with the men and women he/she serves.

The department can order an officer to do whatever it wants done in regard to seeing a psychologist or therapist. This is a known fact. It is also a known fact that the enforcement officer can tell you anything you want to hear in order to fulfill the law. The enforcement officer is not necessarily interested in the spirit of the law in this case. He/she does not really believe this is for his/her mental health. I have learned that from personal experience. If there is a consultation with the chaplain, the officer usually has a significant attitude change toward what is happening. Besides, the chaplain has gained a certain trust and relationship with the officer with whom he rides along. His position as minister of the Lord also helps.

This sets a very sketchy view of the need I find for a chaplain. What he/she does so as not to be overloaded is to seek the assistance of all professionals who are willing and able to be of use. Most agencies have people on staff who can be used for any emergency situation in any need, large or small. Seldom will an officer go on his/her own to one of these agents. They would rather go to the chaplain they feel most comfortable with. This, by the way, is a good reason for the chaplain not to get tied up in lots of paperwork. It is hard to be out with the troops if you are always writing about what you are doing. If you are writing and the troops find out, it could be the end of their trust in you because you might be reporting about them. With trust in the chaplain, officers will come and tell about a buddy they are worried about and suggest the chaplain ride with him. This is a marvelous buddy system, but it is mostly a confidential one. This gives the impetus to a program we have begun to put into action in my department.

The chaplains gathered all the 'brains': the city nurse, all chaplains, the employee assistance agents, mental health liaison, a police training officer, and an administrative captain. In the beginning we met every week at the police department for an hour and a half. Then, when we ironed out where we were going, we met every other week, then once a month. The meetings went on for a year. What did we come up with?

We developed a booklet with the pictures of all the key personnel to include the Chief, heads of the divisions, chaplain, EAP counselors, mental health liaison, department psychologists, etc. The booklet included a little information about their backgrounds, the duties of each of these, and their responsibility sectors in the law enforcement field. It gave all the information about city insurance, death benefits, the Fraternal Order of Police, and the Police Benevolent Association. It has direct phone numbers and information about privacy, reports to supervisors, if any, and addresses and hours. All new personnel have to, as part of their training, attend sessions on the various programs.

Spouses and significant others are invited and sent the booklet in a separate mailing. Their first encounter is with a chaplain who gives them an escort through the department, introducing them to certain key personnel. A ride-along program with spouses or significant others introduces them to the backup features used on the road and allays some of the tensions and fears of the unknown for them. They are invited to some of the training sessions so they can become aware of some of the equipment used by the department and its proper use. The officer in training is invited along to enhance communication between the two about the job at hand.

The second step we took was to begin a peer support system. After attending a seminar given by Ed Donovan, former director of the Boston Police Stress Program, I asked him to come and give a two-day session in Melbourne for its officers and the officers of Brevard County. We had over 100 officers show up for the sessions and asked for volunteers from the audience of those who would like to be peer support personnel. We took name of 23 officers who were interested. The next task seemed to be the one most difficult.

We had to try to make the various administrators admit to the problems and be willing to support the chaplain in making this simple self-help program a winner. It seems that making school for these helpers is not the highest priority. Trying to arrange courses at the police academy is not really a problem. Courses are already designed and in the system. It is finding the time to permit officers to go on department time that is a problem. Courses in "Kinds of Stress," "Physiological Methods of Controlling Stress," "Spotting Problems Related to Stress" are all known as 'specialized courses' and are available. Getting the volunteer officers from the various departments to get to the classes is the problem. We have worked out a system whereby the simple fact of being on the same shift or of being friends can give one the knowledge that a friend is in need. The officers will at times try to talk to their buddies and encourage them to call the chaplain or, as in most cases, they call the chaplain and ask him to ride with their friend.

All of us have times in our lives when we face a major crisis. The better our awareness of these crises, the better our ability to handle them and to help others through them. Here are the major crises that strike law enforcement personnel and their families.

MARITAL CONCERNS--One out of three marriages ends in divorce. The pressures of finances, raising children, in-laws, and outside pressure take a heavy toll today.

DEPRESSION--Depression is a universal problem experienced by most people temporarily, some to acute degrees, and a few for extended periods.

ANXIETY--Stress is known to cause everything from neurotic behavior to physical illness.

FAMILY CONCERNS--This is a broad field that includes runaway children, alcoholic family members, children involved with law breaking, pregnancy outside of marriage, financial problems, sickness, etc.

SEXUAL CONCERNS--Sexual problems within the marriage or outside the marriage, homosexuality, lowered moral standards.

VOCATIONAL CRISIS--Enforcement people worry about their future, getting older and the possibility of injury, damage to their self-esteem by their peers or supervisors.

BEREAVEMENT--Although they don't like to admit it, enforcement officers must also go through stages of grief: shock and disbelief, control up through the funeral, mourning and acceptance.

Too many times the officer or spouse will not come to the chaplain for counseling until it is too late. A sensitive peer support person, or in other words, a "people helper," has a better opportunity to be aware of these problems before they get out of control.

A people helper often can be the first to respond to an emergency. In a sense, they are spiritual paramedics. As one becomes aware of situations, problems and emergencies, remember that an effective peer support person is personable, listens carefully, is shock-proof, is available, and has a sense of humor.

There is no need for anyone to get in over his/her head. There is plenty of help out there. If one cannot handle the situation, go to the chaplain. The chaplain will guide you.

We spread the idea that helping people with their problems is everybody's business. When you are out solving the world's problems you have to have time for your team members. Chaplains and other professionals have special expertise in this area, but in one way or another, all of us are involved in counseling. Even if there were a sufficient number of professional counselors to handle everyone's needs, some people would still prefer to discuss their problems with a neighbor or especially a buddy on the job. The buddy is

around, close by, does not charge fees, and is often easier to talk to than a stranger who goes by the awesome title of 'professional.'

Here are some "BE-ATTITUDES OF PEOPLE HELPERS":

1. Much informal counseling can be done in daily personal relationships. BE AVAILABLE.

2. People want a friend who is sympathetic, understanding, and caring. BE COMPASSIONATE.

3. Everyone should be quick to listen, slow to speak. BE A GOOD LISTENER.

4. Don't be judgmental. This does not mean that one must condone actions that one feels to be wrong. In spite of our behavior, God loves us. BE SHOCKPROOF.

5. Counselors need not be confined to one-on-one relationships. Perhaps the spouse should be present. Group counseling can also be done successfully. BE A TEAM.

The role of the Chaplain is indeed a challenge. There is one thing for sure: Without the support of law enforcement personnel, the chaplain would be just a figurehead instead of a formidable force to make their lives and their jobs a bit easier.

IMPACT OF THE DEATH NOTIFICATION UPON A POLICE WIDOW

Richard Pastorella

ABSTRACT

The subject of this paper is to investigate the impact of the death notification upon a police officer's widow. A pertinent aspect of this investigation centers on the effects of the isolation that are directly due to the manner of notification. Sources used for this paper were personal interviews with widows of slain officers of various police departments; an organization called Concerns of Police Survivors, which was organized specifically to help these widows deal with their loss; and various sources of published literature.

The death of a spouse is a traumatic, emotionally devastating event that can change the remaining partner's life in many ways. Its occurrence can incur emotional as well as physical illnesses and can cause an upheaval difficult, or even impossible, for the surviving spouse to cope with.

This paper will focus on a very minute aspect of this problem, the effect of the death of a police officer upon his wife; specifically, the manner in which she is apprised of her husband's death, and the effects that the manner of notification will produce. I will explore the way in which the wife is told of her husband's death, the effects upon her of the hospital visit, which she is forced, in most cases, to endure, and the overall emotional impact of the suddenness of the situation.

I will be including in this paper case vignettes to point out the different effects that this traumatic situation has had on various widows of slain police officers in the eastern portion of this country. I have been in contact with an organization called Concerns of Police Survivors, which is a support service to help the widows of these officers in coping with such a devastation. Much of my information will be provided by the personal interviews of the widows in terms of what they actually went through when apprised of the death of their husbands and subsequent emotions and coping mechanisms that are idiosyncratic to each yet common to all.

Usually the manner in which a police officer's wife is informed of her husband's death is handled as best as possible, under the worst of possible circumstances. Every wife dreads the radio car pulling up in front of the house, lights flashing, with three officers in blue exiting the car and knocking on the front door. Statistics have shown that this usually occurs in the evening, or late night when the largest percentage of crime occurs in the city (FBI, 1987). Therefore, the impact of the situation is such that the wife is being informed usually at the end of the day when the body and mind are both in need of rest. The impact therefore hits doubly hard, when resources are depleted both physically and mentally.

Glasser and Strauss (1965) refer to this type of bereavement as the reaction to unexpected, sudden, or shocking death. In their theory, they state that if there is no expectation of the death, the spouse cannot have developed any method for dealing with it. Simply stated, if the husband has never been wounded before, where the wife has been put into the position of nurse, she may have denied the prospect of death, unconsciously blocking the fears and emotions connected with it. In this case, when informed of her husband's death, the wife is using the mechanism of denial. Statements like, "It can't be true," or "But he was never hurt before," are indicative of this denial. In their study, Ramsay and Happee (1977) suggest several stages that are preeminent early in grieving, denial being a relatively immediate one. They state that during this phase, even psychotic-like hallucinations can occur.

Case Illustration

> I received a telephone call. They (the Capital Police Department) called me and they said, "Your husband has been shot and it doesn't look good, and now that we know you're home, we'll send somebody to pick you up." So immediately, of course, denial set in, and I'm thinking, "Oh, he's been shot in the foot." You know, you don't think the worst. And I'm putting on some makeup and fixing my hair, thinking that I wanted to look nice for him when I got to the hospital. And I no sooner got that done when this incredible panic set in. And I was getting ready to just jump into the car and try and find him somehow, when there was a knock on the door. It was two County police officers, and they said, "We understand that somebody's going to come and pick you up. We'll just stay here with you."

Lindemann (1944) describes this denial as a change in the victim's attitude of reality to a sense of unreality--"Feelings of not being there, of watching from the outside; that events in the present are happening to someone else" (p. 141).

Case Illustration

> I very much had a feeling like I was outside of myself, watching all of this go on; as if it wasn't quite real. And for a long time, for several weeks, any time the phone rang or any time there was a knock on the door, I mean the split-second reaction was, "It's him. He's going to tell me it's OK. There's been a mistake."

Therefore, when death occurs, it produces a reduction in control of the emotions, often bringing on an hysterical reaction. Lipinski (1980) views this type of reaction as separation anxiety, which is "the feeling of distress, be it a passing sense of disquietude, or overwhelming panic, which is felt at the threat of loss and at the time of loss" (p. 5). This view is shared by Dr. John Stratton, who believes that there are usually two possible reactions seen from widows of police officers at the time of notification--either an outburst of emotion or a dazed, controlled reaction. Stratton (1984) believes that the controlled reaction may be due primarily to shock. However, he also presents a conflicting idea that this calm, controlled reaction may be due to fear; fear of the future without the husband who was, most likely, the dominant partner. The widow has, in a sense, lost her identity by losing her husband. She has lead a protected existence; therefore, the abrupt loss of the spouse leaves the widow feeling insecure, vulnerable, and terrified about being able to cope with life alone. It is therefore important for the notifying officers to be aware of these possible reactions in the widow to be able to deal effectively with her. If this is done incorrectly, the officer can enhance these feelings of fear and inhibit the widow from expressing her true emotions, which would thereby release the pent-up anxiety.

Another unfortunate aspect of the situation in which the wife is informed is the lack of trained personnel in making the notification. It is interesting to note that although the New York City Police Department has rules, regulations, and training for the handling of every type of emergency or situation that a police officer may encounter, it has none regarding death notification. Not only are there no procedures or guidelines in the Patrolman's Guide, Administrative Guide, or Interim/Operations Orders, there is also no training given to the rank and file or supervisors handling such a situation. A notifying officer is required to handle the situation with no previous experience and with little time to prepare. Consequently, these conditions may in themselves serve to foster the crisis rather than to alleviate it.

The police department handles the notification in the following manner. Usually two police officers, one male and one female (the addition of the female officer is only a recent one) are sent to the deceased officer's house along with a supervisor. This supervisor is generally the deceased officer's commanding officer. While it is an improvement in having a female officer present, there is a lack of training on the part of all three

in handling the situation. Danto (1975), in his study of the widows of slain police officers of the Detroit Police Department, offers a typical scene of the notification procedures of that department:

> Once she undid the lock and opened the door, she saw them. The two police officers were somber faced, blowing vapors of cold breath, with cheeks that turned blue and then red from the light reflected from the blinking flasher of the police car. "Janice, Jack's been hurt. We gotta take you to the hospital." "Is he hurt badly? How did it happen?" The same face said, "We gotta take you to the hospital. We don't know more than that." (p. 150)

Most officers who are put into the position of having to make a notification are quite young, having only two to six years on the job, and this type of situation is not a common one that they have dealt with before. Under better circumstances, sometimes a department chaplain is sent along to provide spiritual comfort for the widow. However, the chaplain is not the one who makes the notification since he or she cannot officially apprise the wife of all known facts.

Case Illustration

> When I got there [the hospital], the hospital chaplain said, "Let's go into this room and wait for the doctor." And it still didn't hit me what was going on. The chaplain knew, but she said nothing. So I just figured, "Well, we're just waiting for the doctor to come in and tell me how he's doing."

Another issue that must be addressed in this situation is the theory of the notifying officer being a "co-victim." The officers who are making the notification are themselves under considerable stress, and have probably been working several hours. They have had to deal with the situation that a fellow officer has been killed, and this in itself is causing a high level of anxiety. Juda (1985) coined the term "co-victim" and states, "Co-victims experience the victim's crisis as their own unique crisis, and not only as reactions to the victim's needs and responses to the crisis" (p. 4). While Juda is talking about the co-victim of a crisis rape, this theory also seems to fit into these circumstances, the co-victim being the police officer whose life is also altered by the devastating event of another officer's death. According to Juda, the complexities of both "intrapsychic and interpersonal processes (which the co-victim goes through) will significantly hamper the co-victim from successfully adapting to the crisis and to his victim mate's needs" (p. 46). In this case, since the officers are under considerable anxiety, it is difficult for them to be empathetic to the anxieties of the widow. Therefore, the responding officers cannot really meet the needs of the widow adequately. This creates a deplorable situation for both the informing officers and the widow.

How then do these co-victims (the officers) deal with the victim (the wife)? In some cases, this is done by holding back and staying aloof from the victim; by putting distance between what they feel and what the victim is experiencing. Suzie Sawyer, executive director of Concerns of Police Survivors, believes that the reasons for this are twofold. First, there is fear in the officer who is going through the trauma of losing a co-worker. Second, there is confusion as to how the officer should act (Sawyer, 1988). In effect, the defense mechanism that the officer is using is isolation of affect; divorcing his emotions from the event.

Case Illustration

> I wasn't too pleased with him [one of the officers making the notification]. He seemed, and I know it was a hard time for everybody, but he seemed so . . . cold. And I guess maybe it was just his job, I don't know. But he came across to me as being so cold. "Give me the phone numbers of the family. Give me this. The phone is busy." He actually came over to me to tell me that my in-laws' phone was busy. And I'll never forget looking up at him and saying, "So make an emergency phone call." But at that time, he had to do this to me? And out of all the people in my house, I picked him out to hate because he was so cold.

The officer here seems to be denying any emotional stake in the situation in order to stay in control of the situation. This has the effect of isolating the wife, making her feel alone at a time when she most needs comfort and understanding. This isolation may be caused by the misconception that the spouse is somehow more prepared for the loss due to the nature of her husband's work. Since the wife was aware of the danger in the work, it is assumed that she is somehow emotionally stronger and better prepared for the tragedy than other people. This misconception, along with the reticence of the police officer in dealing with the grief of the wife, would further give the impression of abandonment to the wife. Coupling this isolation with the intense feelings of loneliness for the lost spouse can create anger or hostility toward the notifying officers.

According to Lindemann (1944), this anger may even be an indication of the anger that the wife feels toward the dead husband. In essence, the loneliness and anxiety that the wife is experiencing from the notification is only an extension of the feeling of having been left alone by the husband. However, since the husband is gone, the wife will unconsciously choose the most convenient avenue to vent her anxiety, those immediately surrounding her. Stratton (1984) concurs with this opinion about displacement of anger when he states, "There might be emotions about a husband who was so dedicated to his job that at times his family suffered" (p. 325). I believe that this hostility is in one way or another present in any person whose spouse identifies so completely with his profession. Thus through the mechanism of displacement, the wife may use these feelings of hostility and blame the officers indirectly or directly for the husband's death. "It's all your fault. Why didn't you protect him. You let him die," may be statements heard from the wife. This type of reaction only serves to further isolate the wife. Sensing the hostility, the officers will further withdraw, creating what seems to be a vicious cycle of withdrawal and isolation where no one is getting the needed support.

The effects of this isolation may serve to further another symptom of grief in the wife, that of guilt. The feeling of guilt is common, in one form or another, to those who experience grief. It can encompass self–blame about past events, feelings about behavior toward the partner who is dead, real or imagined negligence, or even regret for not having expressed enough love. If the wife is experiencing isolation or withdrawal by the notifying officers, she may interpret this as disapproval or blame. This may enhance the feelings of guilt that she is already experiencing. Freud (1917) interprets this self–blame as blame against the lost love object, ". . . by perceiving the self–reproaches as reproaches against a loved object which have been shifted onto the patient's own ego" (p. 128). Therefore, since the wife in reality blames the husband for dying, she then shifts this guilt to herself and blames herself. The blame, which she is then perceiving from the officer, serves to confirm this guilt, possibly intensifying it.

Such intense feelings of guilt can lead to pathological grief or bereavement. Lindemann (1944) argues that this pathological grief may involve alternations or distortions in the bereaved's behavior (e.g., acquisition of symptoms of illness belonging to the deceased, or hostility). "These alternations may be considered as the surface manifestations of an unresolved grief reaction, which may respond fairly simply and quickly when psychiatric management is recognized" (p. 142). In relating this to the notifying officer's situation, it would seem that feelings of isolation can enhance the guilt feelings within the wife, having a maladaptive effect on her that can lead to pathological grief.

Another aspect of the notification that can seriously harm the wife is the effort of the police officer to somehow check or block the emotions of the wife––"You have to be strong." A reason for this blocking may be that as a society we are taught to conceal our emotions. Instead of offering support, we seem to avoid the feelings of others during the time of bereavement. It is easier for us to intellectualize problems away, thereby avoiding them. We use the cliche, "Time heals all wounds," instead of saying, "Share your emotions with me and let's work them out." Two reasons for this are:

1. It shows us a vulnerability that all people, including ourselves, have, and that we are afraid to face.

2. If we share another's feelings, it makes us fear that we too will have to open up.

In her book, Necessary Losses, Judith Viorst (1986) states that if we do succeed in deceiving ourselves into thinking that we are "taking it very well" by blocking our emotions, we are in reality not doing well at all. This blocking of emotions or unresolved grief may at some later time give rise to somatic symptoms such as headaches, nausea, cramps, or palpitations (Stroebe, 1983).

Most of the actions and reactions discussed thus far have centered upon the notifying officer and the wife of the deceased officer, before reaching the hospital. I have also found that the notification procedures in the hospital itself are conducive to blocking the emotions of and creating isolation in the wife.

Hospitals are impersonal places at best. The sterile, severe surroundings are conducive to feelings of alienation. However, this alienation is multiplied in terms of the effect upon the widow when the hospital personnel or physician do not convey humanism, must less empathy. An example of this is described very well in the following illustration where the widow was informed by a callous doctor.

Case Illustration

> So the doctor walked in. He sat down in front of me and said, "I tried everything I could. Your husband is dead." And he walked out of the room. So I could feel these emotions start to roll up inside of me, but I immediately pushed them down because my thought was, "Oh my God, I've got to get my children. I've got to get my people in." And all of a sudden, I had to be in charge. I couldn't afford to be emotional because there was nobody there to help me. . . All of a sudden I withdrew into myself. I guess what I was doing was I was setting up my own walls so I could function. Because I knew that there was nobody else there to function.

A final effect of isolation produced by the notification process to which the widow is susceptible is the kind where a person is too sheltered, too protected. In many cases I have encountered, I have found that this has the effect of isolating the widow from her own emotions or her own capacity to cope.

Case Illustration

> They [the police] had guys over here twenty-four hours a day. That night [the night of the notification] there must have been ten guys in the house. And they asked me, "If the phone rings, do you want us to get it?" And I said, "Yes, I would." They were just here. I didn't even have to take care of them. They were there to take care of me. It got funny after a while, because one would be sleeping in the bed with my son, another one on the love seat, another one on the floor. They had the doctor here, and I was sedated most of the time.

The overprotectiveness on the part of the police department, in this case, had a very damaging effect. The widow had a hard time expressing her emotions or making even the smallest decision once the entourage of police officers left. This problem persisted for a very long time. The anger that she suppressed finally erupted one day several months later when, upon hearing that her husband's killers were apprehended, she repeatedly pounded her hand on a door, breaking her wrist, knuckles, and several fingers. This suppression of emotions due to the initial overprotectiveness also served in helping to forge a new "self" in the widow. In her own words, she refers to this new self as "the front." "That was the day I learned to put on "the front." My kids walked in the door and all of a sudden I sucked in my gut, dried my tears, and I became 'mother.' And I learned to do that very well from that point on."

In researching the reactions and likely reactions of a police widow upon being informed of the death of her husband, I have found that the manner of notification can have long-range effects. Lindemann (1944) cites one of these effects as delayed grief, which ". . . takes place when a normal or chronic grief reaction occurs only after an extensive delay, during which the expression of grief is inhibited" (p. 145). It is therefore imperative for the notifying officers to be aware of likely reactions from the widow and to be prepared for

them. It is equally important for the widow to be able to vent her feelings in order to work them out. Therefore, the notifying officers must make an effort to establish a relationship with the widow, where the widow is given support, while at the same time she is allowed to develop her own sense of autonomy. Personnel training would seem to be the key, and would seem to be indicated for any profession in which there is a present danger that could incur loss of life.

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POSTTRAUMATIC STRESS DISORDER AND THE POLICE EXPERIENCE

Richard Pastorella

ABSTRACT

The purpose of this paper is to explore the diagnosis of Posttraumatic Stress Disorder (PTSD) as it relates to the New York City Police Department. I will be exploring the causes of this disorder, both from the traditional perspective of the "single event" and from the theory of "chronic stress." My information was gathered from published data, reports and articles, as well as from personal interviews with people who have suffered from events that fit into the "single event" category. I have also included an interview in this paper that I believe confirms the theory of "chronic stress" as leading to PTSD. A further purpose of this paper is to explore the causes of PTSD that affect the law enforcement officer, the impact that it causes, and the possible effectiveness of peer counseling that can be used to intervene effectively in the course of the treatment of it.

The DSM-III-R (APA, 1987, p. 247) defines posttraumatic stress as ". . . the development of characteristic symptoms following a psychologically distressing event that is outside the range of human experience." The characteristic symptoms of PTSD are as follows: a reexperiencing of the injurious event, a psychic numbing, a reduction of involvement in outside events, and specific symptoms not present prior to the event. In his book, Stress Response Syndromes, Horowitz (1986, p. 29) describes some key reactions to traumatic events that are characteristic symptoms of PTSD. For the sake of brevity, I will list only the symptoms with the highest frequency of response:

Intrusion Items	Denial Items
1. Pangs of emotion	1. Numbness
2. Rumination or preoccupation	2. Reduced level of feeling or responses to outer stimuli
3. Intrusive ideas	3. Unrealistic narrowing of attention, vagueness
4. Bad dreams	4. Inattention/Daze
5. Intrusive thoughts or images	5. Inflexibility or constriction of thought

According to the late Dr. Hans Selye, a noted researcher in stress symptoms, the characteristics of PTSD can also include somatic responses such as ulcers, gastric disorders, and heart disease (1956).

Before the term was coined, posttraumatic stress disorders were known as "shell-shock" or battle fatigue, terms used to describe the overwhelming influx of external stimuli that causes anxiety (Brenner, 1973). Sufferers of this "shell-shock" were seen as defective in some way; that is, they were seen as having a preexisting pathological condition present. After the concept of PTSD was accepted, it became recognized that sufferers did not have to be unstable for this type of stress syndrome to occur.

In essence, previously we were blaming the victim; the reason why people suffered from trauma is that somehow they were premorbidly defective. The concept of posttraumatic stress disorders gained prominence because of the experiences of the Vietnam veteran and the difficulty that he had in assimilating himself back into society.

There is a current innovative theory, however, stating that posttraumatic stress symptoms may develop not only following a single distressing event, but also from less powerful or immediately threatening events

that pose chronic or recurrent danger. "Continuing concerns and fears, rather than those associated with an initial event could be responsible for both the chronic stress and the symptoms of PTSD that we have observed" (Davidson, Fleming, and Baum, 1987, p. 57). Such chronic events causing stress are characteristic in police work.

In the past several years, an informal consensus has arisen that stress and stress-related disorders are significantly greater for law enforcement officers than for other occupational groups. Stress has now become an everyday word in the vocabulary of most officers; we are now paying more attention to the inner emotional turmoil that a police officer incurs in the course of doing the job than ever before.

The police officer, throughout the years, has experienced stressors comparable to the Vietnam veteran. Today's officer can be overwhelmed by the constant violence from the drug wars in the streets, to the carnage on the highways, to the domestic violence that is part of his everyday job. By virtue of what he sees and does, he is more likely to experience powerful stressors than the general population. Because of this, the job stress experienced by the police officer can lead to debilitating symptoms, reactions known as posttraumatic stress disorders.

STRESS REACTIONS--CAUSES AND EFFECTS

According to Freud, neuroses arising from what used to be called "shell-shock" or posttraumatic stress, as we now call it, result from an overwhelming influx of stimuli (external or internal), which gives rise to anxiety. "Freud believed that the tendency or capacity of the mental apparatus to react to an exclusive influx of stimuli is by developing anxiety" (Brenner, 1973, p. 80). In addition, he stated that the development of anxiety is as follows:

1. Anxiety develops when internal or external stimuli overwhelm the psyche, which is then too great to be mastered or discharged.

2. These stimuli can be of internal or external origin.

3. A situation is called traumatic when anxiety develops according to this pattern.

Traumatic stress may then be defined as a process that occurs when events go beyond a person's coping abilities.

NATURE OF POSTTRAUMATIC STRESS

To adequately understand the reactions to posttraumatic stress disorders, one must first be familiar with key elements of trauma that may trigger the response and that are relevant to police work. "The syndrome can begin with an event in which the individual is threatened with his or her own death or the destruction of an important part of his body. . ." (Titchener, 1986, p. 5). In police work the threat to the officer's health and safety is a constant factor. With violent crime on the increase in America, police officers are more likely to encounter situations that involve the use of deadly force.

Situations in which the individual must act contrary to his personal beliefs or behave deviantly to the socially accepted norm may also be perceived as extremely stressful and initiate the onset of the syndrome. Titchener (1986) agrees with this theory; he concludes by saying ". . . or to such humiliation and manipulation that personal identity may be lost." This element is reminiscent of Anna Freud's theory of superego anxiety. According to her theory, which she claims is the basis of all neuroses in adults, the conflict is this: The id wants immediate gratification. The ego is amenable and would submit to the id's wishes; however, the superego protests. The ego submits to the superego and is completely deprived of its independence and reduced

to the status of an instrument for the superego's wishes (Freud, 1966, pp. 54–56). To put this into simpler terms according to the actions of the police officer, we would have to suggest that the violent and abnormal tendencies are the id instincts. The personal beliefs would be the superego tendencies, the socially acceptable mores. Therefore, the anxiety and symptoms of PTSD would be the resulting symptoms exhibited between the ensuing struggle between the violent tendencies of the police officer and his conscience.

A third element that can initiate posttraumatic stress in the police officer is personal loss or sudden death, the loss of one's own physical abilities through injury, or the loss of one's partner during a confrontation (Epperson, 1977).

There are numerous other stressors inherent in police work that can cause chronic stress and therefore result in PTSD in the police officer. Besides the threat to the officer's safety, the need to control emotions, the continued exposure to people in distress, there are the changes in shifts that require biological adjustment, the boredom alternating with the need for sudden alertness and motivation of energies, and the presence of weapons both on and off duty. Even administrative pressures such as poor equipment that the police officer is forced to use and the overly harsh penalties for minor infractions of rules can lead to the onset of PTSD (Goolkasian, Geddes, and Dejong, 1985).

An important study was done in the field of stress research by Dr. Hans Selye, who described the incapacitating effects of negative stress, referring to is at the General Adaptation Syndrome. The three stages Selye observed in people who have been exposed to negative stressors are:

1. The Alarm Reaction Phase--where the body readies itself by secreting stress hormones.

2. The Resistance Phase--where the level of resistance increases, and defense mechanisms are activated.

3. The Exhaustion Phase--where the defenses are exhausted and reserves are depleted.

As per Selye, so long as the threat or stressor is present, there will be this triad of effect. However, when the stressor has ended or passed, if the individual is kept in the same surroundings or circumstances, the resistance phase will be drawn out and the person will "break" due to mental/psychological exhaustion. It is during the stage of exhaustion that symptoms of PTSD are thought to occur.

SYMPTOMS OF POSTTRAUMATIC STRESS DISORDER

Whether PTSD is incurred through chronic stress as Davidson, Fleming, and Baum have postulated, or through a specific traumatic experience as stated in the DSM–III–R, a pronounced symptomatology is likely after the impact of any traumatic experience. Differentiating the "normal" reactions to the pathological reactions can be accomplished by considering the duration of the symptoms. In order to meet one of the criteria, the onset of the symptoms has to have occurred within six months after the trauma (APA, 1987). If this is the case, it is an indication that immediate psychological intervention should be undertaken.

Titchener (1986) divides the syndrome of PTSD into two phases. The acute phase begins immediately after the traumatic event and is characterized by the following: "shock effects, fear, inexpressible feelings of loss, disorganization of thinking, impairment of memory, concentration, and judgment, and interference with comfortable affect" (p. 6).

CASE ILLUSTRATIONS

Case One

Detective A, after witnessing a fleeing bank robber fire at a civilian with a sawed-off shotgun, engaged in a shooting with said robber and was critically wounded. He was rushed to Bellevue Hospital, having suffered gunshot wounds to the arm and chest. Upon awakening after surgery and within the next few days, Detective A notices severe mood swings when members of his unit had come to visit. He would tell jokes and laugh with them, and after they left he would be reduced to fits of tears. One of the most frightening symptoms he exhibited was that of the inability to read a report of his incident that was given to him to sign. He could not seem to make any sense of the written words on the page, but was afraid to tell anybody of this because he feared he was losing his mind. Detective A also experienced memory loss of events that happened only hours before. A specific occurrence of this was when he had received a small gift from a neighbor who had visited in the morning, yet he could not remember who had brought it that evening. To this day, ten years later, he still has recurring dreams of the incident. They are not as frequent as before, but they persist on an irregular basis.

Case Two

Police Officer C, a female transit officer, was confronted by an emotionally disturbed person on the catwalk inside a subway tunnel between two stations. As she attempted to bring the man onto the train, he pulled a razor from his pocket and slashed her throat, arm, chest, and back. Due to her injuries, she was unable to draw her weapon to defend herself, and the emotionally disturbed man was subdued by passengers on the train who came to her assistance. She states, "The bad dreams that I have, I can never remember. When I wake up, there is a complete blank in my head. I have awakened crying, frightened, scared, my heart pounding. My whole entire life, I have always remembered my dreams; now, I never remember anything. I have a hard time now falling asleep. If I sleep three hours at a time, I feel lucky. What really kind of bothers me is that I am not feeling anything. It was like nothing ever happened to me. I know I should be feeling something, but--nothing. I'm afraid it's all going to hit me at once. I feel as if there is a blanket around my feelings. I feel as though I have mittens on, like I can't grasp anything. There is something blocking me, and I don't know what it is."

The two case illustrations above embody several classic examples of the acute phase of PTSD. In each case, there occurred the one distressing event outside the range of usual human experience (DSM-III-R, 1987), and in each case the symptoms showed themselves within a few days after the event. It is interesting to note that each officer believed his or her personal reaction to be "crazy," almost as though the symptoms were a stigma and something to be hidden. I believe this notion is a throwback to the theory that the victim is considered somehow premorbidly defective. Each officer feared that his or her symptoms would in some way blemish his or her career or personal life. It would seem to indicate that while the theory of PTSD has been in existence for over eight years, society has yet to acknowledge its veracity and application.

The second phase, the sub-acute phase described by Titchener, deals with altered attitudes in human relationships as a result of the traumatic event. Titchener describes these as follows: ". . . regressive deterioration of trust in others, alternating with unrealistic dependence and pathetic longings for help from others" (1986, p. 6).

Case Three

> Police Officer D was assisting a motorist who had a flat tire on the Major Deegan Highway. As he was placing cones behind the vehicle to avert oncoming traffic, he was struck by a truck and dragged 40 feet by the vehicle. Unconscious, he was airlifted to Bellevue Hospital in an attempt to save his leg. The surgeons ultimately decided that his leg was too mangled to be saved, and it was amputated above the knee. Shortly after the surgery, Police Officer D exhibited various symptoms of PTSD--the recurrent dreams, feelings of detachment, sleep disorders, restricted regulation of affect, and withdrawal from loved ones and outside interests. In the weeks that followed the traumatic event, Officer D began to exhibit unusual behavior contrary to his character before the incident. His dependency on his partner, who was assigned to him in the hospital, became extreme. The partner soon found himself attending to all of Officer D's needs (e.g., shaving, feeding, and washing him).

This case illustration is a good example of Titchener's sub-acute phase. The traumatic event was sudden and unexpected and resulted in the loss of physical ability through injury. The traumatic event, in this case, has brought about a dramatic change in lifestyle for Officer D from independent to unrealistically dependent.

The previous vignettes were classic examples of a singular traumatic experience leading to PTSD, which adhere to the traditional guidelines in the DSM-III-R. The following case study is an example that I believe verifies the theory of PTSD resulting from chronic or recurrent stressors, as postulated by Davidson, Fleming, and Baum (1987).

Case Four

> Detective J had 23 years of service with the New York City Police Department, 16 of which were spent in the Crime Scene Unit. The Crime Scene Unit's job is specifically to gather forensic evidence in major cases such as homicides, acts of terrorism, bombings, etc. In my interview with Detective J, I asked him what he felt was the most onerous aspect of his work. He immediately responded with, "I hated responding to the morgue every day to photograph and fingerprint the cadavers. I also hated responding to scenes of homicides involving children. Part of my job involved handling carcinogenic chemicals for lab tests, specifically Ninhydrin Spray and Benzidine. We were also responsible for collecting blood samples at crime scenes. I never knew if I has handling the blood of an AIDS victim. It really scared the hell out of me. You know, 16 years of that work took its toll on me. I noticed several changes. I had difficulty sleeping, for one thing. I couldn't get the thoughts of those kids out of my mind. I found that I was distancing myself from my wife and kids. I didn't want them to know what I was going through. I just kept it all bottled up inside of me. I felt angry all the time, like a volcano waiting to go. I found that the most frightening thing of all."

This case illustration was included in this paper for two specific reasons. First, I believe that an application can be made that associates the chronic stressors in police work with the Posttraumatic Stress Syndrome. According to Davidson, Fleming, and Baum (1987), "Continuing concerns and fears, rather than those associated with the initial event could be responsible for both chronic stress and the symptoms of PTSD that we have observed" (p. 66). Second, this correlation should be considered not only in the treatment of wounded police officers (i.e, the single event), but also in the police officer who is exhibiting the symptoms of PTSD without having been wounded (i.e., the chronic stressors).

TREATMENT APPLICATIONS

Police officers who exhibit the characteristics of PTSD tend to harbor these feelings and try unsuccessfully to deal with them on their own. They do not trust police surgeons whom they feel do not fully understand the police experience. The theories behind this are varied. If we can make a comparison between the military survivor and the paramilitary survivor (i.e., the police officer), one concept that can be used to explain this is Lifton's "counterfeit universe" (1973). According to Lifton, there was rage and distrust toward the chaplains and psychiatrists of the military during the Vietnam conflict. They promoted and sanctioned the killing and atrocities in Vietnam in the name of God, country, and survival. "We can then speak of the existence of a 'counterfeit universe' in which pervasive, spiritually reinforced inner corruption becomes the price of survival" (Goldman and Segal, 1976, pp. 45–64). In essence, the psychiatrists and chaplains were preaching immorality in a moral way. The police department's rules and ethics are essentially the same. The police officer is sent forth to deal with the dregs of society, the immorality of the criminal, but must remain within the limits of "society" to do it. "Do anything you have to do to protect us, but don't get dirty doing it" is the department philosophy.

Another problem involves the fear on the part of the officer that anything he or she may do will not be held in strict confidence; it will ultimately become part of his permanent record and follow him, hampering his career moves. Some departments, as a matter of policy, remove the police officer's weapons once he has come to the attention of their Psychological Service Division. Once the officer's guns have been removed, this becomes a visible stigma to the officer, who, in asking for help, now becomes labeled "psycho" by his peers.

Still another problem in seeking counseling by the traumatized officer is that society has stereotyped his role as being strong and capable of handling even the most difficult of problems. Stress is handled by being tough and not showing feelings. By seeking counseling, the officer is, by his own standards, showing weakness and an inability to handle his own problems.

In my opinion, all of the problems inherent in the treatment of PTSD can be addressed through the intervention of peer counseling. This can help the officer through the trauma in several ways. First, someone who has experienced similar trauma is more in touch with the feelings of the traumatized victim and can empathize with him and validate his reactions as being correct. Second, police officers tend to trust other officers who have been through similar experiences and have survived them.

It is not enough, in my opinion, to feel that one can help others just commiserating with them, by lending a sympathetic ear. The idea of a peer support group is a good one, but one that must be taken a step further. Training is the key to good counseling. Therefore, it is necessary to train members of the police department who have experienced trauma to deal with other officers. It is not the function of the peer counselor to compete with or replace the psychological services provided by the police department. It is, rather, a supplementary resource that has heretofore been inadequately tapped. To make this peer counseling a more viable and effective tool, it is essential that the peer intervener receive extensive training in facilitative listening, assessment techniques, and crisis intervention.

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THE LITTLE BOOK OF STRESS MANAGEMENT: BIBLICAL PRINCIPLES FOR STRESS REDUCTION

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ABSTRACT

Stress has been examined from almost every conceivable angle. However, very little has been done to analyze the Biblical material and incorporate the findings into a strategy for stress reduction. This paper presents Biblical material that relates to stress and its management. Six principles that offer directive counsel for stress reduction are shared in a format called "The Little Book." These principles are based upon the understanding that people are multidimensional beings with intellectual, emotional, physical, and spiritual needs.

INTRODUCTION

This paper will describe a book that has become very special to me. The book is quite brief, but very meaningful to anyone who discovers its power. Called "The Little Book," it is so concise that its owner can carry it wherever he goes. It strikes at the heart of stress in our fast-paced society.

The Little Book is based on Biblical principles. It was given to me by a Christian friend in Melbourne, Florida. It originated with a Christian physician in Ogden, Utah, Dr. Carl Darby. Dr. Darby is a wise physician who treats people with his medical knowledge as well as with knowledge that he has learned from the Great Physician.

Dr. Darby says that often after he has examined patients and diagnosed their problem, he will sit them down in his office. He will tell them whatever problem they have medically; however, to many of his patients, he says, "You are suffering from what I call the gray sickness. The gray sickness is what happens to virtually all of us as a result of the tensions and the pressures of life. We are all living in a pressure cooker, so to speak. Those pressures begin to take their toll on us physically as well as emotionally. They even take their toll spiritually." So, along with his medical treatment, Dr. Darby gives out pages of The Little Book. The pages of this Little Book really do help, especially since they are based on the Word of God.

The Little Book is composed of a preface and five pages. Every time I set foot in a police cruiser or respond to an emergency call, The Little Book goes with me. Its pages are full of applications for police work. My prayer is that you will be able to see power in these principles that will apply to your particular area of work in law enforcement. The Little Book has proven itself again and again by reducing stress in the lives of those who adhere to its principles.

PREFACE: BE LIGHTHEARTED AND HAPPY

That is a powerful and life-changing statement. How long has it been since you were really happy? This paper is based upon the thesis that real happiness is from the Lord. The Biblical terms are salom and eirene (Brown, 1976). Biblical happiness **is not** equal to a positive mental attitude or optimism. It is far deeper than either of these ideas. Biblical happiness is based on what is within the person rather than his/her circumstances. External problems and circumstances are very real, but if the right elements are within the person, he/she can cope with these problems.

In our Western culture, we have bought into a false philosophy. The core of this philosophy teaches that happiness depends upon our circumstances (what happens to us). If one has the best job, drives the best car, is in good health, etc., one will be happy. It is simply not true that to be happy all of the circumstances have to be right. If we could learn the far-reaching truth of one statement, our lives would be changed. Happiness depends on how we react to circumstances. Take a moment to think of some of the happiest people you have known. The experiences of these people will teach you that happiness is a decision.

Paul the Apostle had learned that happiness is something from within and that happiness is a decision. Philippians 4:11-13 (New International Version of the Bible is used throughout):

> I am not saying this because I am in need, for I have learned to be content whatever the circumstances. I know what it is to be in need, and I know what it is to have plenty. I have learned the secret of being content in any and every situation, whether well fed or hungry, whether living in plenty or in want. I can do everything through Him who gives me strength.

This is a practical statement because it is written, not from an ivory tower, but from a Roman jail.

Police personnel are some of the most unhappy people with whom I have spent time. They have not learned the secret that happiness is a decision. Even a positive mental attitude will run out eventually, but faith in God will never run out. Happiness doesn't depend on what we have, but it depends on our decision to make the best of what we have and to trust that the Lord will bless us no matter how bad our situation may be. The reason that it is possible to decide to be happy is God decided to do for us what we could never do for ourselves.

PAGE 1: TAKE CARE OF YOUR PHYSICAL BODY

This page is quite convincing. Taking care of one's physical body is certainly a Biblical principle, especially for the Christian. According to I Corinthians 6:19-20, the Christian's body is "the temple of the Holy Spirit." What we do to our temple we do essentially to the Spirit. So taking care of one's physical body is linked to one's spiritual health.

One overworked minister tells of his visit to the doctor's office. The doctor gave him quite a shock when, after his examination, he told him he would have to send him to three specialists to deal with his ailment. The minister got the point when the doctor told him the names of the three specialists: Dr. Diet, Dr. Rest, and Dr. Exercise.

Police personnel are notorious for being out of shape and not eating properly. Being out of shape, combined with the high level of stress in police work, makes for a powder keg waiting to explode. One does not have to do much research to see why the average life span of police officers is less than 60 years of age.

The power of taking care of one's physical body to reduce stress must not be underestimated. Dr. Kenneth Cooper, in The Aerobics Program for Total Well-Being (1982), calls this idea total well-being.

The human body is just another part of the universe that is meant to be in perfect balance. We have been constructed in such a way that we need just so much exercise, no more and no less. We need just so much food of certain types. And we need just the right amount of sleep and relief from the tensions and stresses of daily life. If a person goes too far in either direction--too little or too much exercise, food, or rest--then his or her entire physical and psychological system gets out of kilter. And where there is lack of balance, there is also a lack of personal well-being. By the same token, on the positive side, where there is balance, there is a sense of well-being. And where there is perfect balance, there is what I call total well-being.

PAGE 2: FRET NOT

Page 2 is a direct quote from Psalms 37:1: "Fret not" or "Do not fret." This is more than good advice. You could call it an admonition, an exhortation, even a command from the Lord Himself. Americans live in an age of anxiety. Historians of the 20's called it the aspirin age. The designation for the 80's will have to be stronger than aspirin. I want to emphasize again that by looking at the principles of The Little Book, I am not trying to ignore problems or trying to suggest some type of positive mental attitude or optimism versus pessimism, but rather, I am interested in building our inner spiritual resources so that we can be victorious in spite of our problems.

Matthew 6 has several insights concerning our tendency to fret. Our word today for fret is "worry." Worry is a very serious spiritual problem about which Jesus talked a great deal. There are six times in this passage that Jesus refers to worry. No more concentrated section against worry exists in Scripture. Matthew 6: 25, 27, 28, 31, 34 contain five exhortations against worry.

Individuals in our day worry in three basic realms:

(1) Physical life: Health, death, fear of disease, worry about the physical ailments of life. Some of you who read this paper are no doubt worried about your health as to your future.

(2) Personal failure: Disobedience, sin, what will happen because of failure brought about by disobedience.

(3) Daily problems: People; work; children; finances; inflation; the whole promise of tomorrow, which looks bad in some cases; education; the fulfillment of assignments; mother-child worries; husband-wife worries.

The same word for worry is used throughout Matthew 6:25-34. The word basically means to have anxiety, be anxious, be (unduly) concerned (Bauer, 1957). The term is used in a classic passage in Luke 10:38-42 where Martha was worried and upset about many things when Jesus came, and Mary was satisfied to sit at His feet and learn. Jesus said, "Martha, Martha, you are worried and upset about many things, but only one thing is needed. Mary has chosen what is better, and it will not be taken away from her."

Let's look at the negative effects of worry. They are taken directly from Matthew 6:25-34. Notice verse 25 is a transition verse. Look at verses 24 and 25:

> No one can serve two masters. Either he will hate the one and love the other, or he will be devoted to the one and despise the other. You cannot serve both God and Money.
>
> Therefore I tell you, do not worry about your life, what you will eat or drink; or about your body, what you will wear. Is not life more important than food, and the body more important than clothes?

Reason number one against worry: Worry keeps you from enjoying what you have.

Second reason: Worry makes you forget your importance. Verse 26: "Look at the birds of the air; they do not sow or reap or store away in barns, and yet your heavenly Father feeds them. Are you not much more valuable than they?" Passages such as John 3:16 make it clear that God wants you to realize your worth in Christ. The world tends to make you feel insignificant.

There is a third reason. Verse 27: "Who of you by worrying can add a single hour to his life?" or as in some translations: "add a single inch to his height." Reason number three against worry. Worry is

totally useless. You can worry all you want and you get absolutely nothing from it except ailments, frowns, gray hair, ulcers, and sickness.

Look at verses 28–30:

> And why do you worry about clothes? See how the lilies of the field grow. They do not labor or spin. Yet I tell you that not even Solomon in all his splendor was dressed like one of these. If that is how God clothes the grass of the field, which is here today and tomorrow is thrown into the fire, will he not much more clothe you, O you of little faith? So do not worry, saying, "What shall we eat?" or "What shall we drink?" or "What shall we wear?"

Fourth reason: Worry erases the promises of God from your mind. All you can remember when you worry is what **hasn't** taken place. Worry acts like a giant eraser that erases God's promises from your mind.

Verse 32, "For the pagans run after all these things, and your heavenly Father knows that you need them."

Worry is characteristic of the nonbeliever. That's the fifth argument. These are the things the pagans think about. Worry is the lifestyle of the pagan.

Worry is nothing more than assuming responsibility for what we are incapable of handling. Why do we try to handle something we were never designed to handle? Because we are proud. We really believe we can handle it better than God. It goes against our nature to trust.

Listen to the words of one man.

> There are two days in the week about which I never worry. Two carefree days kept sacredly free from worry and apprehension. One of these days is yesterday. The other day is tomorrow. It isn't the experience of today that drives people mad. It's the remorse for something that happened yesterday and the dread of what may happen tomorrow.

Isn't that the truth? You see worry is not only a sin, it is a skillful sin. We have become proficient at it. We have the most marvelous way of handling worry. We call it "concern." Some of you have perfected it so that from the time you arise in the morning until you retire at night, you have a lifestyle of worry. God taps his foot waiting for you to say, "Lord, please take care of this."

What do we do? Verse 33, "But seek first his kingdom and his righteousness, and all these things will be given to you as well."

First of all, we put our mind completely on the Lord. 1 Peter 5:7, "Cast all your anxiety on him because he cares for you." Philippians 4:6–7, "Do not be anxious about anything, but in everything, by prayer and petition, with thanksgiving, present your request to God. And the peace of God, which transcends all understanding, will guard your hearts and your minds in Christ Jesus."

Verse 34, "Therefore do not worry about tomorrow, for tomorrow will worry about itself. Each day has enough trouble of its own." Second technique: Learn to live one day at a time. One day at a time. That's a tough assignment isn't it?

PAGE 3: DO NOT MAGNIFY YOUR PROBLEMS

Philippians 2:14–18 says,

> Do all things without grumbling or disputing; that you may prove yourselves to be blameless in the midst of a crooked and perverse generation, among whom you appear as lights in the world, holding fast the word of life, so that in the day of Christ I may have cause to glory because I did not run in vain nor toil in vain. But even if I am being poured out as a drink offering upon the sacrifice and service of your faith, I rejoice and share my joy with you all. And you too, I urge you, rejoice in the same way and share your joy with me.

So often when we have problems, we begin to imagine worse problems. Before we know it, the imagined problems are doing more damage than the real problems. There is not only true guilt but false guilt; not only a legitimate fear but a false fear; not only a legitimate concern but false anxiety. Page 3 speaks to those imagined problems.

People have the tendency to complain and exaggerate while consistently expecting the worst. If they have a headache, they are sure it is a brain tumor. If they have chest pain, they are sure it is a pending heart attack. Even if they hear good news, they tend to put some bad interpretation on it like: "I'm sure it won't last. Tomorrow the roof will cave in." The tendency to magnify our problems gradually chips away at our faith and our self–esteem.

The Bible is full of examples of individuals and groups of individuals who magnified their problems. 1 Kings 19 tells of Elijah's unfounded fear that he was the only faithful prophet left in Israel under God's direction. The truth of the matter came to light that in reality there were 7,000 prophets who were faithful to God. A slight exaggeration of the problem, don't you think?

Moses panicked and asked God to take his life because he thought he had to bear all the burdens of the Israelites as they left Egypt. God reminded him that there were 70 men who could assist him with his task (Numbers 11).

Even Jesus' own trusted disciples fled when he was taken into custody (Mark 14:50). After His death, Jesus himself had to appear to his disciples, who were very near going back into the fishing industry (John 21:3). He reminded them that the dream of His kingdom was still very much alive.

These few examples from Scripture remind one that the situation is not always what it seems. Before one panics, one must remember that God makes impossible things possible.

Jesus' statement in John 6:43 gives the spirit of Page 3. "Do not grumble among yourselves."

PAGE 4: NEVER SAY ANYTHING ABOUT ANYBODY UNLESS IT IS GOOD

Communication is absolutely necessary to enjoy the fellowship and friendship of other people, though on an individual basis, a person does not converse with everyone on the same plane. Regardless of which level is attained, God desires an exhibition of maturity in one's speech. The following illustrates various levels of interpersonal communication (Powell, 1969).

1. Complete emotional and personal communication
2. My feelings
3. My ideas and judgments
4. Reporting the facts
5. Cliche conversation

The Book of Proverbs is designed to direct a person to the proper attitudes and actions in life situations. Because interpersonal communication is a vital link in mature relationships, specific principles are given in Proverbs to help each person evaluate and change communication patterns according to God's ideal concept of communication. Three principles from the Book of Proverbs seem to give the general theme of the type of speech that is necessary to have mature conversation.

1. A good person thinks before he speaks (Proverbs 15:28; 18:4; 16:23; 10:14; 17:27–28).
2. Realize the therapeutic potential of your speech (Proverbs 2:18; 11:9; 25:18).
3. Reflect upon the tone of your speech (Proverbs 15:26; 31:26).

The following questions will be helpful **if you are in doubt** about sharing some information:

1. Is it true?	Proverbs 6:12; 13:17
2. Is it really necessary?	Proverbs 18:21
3. Is it kind?	Proverbs 11:9; 12:18; 15:4; 16:24
4. Is it confidential?	Proverbs 18:24; 25:19

H. Norman Wright (1981) has excellent suggestions in the area of family communications, which actually apply to most all communication settings. The principles are arranged in a chart in the Appendix.

PAGE 5: CONTROL YOUR THINKING

This page is by far the most important because it impacts all the other thoughts contained in The Little Book. For this reason, I will give more space to this idea.

The gifted concert violinist Niccolo Paganini was standing before a packed house surrounded by a full orchestra. He was playing a number of difficult pieces and he came to one of his favorites, which was a violin concerto. Shortly after he was under way in this piece and had the Italian audience sitting in rapt attention, one of the strings on his violin snapped and hung gloriously down from the instrument as he, relying on his genius, improvised and played on the remaining three strings. To his surprise and the conductor's as well, shortly thereafter, a second string broke on his instrument. Now there were two dangling as he again began to improvise and play the piece on the two remaining strings. You guessed it, almost at the end of this magnificent concerto, a third string snapped. Now there are three dangling and he finishes the piece on one string.

Afterwards the audience stood and applauded and applauded until their hands were numb, never thinking, of course, to ask for an encore. They expected to leave. They sat down. He held his instrument high in the air and said, "Paganini and one string," as he played an encore with the full orchestra accompaniment. He made more music out of one string than many violinists ever could on four. And, might I add, with the attitude of fortitude.

Dr. Victor Frankl, a Jewish physician, was taken captive by the Nazis in the early 1940's. He meant more to them than a body in a trench. They killed his family. They took his clothing. They took his jewelry, even his wedding ring, and shaved his head. As he stood before the glaring lights in the Gestapo courtroom, completely naked, humiliated, he suddenly came to realize that they might take his family and his clothing and his possessions and even his hair, but there was one thing they could never take away---his choice of attitude. He endured with the attitude of determination and discipline, and he survived that German concentration camp. I guess one could say it boiled down to Victor Frankl and one string.

How else can you explain the determination that Joe Namath displayed some years ago in the professional football ranks? When he was 30 years old and still playing ball, it was said that he had 65–year–old legs. Sports Week magazine carried an interesting article about him back in the early 80's. It said,

"Namath's medical history sets him slightly above his colleagues. His particular cross is his knees, which remained until today as a pinnacle of surgical ingenuity. Because of severely battered knees, Namath was told by his physician that if they survived four years in the professional ranks, he could consider himself fortunate. With the help of an unnerving number of operations (and an attitude to continue), he played 12 seasons, not 4. Now he admits that he has difficulty stepping sideways and walking up one flight of stairs. His other injuries include separations of both shoulders, a broken wrist, a broken cheekbone, a dislocated finger, a broken ankle, and a torn hamstring muscle." The interviewer admitted that as he interviewed Namath, he saw a bulge in the back of his trousers. He asked, "How long will you wear that bandage?" Namath said, "Oh, that's not a bandage. Feel." The hamstring muscle had been pulled and had knotted up the size of a small grapefruit. He just hadn't bothered to get it operated on. I guess one could say it came down to Joe Namath and one string.

In an article summarizing the effects of helplessness, New York Magazine cites the example of Major F. J. Harold Cushner, an Army medical officer held by the Viet Cong for five and a half years. Get this.

> Among the prisoners in Cushner's POW camp was a tough young Marine, twenty-four years old, who had recently survived two years of prison camp life in relatively good health. Part of the reason for this was that the camp commander had promised to release the man if he cooperated. Since this had been done before with others, the Marine turned into a model POW and the leader of the camp's thought reform group. As time passed, however, he gradually realized he was being lied to. When the full realization of this affected his attitude, he became a zombie. He refused to do all work, rejected all offers of food and encouragement. He simply lay on his cot, sucking his thumb, and in a matter of weeks he was dead.

The fourth string broke. Dr. Martin Segelman of the University of Pennsylvania attributes the Marine's death to the attitude of helplessness.

Some of you have come down to one string. The tragedy is that you are focusing your full attention on the three that have snapped. This attention span of yours has grown into a sense of bitterness, sorrow, self-pity, and perhaps blame because those three strings have broken and you deserve four like everybody else, or so you think like everybody else. The result has been a tragic souring of your attitude.

I cannot stress to you enough the impact of attitude on life. You may not like this, but attitude is more important than facts. It is more important than past, than education, than money, than circumstances, than failures, than successes, than what others think or say or do. It is more important than appearance, giftedness, or skill. It will make or break a company. It will cause a church to soar or sink. It will be the difference in a happy home or a home of horror. It's attitude. The remarkable thing is that you have a choice every day regarding the attitude you will embrace for that day. You can take the three strings that dangle or you can play your melody on one. And, oh, the difference it makes. We cannot change our past. We cannot change the tick of the clock. We cannot change that march towards death. We cannot change the fact that people will act a certain way. We cannot change the inevitable. Those are the strings that dangle. The only thing that we can do is play on the one string we have and that is our attitude--like Frankl, like Namath, like Niccolo Paganini and one string.

Life is ten percent what happens to me and ninety percent how I react to it. And so it is with you. Tucked away in the second chapter of Philippians, God addresses the subject of our mind. It is so important that wherever you are in life I would urge your attention now. You will never be younger than you are today, never. The rest of your life stretches out before you. For some of you it is six months. For some it is six years, and if Christ tarries, for some it is sixty. You have a choice to make every morning when you wake up, throughout the day when interruptions come or surprises or circumstances or what you and I would call calamity. That response, that attitude will mean everything to you and to those around you. As we will see

a little later, you can act aggressively and blame or you can act passively and submerge in self-pity. When you do either one, your circle of friends will be reduced to one, if that, and that is yourself.

Philippians 2 begins with four "if's." "If you have any encouragement from being united with Christ, if any comfort from His love, if any fellowship with the Spirit, if any tenderness and compassion," then the attitude must be changed, says Paul. The church at Philippi was evidently struggling a bit with division. Paul says, "I plead with you, I beg you to take a long look at your short life and determine your attitude, especially the one you will have with fellow believers in the family of God." Verses 2 and 3a, "Then make my joy complete by being like-minded, having the same love, being one in spirit and purpose. Do nothing out of selfish ambition or vain conceit. . ."

Before you're tempted to turn your attitude back to yourself--Stop! Control your thinking! There are some who do not like direct counseling but the Bible is full of it. This passage is directed to the Christian and it tells us, "You are in charge of your attitudes. You are in charge of whether you will live a selfish life or a self-giving life. You determine each day whether you will be filled with selfishness and empty conceit or humility of mind."

Verse 3 continues, "but in humility consider others better than yourselves." You are in charge. You call the shots.

I begin my day the same as you do--with a full agenda. That means we are just alike. I face a choice, just as you face, every single morning of my life, whether I will be glum, gloomy; whether I will be sad and fall under my circumstances, or whether I will live above them. I can choose friends that will keep me under them and poison my mind, or I can be around friends that will lift me above my circumstances and cause me to see life through God's lens. I prefer the second, and that's the kind I choose. I will not run with people who poison my mind. I will not work with people who pull me down. I choose to live a life according to chapter two of Philippians, and it's only by the grace that I am able to do it. With God's help I can live a life that is above my circumstance, not under it. I get into trouble when I fall into the swamp of it.

Paul says in verse 4, "Each of you should look not only to your own interests, but also to the interests of others." What a marvelous piece of advice. You show me a person submerged in self-pity, and I will show you a person who talks about me, I, mine, and myself constantly. It is an attention-getting device, and before long we wear out the attention of others and they finally give up hope on our behalf.

But the positive side of this passage is in verse 5. You've got one string. Play the piece on that. "Your attitude should be the same as that of Christ Jesus." The difficulty of that is that we were not there. It's hard for us to know what Jesus gave up. He had an attitude that said, "I do not consider this position I have in heaven to be something to be grasped. I will go. I will offer myself for the sins of the world. I will be the scapegoat." That is what is meant in this verse. Have this attitude in yourselves that was in Christ Jesus. There is a lot of wasted energy spent worrying about the inevitables in life; those things we cannot change, like death, marriage, lack of marriage.

A lady who married at 31 tells how she never worried about it, but put it before God. She eventually had 12 kids. She put a pair of man's pants on the bed and every night she would kneel down and pray this prayer. "Father in heaven, hear my prayer and grant it if you can. I've hung a pair of trousers here, please fill them with a man." We laugh at that, but here is a lady who knows the way to live. You will not find that prayer in the Bible, but you will find something similar to it.

Philippians 4:4 says, "Rejoice in the Lord always. I will say it again: Rejoice!" You may say this passage must have been written in time when things were easy. Take a look at the historical setting of this passage, and you will find that Paul was more than likely in a Roman prison. Take note of his point. We are to rejoice in the Lord and not in the circumstances. Verse 5 says, "Let your gentleness be evident to all." In other words, do not hide your rejoicing in the Lord. You will be a remarkably contagious person.

Verse 6, "Do not be anxious about anything. . ." What is the anxiety that is weighing you down? Your marriage? Your lack of marriage? Your child? Your parent? Your job? Your lack of job? Your lack of feeling satisfied in life? Some tragic experience? The Bible says that is an anxiety. You do not have to live under the wake of it.

Verse 6 continues, "but in everything, by prayer and petition, with thanksgiving, present your requests to God." Guess what's going to fill the place where those anxieties were? Verse 7 has the answer, "And the peace of God, which transcends all understanding, will guard your hearts and your minds in Christ Jesus."

You have a choice of dispositions. No one could dictate to Victor Frankl how he would view his life in the camp. No one would dictate to Joe Namath how he would play the game of football. No one dictates to you in the morning what you will do in your attitude that day. You make the choice.

Let me show you the alternative. Philippians 2:14, "Do everything without complaining or arguing." Complainers and grumblers are in every office. There is at least one in every home. They are in every police department. You live that way if you choose to live that way. You will find a lot of company of people who want to live that way. Complaining brings disappointment in life.

How different is life when the peace of God that surpasses comprehension reigns in a life. You may not be able to explain how you have the peace. You only know that you handed off your anxieties to Him and peace has come. It's your choice. I choose Philippians 4:7.

"Finally, brothers, whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable--if anything is excellent or praiseworthy--think about such things" (Phil. 4:8).

A word should be added here about blame and self-pity. Blame never heals, it hurts. Blame never makes people whole, it fragments. It never affirms, it attacks. It never builds, it destroys. It never solves, it complicates. It never unites, it divides. Back in 1974, UCLA was riding the crest of an 88-game winning streak. They were scheduled to play Notre Dame. Notre Dame beat UCLA and broke that 88-game streak. The alumni threw up their hands. John Wooden found himself in the headlines of the sports page, which said, "Wooden says, 'Blame me.'"

> With an eleven-point lead, it seemed inconceivable to me that we could lose it. Our teams are not usually criticized for their lack of poise, but if we did lose our poise, you blame me. We learned a lot which we will use next Saturday.

Learn they did. They went back and beat Notre Dame by 20 points. Isn't that significant that Wooden says, "Let's end the complaining and blame game. Blame me."

Now, private enemy number one is self-pity. Self-pity sings this little song. "Nobody loves me. Everybody hates me. I think I'll eat some worms." Ever sing that song? You don't eat worms, but you feel wormy. You feel low, you feel crummy, you feel little. "I have become a victim of unfair treatment. I am getting what I do not deserve, and what is worse, it is at the world's worst time. Woe is me." It's like Elijah, "I'm all alone," and God says, "I have seven thousand who have not bowed the knee to Baal."

Are you divorced? You are surrounded by divorced people. Are you broken? You are surrounded by broken people. Have you failed? Welcome to the club. We have a lot of room for failures here. Have you sinned? So have I. God will forget when you lay it on him. Self-pity has no basis whatsoever when you get right down to it.

Verse 8 brings it all to a conclusion by sharing with us how we should think. Don't focus on the three broken strings. Play the one you have.

CONCLUSION

I hope you have enjoyed this passage through The Little Book. I know the material has ranged from technical to sermon notes, but I wanted to share with you not only information, but my heart. I truly believe that if we are to change people's lives, we must change the people. The Little Book has helped to change my life. I pray that it will help to change your life.

PREFACE:	**BE LIGHTHEARTED AND HAPPY**
PAGE 1:	**TAKE CARE OF YOUR PHYSICAL BODY**
PAGE 2:	**FRET NOT**
PAGE 3:	**DO NOT MAGNIFY YOUR PROBLEMS**
PAGE 4:	**NEVER SAY ANYTHING ABOUT ANYBODY UNLESS IT IS GOOD**
PAGE 5:	**CONTROL YOUR THINKING**

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APPENDIX
FAMILY COMMUNICATION GUIDELINES

Job 19:2; Proverbs 18:21; 25:11; James 3:8–10; 1 Peter 3:10

1. Be a ready listener and do not answer until the other person has finished talking (Proverbs 18:13; James 1:19).

2. Be slow to speak. Think first. Don't be hasty in your words. Speak in such a way that the other person can understand and accept what you say (Proverbs 15:23, 28; 21:23; 29:20; James 1:19).

3. Speak the truth always, but do it in love. Do not exaggerate (Ephesians 4:15, 25; Colossians 3:9).

4. Do not use silence to frustrate the other person. Explain why you are hesitant to talk at this time.

5. Do not become involved in quarrels. It is possible to disagree without quarreling (Proverbs 17:14; 20:3; Romans 13:13; Ephesians 4:31).

6. Do not respond in anger. Use a soft and kind response (Proverbs 14:29; 15:1; 25:15; Ephesians 4:26, 31).

7. When you are in the wrong, admit it and ask for forgiveness (James 5:19). When someone confesses to you, tell him/her you forgive him/her. Be sure it is forgotten and not brought up to the person (Proverbs 17:9; Ephesians 4:32; Colossians 3:13; 1 Peter 4:8).

8. Avoid nagging (Proverbs 10:19; 17:9).

9. Do not blame or criticize the other but restore him/her, encourage him/her and build up him/her (Romans 14:13; Galatians 6:1, 1 Thessalonians 5:11). If someone verbally attacks, criticizes or blames you, do not respond in the same manner (Romans 12:17, 21; 1 Peter 2:23; 3:9).

10. Try to understand the other person's opinion. Make allowances for differences. Be concerned about their interests (Philippians 2:1–4; Ephesians 4:2).

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JUSTIFICATIONS FOR MANDATING CRITICAL INCIDENT AFTERCARE

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ABSTRACT

Of the many hazards challenging the emotional well-being of contemporary law enforcement officers, their most formidable foe may well be their response and subsequent reactions to critical incidents. Law enforcement officers continue to be an "at risk" population with regards to exposure to such incidents. While many police agencies have instituted policies mandating critical incident training and aftercare, some have not. Experts agree that even in cases in which apparent "normal" psychological adjustment has occurred, there is a high probability that there is or will be some degree of disequilibrium. Therefore, critical incident training and aftercare must be a mandatory part of a law enforcement agency's policies and procedures. The Federal Bureau of Investigation's (FBI) Critical Incident/Peer Support Program is discussed. Justifications for mandatory critical incident training and aftercare are presented.

INTRODUCTION

"If all men were just there
would be no need of valor."
Agesilaus

The first post-critical incident interview I conducted has had a far-reaching effect upon my opinion that post-critical incident care must be a nonnegotiable mandate in law enforcement. The notoriety of this critical incident focused upon a young, disturbed man named Charles Whitman. In 1966, Whitman killed his wife and his mother and left a note admitting his confused state of mind. In this note he also requested an autopsy be performed on him. Following these murders, he climbed the tower at the University of Texas at Austin and began shooting indiscriminately at people below. Within 90 minutes he had killed 16 and wounded 32 passersby. It wasn't until an off-duty deputy sheriff climbed the tower and killed Whitman that the slaughter came to an end (Reese, 1987a).

During this interview with the deputy (about 14 years following the incident) I learned that there were no psychological services available for him through his employing agency. In fairness to the agency, I know of no law enforcement agencies that, in 1966, had established a policy for mandating debriefing or other forms of psychological services following a shooting. Following the killing of Whitman, the deputy was questioned by authorities concerning what had taken place in the tower and then allowed to go home. He, like many law enforcement officers involved in critical incidents before him, returned to his home and family to attempt to cope with the events of the night and his reactions to them.

It is my assumption that the individuals of that era (1966) may recall the event and may even recall Whitman's name. The disturbance in the life of Whitman ended that day. Few, if any, will recall the name or names of the officers involved. The potential for disturbance in their lives began that day, with the potential of living on.

Out of fairness, it is important to state that at the time of this interview I was not well versed with regards to critical incident reactions, or as it was then referred, postshooting trauma. I knew only that which had been taught to the FBI by Dr. Michael Roberts, San Jose, California Police Department, and information

gained through the publications of Dr. Martin Reiser, Dr. S. Al Somodevilla, Dr. John Stratton, and a few others. Perhaps more importantly, the interview of this deputy sheriff was in concert with an FBI National Academy course entitled "Psychological and Sociological Aspects of Community Behavior," a University of Virginia School of Continuing Education course offered as a portion of the FBI National Academy curriculum. Thus, the interview focused upon the behavior of Whitman, not the reactions of the deputy. Retrospectively, it was not unusual to study the criminal behavior of the shooter rather than any potential psychological maladjustment by the officer(s) involved.

In this case, upon reflection, the shooter showed no signs of psychological maladjustment (some 14 years later) following the shooting and appeared to have been able to cope with the event satisfactorily and effectively and get on with his life. While it is true many officers involved in critical incidents adjust well, adapt quickly, and continue living normal lives, there are others who are less fortunate, through no fault of their own.

Research has shown that even the percent of officers who have adjusted well have undergone a significant event creating some change in their lives. Change has been referred to as the most common denominator to stress (Reiser, 1976). Therefore, critical incident debriefing and aftercare following such an incident should be mandatory.

The interview of the deputy sheriff in the Whitman case, given freely and objectively as possible, caused me to give a lot of thought to the obligations of many law enforcement organizations to its members. If, in fact, the whole is no more than the sum of its parts, then it must be realized that the "parts" of the law enforcement's "whole" are its officers, and a new significance is added to critical incident aftercare. I believed then, and have even more reasons to believe now, that critical incident care is a nonnegotiable responsibility for law enforcement agencies, not only to the participants and the observers of the incident(s), but to their support systems as well (Reese, 1982).

Events such as the one just described, together with other notable incidents such as the "onion field" incident (Wambaugh, 1973), serve as spectacular examples of events that have the potential to create psychological and physiological disequilibrium for law enforcement officers and their support systems. Officers, however, experience less spectacular critical incidents on a day-to-day basis throughout the world. These incidents include the use of deadly force, being the victim of intended deadly force, responding to serious accidents, natural disasters, terrorist incidents, dealing with the victims of crime and abuse, and myriad others.

Officers do not have to witness violence and death to suffer the potential hazards of critical incidents. Often the investigation of such events can cause an officer to become a vicarious victim (Reese, 1987b). As evidence of this, in 1987, I was invited to King County, Washington, to speak to the Green River Murders Task Force on the topics of stress and burnout. The officers of this task force had been involved in the investigation of multiple homicides for several years. Candid responses during the course of this talk with them revealed that some were experiencing varying degrees of the posttraumatic stress disorder. Almost a decade prior to this lecture, I addressed the Tylenol Task Force in Chicago. This task force included officers and federal agents involved in the investigation of deaths resulting from the lacing of Tylenol with cyanide. Similar symptoms as those observed in King County were present. In both cases, however, it is noted that officers and agents were coping well and functioning effectively.

It is also noted that surviving relatives, whether or not they themselves witnessed the death of their loved one(s), suffer long after the event. They, in fact, become "indirect victims," many of whom suffer all of the symptoms of posttraumatic stress disorder. Posttraumatic stress disorder has been described as a sequela to victimization (Raymond, 1988). Earlier, during the National Symposium on Police Psychological Services, held at the FBI Academy in 1984, Stillman (1986) identified invisible victims as police survivors, injured officers, and officers who kill.

While not appearing to be easily defined as critical incidents, events as well as the subsequent investigations of events can also have a cumulative emotional effect upon officers and others if not treated. The emotional effect is one of disturbance, not well-being. As stated by Tozer (1955), "the bias of nature is always towards the wilderness, never the fruitful field." Using this premise, if left untreated emotional wellness will decline. Needless to say, this distress will be reflected in individual behavior and will touch every aspect of life.

Having lectured to thousands of law enforcement officers in my capacity as faculty member at the FBI Academy, and having counseled hundreds of officers, it is apparent to me that many departments are still not mandating, and in some cases not even providing on a voluntary basis, critical incident care. Ironically, except for a rare exception, the students I informally poll at the FBI Academy consistently believe that critical incident aftercare should be provided and should be mandatory. It seems difficult to believe that this concept of mandating critical incident care is still being debated.

TRAINING

"Learning without thought is labor lost;
thought without learning is perilous."
Confucius

Critical incident care should begin before the event occurs, with the hope for each officer that critical events will not occur. It has been stated that an officer must assume that, at some point in time, he/she will be involved in a critical incident. This has been referred to as "inoculation" training. I agree with this training concept. Among the many personal benefits to the law enforcement officer is the potential morale boost in simply knowing that the agency cares enough to provide them with information on critical incidents and that the agency has a policy to provide assistance to him/her if such an event occurs.

The argument to inoculation training most often voiced centers around the "self-fulfilling prophecy." It has been said that if people are informed concerning what may happen, it surely will. Statements such as this are irresponsible with regards to inoculation training. While it is true that "doctor-induced illnesses" do exist (Nash, 1985), information provided through properly designed training is proactive and can prevent, rather than induce, emotional crisis among officers. Law enforcement officers are basically intelligent, highly motivated people. Armed with the proper information, they are able to maintain themselves and, if needed, seek help. Such help can only be sought in an agency that allows officers to know the early warning signs of maladaptation and that offers a source for the help needed.

The FBI's Critical Incident/Peer Support Program, initiated and maintained by the Behavioral Science Services Unit (BSSU) of the Training Division, has progressed to the point of immediate, mandated critical incident aftercare. A pamphlet entitled Shooting Incidents: Issues and Explanations for FBI Agents and Managers has been distributed throughout the FBI. The pamphlet "summarizes the results of the research that the Bureau has conducted into shooting incidents in which agents have been involved." It takes into consideration not only the psychological but also the physiological and legal ramifications of such incidents. The pamphlet was written with emphasis on providing support to agents involved in shooting incidents from their own families and from "the FBI family."

The research was conducted by Supervisory Special Agent (SSA) John Henry Campbell, Unit Chief of the BSSU, and the pamphlet was authored by SSA Campbell in concert with SSA Robert Schaefer and SSA Thomas Miller. The program is now under the direct supervision of, and is continually being refined by, SSA James M. Horn. As a part of this refinement, recommendations have been forwarded to the Director of the FBI to make changes, including changing the word "shootings" to the term "critical incidents."

The pamphlet is divided into three parts. The first part addresses the psychological and physiological aspects of shooting incidents involving FBI agents. Part II concerns legal issues while Part III delineates guidelines for supervisors and managers. Part III directs that managers ensure that contact has been initiated between the involved agent(s) and psychological services, and that involved agents receive a briefing concerning postcritical incident trauma.

Each new agent entering the FBI is provided with three hours of instruction concerning law enforcement stress and critical incident reactions. If an agent experiences a critical incident within the course of his/her career, that agent is afforded an opportunity to return to the FBI Training Division (FBI Academy) for a three-day intensive Critical Incident/Peer Support Agent in-service training program. During this time, each agent is exposed to lectures and discussions concerning critical incidents, posttraumatic stress disorder, and counseling skills. They are then provided individual interviews/counseling sessions by members of the BSSU. It is during this time that an evaluation is made concerning their willingness to serve as a peer support agent as well as the interviewer's recommendation with regards to whether they are likely candidates for this position at this time. This "judgment call" is based upon their adaptation to the critical incident they were involved in. This session also offers an excellent opportunity for referrals if deemed necessary. All of the reasons for the interview/counseling session as stated above are clearly stated to each agent prior to any interview.

Following the training program, each attendee is asked to provide an evaluation of the training received, as well as critique the critical incident/peer support program within the FBI. The results of these critiques are provided to the Deputy Associate Director for decisions regarding appropriate action. It is noted that many changes within the program have been the direct result of FBI management consideration of these critiques by the agents involved in critical incidents.

JUSTIFICATIONS FOR MANDATORY CRITICAL INCIDENT AFTERCARE

> "Civilians have seldom understood the real danger inherent in police work. It has never been particularly hazardous to the body, not since Sir Robert Peel first organized his corps of bobbies. This line of work has always been a threat to the spirit."
>
> Joseph Wambaugh
> Echoes in the Darkness (1987)

There still remains a chasm in police psychology concerning whether critical incident aftercare should be mandatory or voluntary on the part of the involved officers. While arguments have been presented both pro and con, there seems to be overwhelming support for mandatory aftercare. While research is currently being conducted with regards to critical incident aftercare, I believe that common sense has told us what must be done long before research will confirm that it should be done.

Timely and proper crisis intervention relies upon several factors. Among these are an individual's ability to recognize and state that he/she needs help; information with regards to where help can be obtained; and the timely availability of this help at the time it is requested (Leavitt, 1976). The initial two factors can be achieved through proper training with regards to informing officers of early warning signs and symptoms, letting officers know that they should monitor themselves, and providing information about the helping services. The last factor, availability of helping services, is the burden of the agency and its agreement with the helping services.

Justifications for a law enforcement agency mandating critical incident aftercare in the form of debriefing, group or personal, are numerous and far outweigh any arguments to the contrary. Some of these justifications are documented hereafter.

Many officers do not seek help following a critical incident because of "image armor"; the need to look strong, competent, and in control. The maintenance of this law enforcement image is due, in part, to the idea among officers that they should not express emotions and that seeking help is frowned upon as a sign of weakness. This image armor and subsequent resistance to seeking help are further perpetuated by the use of psychological defenses such as isolation of affect, denial, and others.

With mandatory visitation to a licensed mental health professional (psychiatrist, psychologist, counselor), everyone involved in a critical incident must honor an appointment to attend a debriefing session. This may be viewed as "anticipatory guidance" (Leavitt, 1976) focusing upon the critical incident rather than the individuals affected by the incident. This is not a counseling session, per se, but may well result in one. The primary purpose of this visit is to provide the affected individual(s) with information germane to critical incident reactions, to include defining a critical incident, providing historical information concerning symptoms that research and experience have shown can develop, and offering suggestions for coping, in the event difficulties arise.

Mental health professionals will be among the first to state that counselors cannot counsel one who wishes not to be counseled. I do not argue with this statement. A law enforcement officer, however, following a critical incident, is in a compromised position concerning his/her ability to see the need for debriefing/counseling. Also experiences of others involved in shootings (critical incidents) are often different (Stratton, 1984).

Absent the recognition of this need, the law enforcement officer will most likely resist counseling. By causing the officer to visit a mental health professional on a mandatory basis, the officer is provided the opportunity to speak, to ventilate feelings, and/or ask questions, without appearing to be seeking help. He/she also has the option of remaining silent while receiving the information deemed to be useful by the mental health professional concerning critical incident reactions.

Of importance is the fact that some individuals experience immediate reactions while others' reactions may be delayed. Regardless of the time frame for the experiencing of possible reactions, many may fail to recognize that a problem exists and/or convince themselves that they can "work it out themselves"; thus, another reason why inoculation training utilizing anticipatory guidance is an absolute. It provides affected officers with valuable information concerning the problem and solution, whether they believe they need it or not, and increases the potential for timely intervention.

For those experiencing psychological discomfort, assistance must be provided during this time of disequilibrium. Armed with proper information concerning critical incidents and being made aware of the help available, officers are more likely to ask for help, or be more amenable to help offered.

A mandatory initial visit eliminates the need for an officer to stand out as one who admits needing help, but of equal importance, this initial visit eliminates the "cold call." It becomes significantly easier for an officer to call a counselor with whom he/she has already spoken and established some rapport. This is especially true when the initial visit ends with the mental health professional encouraging the officer to call if difficulties arise or if he/she has any questions.

An initial visitation also removes self-doubt with regards to feelings about an incident. Not many officers have the time or inclination to review the literature concerning critical incidents. Therefore, the "normal" reactions to abnormal situations, such as survivor's guilt and others, can be explained and reduced in most cases. Self-doubt is also greatly reduced when one discovers that he/she is not the only one who has ever suffered symptoms following a critical incident.

SUMMARY

Mandatory critical incident training and aftercare in a police agency is not a sign of weakness; rather, it is the very strength of the department. In addition, law enforcement administrators may wish to view this mandate in light of vicarious liability; as being not only a form of protection for its officers, but for the agency itself.

When the law enforcement agency takes the initiative to respond favorably and sensitively to officers who have experienced critical incidents, it gives officers a morale boost, a source of help, and gives true meaning to "the police family."

Critical incident training and aftercare must be mandatory and accessible to all involved personnel, to include officers, support personnel, and families. Mandatory aftercare is a way of protecting and serving those who "serve and protect."

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POLICE PSYCHOLOGICAL SERVICES: A HISTORY

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ABSTRACT

The earliest involvement of behavioral scientists in the law enforcement field appeared to be about 1916 in the selection of police candidates. They were employed part-time to do psychological testing. Subsequently, the assistance of behavioral scientists expanded to include operational help in such matters as hostage negotiation, criminal personality profiling, domestic crisis intervention, crime scene analysis, and counseling with police officers regarding personal problems inherent in police work. These early efforts seemed to come together in 1968 when the Los Angeles, California, Police Department hired a full-time psychologist, thereby giving formal recognition of their importance. Some feel that this event marked the birth of police psychology as a specialty within the field of psychology. Police psychology developed notably thereafter. This development is marked by a steady increase in the number of police departments employing full-time and/or part-time psychologists, the growing number of conferences and symposia wherein police psychologists share their successes and failures in the law enforcement setting, and the recognition by the American Psychological Association of police psychology in 1982 by designating a special section of an affiliate for psychologists who work in law enforcement. These developments are evidence that psychological services in law enforcement organizations in the United States have become an essential component of contemporary law enforcement programs.

INTRODUCTION

Although the debilitating effects of stress have been identified in police work, the problem of helping officers in resolving these effects remains very real. Many of today's modern law enforcement agencies are meeting this problem through the use of full-time or consulting mental health professionals. However, such practice is in an early developmental stage. It is therefore important to examine the early roles behavioral scientists played in law enforcement so that the evolution and growth of psychological services in law enforcement can be documented and recorded. It would appear that the introduction and use of psychological services in law enforcement organizations in the United States represents a significant development in police work.

A number of articles have been published in the research literature and proceedings of police conferences and seminars on one aspect or another of the provision of psychological services by mental health professionals to law enforcement agencies. These studies have addressed such matters as the need for psychological services in urban police departments, the identification of problems facing mental health professionals who practice in a law enforcement setting, and the contribution of empirical findings to the body of research data on police psychologists and the psychological services they provide to police who staff law enforcement agencies in the United States. However, no research has been done which, of and by itself, traces the historical development of such services.

Police stress, as well as stress in general, has been studied from many angles. Michael Roberts addressed the problem of an officer's personality changing due to the stress of police work[1] while Morris advised that the personality of an officer can amplify job stress.[2] Rosenman and Friedman examined stress from their now renowned Type A and Type B personality approach to behavior patterns. They asserted that individuals with a Type A personality described as competitive and "driven," were more susceptible to stress than were those with a Type B personality. Neiderhoffer looked at another source of stress intrinsic to the police officer's job; namely, anomie. Anomie is characterized by the absence of faith in people, of pride and integrity.[3] Other influences at work in the creation of stress in police officers are promotions, shift work, and irregular and lengthy court appearances.[4]

Reiser has indicated that change is the most common denominator to stress.[5] Holmes and Rahe, using their Social Readjustment Rating Scale, have attempted to identify the impact change has on one's health. More recently, Sewell, in his dissertation, The Development of a Critical Life Events Scale for Law Enforcement, identified events that cause change in the professional life of a police officer, such as being shot and/or having a partner killed, thereby furthering the efforts made in identifying those events in a police officer's life that may create undue stress.[6]

According to Crime in the United States, in 1986 there were over 470,000 law enforcement officers and more than 12,000 law enforcement agencies in the United States.[7] The growth of the police profession to over 470,000 police officers in today's law enforcement agencies, combined with the ever-increasing and changing role of the police officer in society, indicates a historic growth and change pattern in the profession that seems to embrace an inherent stress on people working in it. Regardless of the many roles society calls upon the law enforcement officer to play, "training typically emphasizes narrowly defined aspects of the job dealing with criminal activity, understanding relevant laws, effective firearms training, self-defense, and other

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[1]Michael Roberts, lecture before the National Executive Institute, May 19, 1979, FBI Academy, Quantico, VA.

[2]Hoyt Morris, "Police Personalities: A Psychodynamic Approach," The Police Chief, January 1981, pp. 49-52.

[3]M. Friedman and R. Rosenman, Type A Behavior and Your Heart (New York: Alfred A. Knopf, Inc., 1974); Arthur Neiderhoffer, Behind the Shield: Police in an Urban Society (New York: Anchor Books, 1967), pp. 95-98.

[4]Robert Schaefer, "The Stress of Police Promotions," FBI Law Enforcement Bulletin, May 1983; S. Cobb and R. Rose, "Hypertension Peptic Ulcer, and Diabetes in Air Traffic Controllers," Journal of the American Medical Association, 224 (1973) 4:489-491; William H. Kroes, Society's Victim: The Policeman (Springfield, IL: Charles C Thomas, 1976).

[5]Martin Reiser, "Stress, Distress, and Adaptation in Police Work," in Job Stress and the Police Officer, eds. William Kroes and Joseph J. Hurrell, Jr., p. 17.

[6]Thomas H. Holmes and Richard H. Rahe, "The Social Readjustment Rating Scale," Journal of Psychosomatic Research, Northern Ireland, Pergamon Press, 1967, (11): 213-218; James D. Sewell, "The Development of a Critical Life Events Scale for Law Enforcement" (Ph.D. dissertation, Florida State University, 1980), p. 118.

[7]Crime in the United States, Uniform Crime Reports, U.S. Department of Justice (Washington, DC: U.S. Government Printing Office, July 27, 1986), p. 242.

survival techniques."[8] Strategies for coping with job-related stress are seldom, if ever, considered. Eisenberg stated that a better understanding of stress is indeed an important requisite for minimizing many of the several dozen sources of psychological stress resulting from police work.[9]

PSYCHOLOGY AND POLICE SELECTION

Although psychological technology has been used in the personnel field for many years, its application in selecting police personnel has covered a much shorter time.[10] Originally, there were few guidelines for the selection of police officers. Some hiring officials were convinced that a fit body was sufficient criterion for employment of police, while others believed the ability to use a revolver and the knowledge of the law constituted adequate qualification. Behavioral scientists suggested a more objective and promising criteria, minimum levels and certain kinds of personality attributes. They claimed to be able to provide these kinds of selection data through psychological assessment of police candidates.

The foundation for psychological assessment in police work can be traced to about the turn of the twentieth century.[11] It was then that mental health professionals first became involved with some law enforcement agencies by helping them to select their police officer candidates.

Lewis Terman and his associates at Stanford University conducted one of the earliest documented studies of police selection. Terman believed general intelligence, notwithstanding moral integrity, was the most important quality needed in a police officer, and he further believed that general intelligence could be successfully measured through psychometric instruments. His earliest attempt to do so was in 1916 and utilized the Stanford-Binet Intelligence Scale, which was the original Binet-Simon Scale, revised and translated by Terman and his associates. Using an abbreviated form of the Stanford-Binet Intelligence Scale, they tested police officers in San Jose, California, to establish their intelligence as a step toward setting criteria for police selection.[12] Terman recommended an intelligence quotient of 80 as a minimum standard for employment for police.[13]

In 1922, Louis Thurstone, an influential psychologist, established valid principles for measuring intelligence, attitudes, and personality. In an article relating to the selection of police officer candidates, he

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[8]John G. Stratton, "Psychological Services for Police," Journal of Police Science and Administration, 8 (March 1980): 38.

[9]Terry Eisenberg, "Labor Management Relations and Psychological Stress: View from the Bottom," The Police Chief, November 1975, pp. 54-58.

[10]Philip A. Mann, "Ethical Issues for Psychologists in Police Agencies," in Who is the Client?, ed. John Monahan (Washington, DC: American Psychological Association, 1980), p. 18.

[11]Michael P. Maloney and Michael P. Ward, Psychological Assessment: A Conceptual Approach (New York: Oxford University Press, 1976), p. 20.

[12]Lewis Terman and Arthur Otis, "A Trial of Mental and Pedagogical Tests in a Civil Service Examination for Policemen and Firemen," Journal of Applied Psychology I (1917): 21.

[13]Charles D. Speilberger, Police Selection and Evaluation (New York: Hemisphere Publishing Corp., 1979), p. 15.

reinforced the importance of intellectual ability.[14] Intelligence continues to be a significant hiring criterion in present-day police selection.

Many psychometric instruments and examinations have been utilized through the years in selecting police officers. A major reason for using psychological tests in police personnel work is to predict job suitability of candidates for police positions.[15] The need for testing as a precondition of hiring to find the most competent--and eliminate the disturbed--applicant was emphasized by the President's Commission on Law Enforcement and the Administration of Justice:

> In society's day-to-day efforts to protect its citizens from the suffering, fear, and property loss produced by crime and the threat of crime, the policeman occupies the front line.[16]

In 1968 the President's Commission on Law Enforcement and the Administration of Justice recommended the utilization of psychological tests in the selection of police personnel. The rationale for this recommendation was that through such examinations, the emotionally unstable individual could be identified.[17] The Commission stated:

> Until reliable tests are devised for identifying and measuring the personal characteristics that contribute to good police work, intelligence tests, thorough background investigations, and personal interviews would be used by all departments as absolute minimum techniques to determine the moral character and the intellectual and emotional fitness of police candidates.[18]

In the same year, the U.S. National Advisory Commission on Civil Disorders, in its report to the President concerning the role of law enforcement, stated that there needs to be a method or means to eliminate police officers whose duties would be hampered by their personal prejudices. Their recommendation was that law enforcement departments use psychologists and/or psychiatrists to interview applicants and have them administer a battery of psychological examinations to determine fitness of candidates.[19]

If there is a traditional role for psychiatrists, psychologists, psychiatric social workers, counselors, and other mental health professionals in the United States, it has not been one of helping law enforcement officers function efficiently and effectively. Although psychologists conducted mental tests on law enforcement candidates as early as 1916[20] in efforts to select the very best candidate for the police officer position, the literature indicates they knew little in terms of how they might assist law enforcement in other ways.

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[14]Ibid, Louis L. Thurstone, "The Intelligence of Policemen," Journal of Personnel Research I (1922): 64-74; International Encyclopedia Psychiatry, Psychology, Psychoanalysis, and Neurology, (ed) Benjamin B. Woloman (New York: Aesculapius Publishers, 1978) 11:174.

[15]City Managers' Yearbook (Chicago, IL: International City Managers' Association, 1931), p. 143.

[16]President's Commission on Law Enforcement and the Administration of Justice, The Police: The Challenge of Crime in a Free Society. (Washington, DC: U.S. Government Printing Office, 1967), p. 92.

[17]President's Commission on Law Enforcement and the Administration of Justice Report, 1968.

[18]Ibid, p. 10.

[19]National Advisory Commission on Civil Disorders Report, 1968.

[20]Lewis Terman and Arthur Otis, "A Trial of Mental and Pedagogical Tests," p. 21.

Correspondingly, law enforcement officers did not know what type of help they could receive from mental health professionals. An apparent lack of communication existed between the professions.

In 1974, Charles Rogovin stated that policing and the problems inherent in the occupation, together with the personal problems of its practitioners, were of little interest to behavioral scientists.[21] As testimony to this apparent lack of interest, Arthur Neiderhoffer, a noted author on the police role in society, discovered that during the period 1940 through 1965, the two major social science journals of the time, the American Journal of Sociology and the American Sociological Review, published only six articles relating, even indirectly, to the police.[22] A review of other pertinent literature confirms that the major area of specialization by mental health professionals was that of officer selection, not the personal problems of police officers.

Even though mental health professionals have taught police many techniques of mental health care delivery to use in assisting the public with their problems, such as family crisis intervention, and have helped to provide objective assessments of the caliber and character of officers through the development of selection procedures, they still lack total acceptance within the law enforcement community.

> Psychologists, psychiatrists, forensic experts, and mental health professionals, in general, are viewed with a jaundiced eye by most law enforcement officers.[23]

It has been only within the last two decades that law enforcement organizations started to come to terms with the occupational stress experienced by police through services provided by mental health professionals. These professionals tended to be consultants rather than full-time members of the law enforcement agency. The source for such consultation in many departments can be traced back as far as the 1940s, to employee assistance programs.

EMPLOYEE ASSISTANCE PROGRAMS

Since the 1940s, government and industry have focused on the principle that the welfare of the organization is highly dependent on the welfare of the people in the organization. Industry was first in assisting those with personal crises through its employee assistance programs. A major portion of the clients in these programs had problems with alcohol addiction. Throughout the 1960s and 1970s, alcohol education remained the major thrust of almost every employee assistance program. Later, programs evolved as an outgrowth of the assistance programs begun in the post-war years of the 1940s.[24]

As an example, the current Boston Police Stress Program originated in the 1950s. Initially, it was an alcohol-abuse counseling group and was modeled after the highly successful Alcoholics Anonymous

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[21]Charles H. Rogovin, "The Need is Now," in The Police and the Behavioral Sciences, ed. J. Leonard Steinberg and Donald W. McEvoy (Springfield, IL: Charles C Thomas, 1974), p. 15.

[22]Arthur Niederhoffer, Behind the Shield: Police in an Urban Society (New York: Anchor Books, 1967), p. 4.

[23]Al Benner, "Concerns Cops Have About Shrinks," unpublished paper presented at the Symposium on Psychotherapy and Law Enforcement, San Francisco, CA, 8 April 1982.

[24]John G. Stratton, "Employee Assistance Programs: A Profitable Approach for Employers and Organizations," The Police Chief, February 1985, pp. 31-33.

Program.[25] By 1959 a patrolman, Joe Kelly, was assigned full time to manage the program. Fearing that the title of Alcohol-Abuse Counseling Group might make some individuals reluctant to enter the program, Patrolmen Joe Ravino and Ed Donovan expanded the program in 1973 to include any personal problem regardless of its nature or extent. Later, Donovan became president of the International Law Enforcement Stress Association.

Other early employee assistance programs established in law enforcement were the Chicago Police Officers' Fellowship, started in 1955 for alcohol problems, and the New York City Police Department's Alcohol Program, established on May 12, 1966.[26] The New York City program began as a counseling service by Monsignor Joseph A. Dunne, the department chaplain.[27]

The Los Angeles County, California, Sheriff's Office initiated an alcohol program on September 11, 1975. In the same year, the Chicago Police Department established a counseling office. Boston expanded its alcohol program on November 15, 1976, with the beginning of the Boston Police Stress Program. The San Francisco Police Department followed suit by establishing a Stress Unit on February 3, 1983.[28]

In 1986, the major police departments in the United States had some form of stress unit, or some other means of helping officers cope with personal and occupational problems.[29] In many cases, as previously cited, alcoholism brought on the need. Whether the predication for the assistance was alcohol, brutality, civil liability, or legal decisions affecting the department (among which are notable decisions regarding "negligent retention"[30]), the foundations for the provision of psychological services by mental health professionals in law enforcement organizations were strengthened.

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[25]Edward C. Donovan, "The Boston Police Stress Program," The Police Chief, February 1985, pp. 38-39.

[26]New York City, NY Police Department memorandum, "Counseling Service, City of New York Police Department," attached to Office of the Mayor executive order no. 70, July 7, 1971; this memorandum enclosed material that revealed the date of the origin of the Alcohol Program for New York City Police Department as May 12, 1966.

[27]Police chaplaincy in general has since become even more involved in the emotional and spiritual well-being of police officers as witnessed by the establishment of the International Association of Police Chaplains in 1973.

[28]County of Los Angeles, CA, Office of the Sheriff, Unit Commander's Letter No. 188, September 11, 1975, "Proposed Alcohol Program"; Marcia Wagner, "Action and Reaction: The Establishment of a Counseling Service in the Chicago Police Department," The Police Chief, January 1976, pp. 20-23; Boston (MA) Police Special Order to All Sworn Personnel, November 15, 1976, "Stress Program"; Information Bulletin, San Francisco (CA) Police Department, "Stress Unit," February 3, 1983.

[29]This is based upon professional contacts by the writer with the following (10 largest) police agencies: New York, NY; Suffolk County, NY; Nassau County, NY; Chicago, IL; Los Angeles, CA (police); Los Angeles, CA (sheriff); Philadelphia, PA; Detroit, MI; Houston, TX; and Honolulu, HI.

[30]Negligent retention refers to a police department's decision to retain an officer whose employment should have been terminated due to factors, on or off duty, affecting his ability to perform his duties safely and/or effectively.

PIONEERS IN LAW ENFORCEMENT PSYCHOLOGICAL SERVICES

Among the first in the mental health profession to utilize psychological principles in a useful form for law enforcement officers was Dr. Harold Russell. In 1953, Dr. Russell worked as a psychologist with the first Criminal Court Clinic to serve a Federal Court. Later, as an officer in the U.S. Army as well as following his retirement, Dr. Russell served as part-time consultant to numerous police departments. His utilization of psychological principles ranged from teaching officers about the use of defense mechanisms in interviewing to interpreting behavior and motivations of suspects.

Dr. James Shaw, currently of Olympia, Washington, is another mental health professional who must be considered a pioneer in the field of police psychology. He has been involved continually in police psychology since 1963 and states, "I have had the opportunity to watch the field [police psychology] gain wide acceptance by law enforcement officials."[31]

Another noteworthy mental health professional, Dr. Martin Symonds, a psychiatrist, was named as an honorary surgeon in the New York City Police Department in 1965.[32] His function was to check on officers in his district who were sick. He was also asked to conduct examinations in connection with disability claims. In 1972 he was formally employed as the head of that department's psychological services program.

The evolution from the employee assistance programs instituted for alcohol and related problems in police departments to the use of mental health professionals for personal problems of police officers has been slow and unpredictable. Utilized mostly on a consultation basis and largely for the purposes of police officer preemployment screening, police psychologists had very little chance to interact with the police on a personal basis prior to the early 1970s. Several significant events in the 1960s, however, provided behavioral scientists the opportunity to counsel officers and to assist law enforcement organizations operationally.

CATALYSTS IN THE DEVELOPMENT OF POLICE PSYCHOLOGY

These authors were unable to determine when police psychology first appeared as a career in the field of psychology. While an exact date is unknown, interviews with psychologists, as well as information from the literature, lead one to believe that this specialized occupation within the psychology profession, police psychologist, began in the 1960s.

It is believed that the specialty emerged from a series of critical incidents involving police officers. The following incidents occurred in the 1960s and are representative of those that drew police psychologists into law enforcement agencies. These incidents are deemed significant for illustrative purposes because of their national notoriety.

On a Saturday in March 1963,[33] a night that will long be remembered in law enforcement, two Los Angeles police officers, Ian Campbell and Karl Hettinger, began what seemed to be a normal shift on patrol in the Hollywood Division. Spotting a parked car that appeared suspicious, they decided to investigate. When the police approached the car, one of the two men in the car exited the vehicle and pointed a gun at Officer Campbell. Officer Hettinger had his gun drawn but surrendered it upon the demands of the gunman, fearing his partner would be killed if he didn't. The officers were kidnaped by the two suspects and driven to a

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[31]James H. Shaw to James T. Reese, personal correspondence, 23 April 1984.

[32]Interview with Martin Symonds at Quantico, Virginia, 20 September 1984.

[33]For a more detailed account of this incident, see Joseph Wambaugh, The Onion Field, (New York: DeLacorte, 1973).

secluded onion field. Later Officer Campbell was shot and killed; Officer Hettinger escaped. It was seven years before the suspects were convicted of killing Officer Campbell. As for Karl Hettinger, he returned to duty and continually experienced feelings of guilt about his decision to surrender his gun on that March night.

Another incident that highlighted the need for the expertise of mental health professionals in police work occurred in August 1965. Two Caucasian California Highway Patrolmen stopped a black male, Marquette Frye, following a six-block chase. The chase ended within a 20-square-mile ghetto area called the Watts District of Los Angeles. When the officers attempted to arrest Frye for driving recklessly, he resisted. His resistance and the subsequent force exercised by the officers to subdue and get him into the patrol car were witnesses by blacks in the neighborhood. Before the incident was over, some 1,500 black people had gathered. This incident started the worst rioting and looting in U.S. history to that time.[34] Unlike the Officer Hettinger occurrence, in which a mental health professional could have been of help to a police officer with respect to his resolution of postcritical incident trauma, this incident highlights the need for psychologists to train officers in interpersonal crisis management, social psychology, crowd control, and other topics that would favorably influence police officers' behavior in dealing with the public.

Lastly, in 1966 a young man named Charles Whitman climbed the tower at the University of Texas at Austin and began shooting indiscriminately at people below. Within 90 minutes he had killed 16 and wounded 32 unsuspecting passersby. An off-duty Deputy Sheriff climbed the tower and brought the slaughter to an end by killing Whitman.[35] In an interview with the deputy about 13 years after the incident, it was learned that there were no psychological services available for him through his employing agency. Following the shooting and after being attended to at the scene and questioned by officials, he went home to attempt to cope with his reaction to this traumatic event.

Each incident heretofore described holds significance in its own way with regards to fostering the recognition of the need for services provided by mental health professionals in law enforcement. Collectively, they form a foundation from which the field of police psychology developed.

LOS ANGELES LEADS THE WAY

Psychological consultants have provided various services to law enforcement agencies in the United States for many years on a part-time basis. It was not until 1968, however, that a police department decided to hire a psychologist on a full-time basis. In view of the previously discussed incidents, it is not surprising that the department was the Los Angeles, California, Police Department. The man they hired was Dr. Martin Reiser.[36]

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[34]"Trigger of Hate," Time, Vol. 86, No. 8, August 20, 1965, p. 13.

[35]It was later determined that Whitman had a benign brain tumor that is credited, by some, for the aberrant behavior.

[36]Telephone interview with Dr. Martin Reiser, Los Angeles, CA, 30 July 1986. During this interview, Dr. Reiser advised the writer that he knows of no police department that predated the Los Angeles Police Department in hiring a full-time psychologist.

In Dr. Reiser's opinion, there were three major reasons the Los Angeles Police Department felt a need to hire a police psychologist; namely: (1) the aftermath of the Watts District riots, (2) reports of the President's Commission regarding improvement of law enforcement psychological services, and (3) "bad press" in the Los Angeles area due to questionable police actions.

With no models to follow nor mentors to query, he blazed trails for mental health professionals to follow. Among his many functions in this new role as police psychologist were counseling and therapy for both officers and their families, teaching, research, training in stress awareness and coping, testing, hostage negotiation consultation, and consultation with management about policies as well as with police officers about crime.[37] Dr. Reiser is widely known as the "father of police psychology."

In 1972, Dr. Reiser published a book, The Police Department Psychologist.[38] Obviously aware of his pioneering efforts on behalf of all psychologists, Dr. Reiser stated in the preface that he wrote the book: ". . . with the expectation that in the future the psychologist (behavioral scientist) will be lessof a rare bird in the police profession."[39] Dr. Reiser has since published other books and numerous articles on police psychology.

During the early 1970s, following Dr. Reiser's employment by the Los Angeles Police Department, a large concentration of literature came from the behavioral sciences focusing on the criminal justice system, police agencies in particular.[40] This literature, along with incidents such as those described earlier, helped to advance the cause for the provision for psychological services in law enforcement organizations.

> As a consequence of (a) the recommendation of the Task Force on the Police (President's Commission on Law Enforcement and the Administration of Justice, 1967) and (b) the lack of effective problem solvers in the criminal justice system. . . mental health professionals, particularly psychologists, have become increasingly entrenched in the criminal justice system.[41]

Soon thereafter, the Law Enforcement Assistance Administration (LEAA), now defunct, provided money to police departments to assist in providing them with some expertise and support. The LEAA 1970 Discretionary Grant Program set money aside to fund the hiring of psychiatrists and psychologists to work with a number of medium-sized and larger police departments on a regular basis. Since that time, many departments have included funds for psychological services in their budgets. Thus, psychological services in law enforcement continued to gain support and momentum.

Dr. Reiser names the San Jose, California, Police Department as being the second department in the United States to hire a full-time psychologist. In 1971 the department hired a clinical psychologist, Dr. Michael Roberts.[42] In spite of the fact that there were no funds available, Dr. Roberts volunteered to provide these services during the summer and fall of 1971 free of charge. During that time, he made several trips and telephone calls to Dr. Reiser to consult about his program. Later in 1971, following a fatal shooting

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[37]Martin Reiser, The Police Department Psychologist, (Springfield, IL: Charles C Thomas, 1972), passim.

[38]Ibid.

[39]Ibid., p. vii.

[40]Jeffery A. Schwartz and Cynthia B. Schwartz, "The Personal Problems of the Police Officer: A Plea for Action," in Job Stress and the Police Officer, eds. William H. Kroes and Joseph J. Hurrell, Jr., pp. 130-141.

[41]Stuart Brown, et al., "Roles and Expectations for Mental Health Professionals in Law Enforcement," American Journal of Community Psychology, 5 (1977): 208.

[42]Telephonic interview with Dr. Martin Reiser, 30 July 1986.

of a citizen by a San Jose police officer, the San Jose Peace Officers Association and the Chief of Police managed to fund the psychological services program and hired Dr. Roberts.

In 1971, history was once again made in police psychology when Harvey Schlossberg, a New York City police officer, became the first policeman to earn a doctorate in psychology and become a police department psychologist.[43] According to Dr. Schlossberg, in May 1971, the Police Commissioner for the City of New York, Patrick Murphy, called Dr. Schlossberg to his office. This call was based upon a computer printout within the department's personnel section that showed a patrolman, Schlossberg, with a doctorate. The Commissioner was interested to know from Dr. Schlossberg how the department could benefit from this education. In answer to this question, Dr. Schlossberg wrote a memorandum to the Commissioner stating his ideas on how he could best assist officers of the New York City Police Department. This memorandum set the stage for his eventual transfer to the Medical Section of the department as a psychologist. He was to set up a unit to put psychological principles to work to help policemen in their personal lives and their jobs.

It was believed that his experience as a police officer gave him an additional dimension to bring to the job; namely, first-hand knowledge of the police personality and "real world" interaction with criminals. On January 19, 1973, this added dimension paid off, as demonstrated with the following scenario. In the Williamsburg section of Brooklyn, New York, criminals took hostages in a sporting goods store following an attempted robbery. Within minutes one police officer was dead and two other officers were wounded. This incident became known as the "Williamsburg Siege," or "Brooklyn Siege." Dr. Schlossberg was called upon to assist in the negotiations to attempt to gain the release of the hostages.[44] He assisted in successfully negotiating the release of the hostages and soon thereafter, the New York City Police Department established a Hostage Negotiation Unit.[45]

Up to this time, mental health professionals were used mainly for counseling and testing. While there were isolated cases of psychologists assisting officers during hostage negotiations, nothing that attracted national attention had occurred. The operational assistance provided by Dr. Schlossberg during this hostage incident was accepted by officers and administrators alike as a natural extension of the use of psychologists beyond counseling. Thus a valuable role was added to police psychological services.

A subsequent major development in the history of police psychology occurred in 1973. James Hilgren and Paul Jacobs, clinical and industrial psychologists, respectively, began doing organizational research and some planning for the Dallas Police Department on a full-time consulting basis. In July 1973, Dr. S. Al Somodevilla became a part-time consultant teaching the Dallas officers crisis intervention. Officers soon began to come to Dr. Somodevilla with personal problems. The following April, Dr. Somodevilla became a full-time consultant and the Psychological Services Unit of the Dallas Police Department was established.[46]

About the same time, Dr. John Stratton was consulting with local police departments in southern California on a part-time basis, while employed by the Los Angeles County Probation Department. He left the Probation Department later that year to accept a full-time position as Director of Psychological Services with the Los Angeles County Sheriff's Department. A prolific writer, Dr. Stratton, like Dr. Reiser, helped add

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[43]Telephonic interview with Dr. Harvey Schlossberg, New York City, 4 August 1984; Telephonic interview with Dr. James Fyfe, Annandale, VA, 3 June 1986.

[44]Harvey Schlossberg and Lucy Freeman, Psychologist With a Gun (New York: Coward, McCann, and Geoghegan, Inc., 1974), passim.

[45]Telephonic interview with Dr. Harvey Schlossberg, 4 August 1984.

[46]Interview with Dr. S. Al Somodevilla, Richardson, TX, 10 June 1981.

numerous and meaningful articles to the then scant literature on police psychology.[47] In the same year, units offering medical/psychological assistance to police officers were established in Boston, Massachusetts; Chicago, Illinois; and Detroit, Michigan.[48]

By 1976 the Albuquerque, New Mexico, Police Department had hired an employee assistance counselor.[49] In 1977 a Police Stress Management Program was begun in the Miami, Florida, Police Department; and the Memphis, Tennessee, Police Department had hired Dr. Thomas Hickey as its police psychologist.[50] These are but a few of the police departments throughout the United States that were among the first to contract with mental health professionals for psychological services, either on a full-time or part-time basis.

As has been discussed, psychologists have been used in police agencies for several decades; however, there were only six police agencies with full-time psychologists and/or counselors by 1977 to deal with personal problems other than alcohol abuse.[51] Thus, part-time consultants were still in demand. In many cases, departments could not make offers financially attractive enough to lure psychologists away from lucrative private practices. Consulting psychologists were the next-best option in light of restricted department budgets.

In 1977 a Washington State Police officer, David Smith, became the first state police officer known to earn a doctorate and subsequently become the psychologist for his department.[52] Four years later, Joe Elam of the Oklahoma Highway Patrol earned a doctorate and was employed as department psychologist for the Oklahoma Department of Public Safety.[53]

Mental health professionals also found their way into the law enforcement system of the Federal Government. In 1980 a Psychological Services Program was established in the FBI.

Since the police psychology specialty within the psychology profession is so new, it is understandable that in 1990 no academies or academic institutions are known to have programs that train mental health professionals to be police psychologists. Degrees are obtainable in the behavioral sciences as well as in criminal justice, but there appears to be no formal merging of the disciplines. While there are courses dealing with "psychology and the law," these usually focus on crime-related topics such as "prediction of violence" and "mental status to stand trial."

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[47]Interview with Dr. John G. Stratton, Quantico, VA, 20 September 1984; Interview with Dr. John G. Stratton, Skiathos, Greece, 10 May 1985.

[48]These data were obtained from an unpublished manuscript produced by ABT Associates, Inc., Cambridge, MA.

[49]Interview with Jack Price, Chaplain, Albuquerque, NM, Police Department, at Quantico, VA, 12 June 1984.

[50]Interview with Dr. Thomas Hickey, Quantico, VA, 20 September 1984; telephonic interview with Dr. Thomas Hickey, Memphis, TN, 8 July 1986.

[51]John G. Stratton, "The Police Department Psychologist: Is There Any Value?" The Police Chief, May 1977, pp. 70-75. According to Dr. Stratton, these department were Boston, MA; Chicago, IL; Dallas, TX; Los Angeles, CA (Police); Los Angeles, CA (Sheriff); and San Jose, CA.

[52]Interview with Dr. David Smith, Quantico, VA, 17 December 1985.

[53]Interview with Dr. Joe Elam, Quantico, VA, 18 December 1985.

EMERGENCE OF UNITY

Police psychology has evolved slowly since the 1960s from a relatively unknown new discipline with an uncertain future to a recognized specialty within psychology, with roots firmly planted in the criminal justice system. In the past two decades, police psychologists have become widely recognized and accepted as integral parts of law enforcement organizations by police officers and administrators alike.

This successful evolution of police psychology is a product, to a large extent, of the professionalism and tenacity of early practitioners in the field. Their professionalism was critical in that their activities with law enforcement agencies were continually scrutinized, not only by police, but by mental health professionals as well. Their tenacious efforts to provide services such as counseling and psychological testing, as well as innovative applications of psychological principles in such matters as consultation in hostage negotiations and criminal personality profiling, aided greatly in its acceptance and continued popularity.

Also assisting in the growing popularity and success of police psychology was the willingness of these early practitioners to add their views and experiences to the expanding body of literature in police psychology. Not only did they present papers detailing their successes and failures as police psychologists, but they submitted written accounts of these matters to various mental health journals and police periodicals for publication.

As police psychology matured, the one topic that drew sustained interest among its practitioners was police stress. As more literature appeared in the 1970s indicating the debilitating effects of stress and the inordinate amount of stress endured by police officers, police administrators, many of whom were familiar with some of the research reported in the various mental health and police journals, started employing clinical psychologists to assist in the reduction of job stress.

Aside from the annual meetings of the APA, when psychologists who had a mutual interest in police work made an effort to seek each other out informally and discuss law enforcement issues, police psychologists were isolated from each other. There was no established network through which they could communicate. To remedy this situation, in the early 1980s, a local group of 10–15 mental health professionals and law enforcement officials (the number varied from month to month) began to meet monthly to discuss their concerns, problems, and ideas about psychological services in law enforcement organizations. Among them were Dr. Ellen Scrivner, then full–time consultant to the Fairfax County, Virginia, Police Department; Dr. Paul Clavell, the provider of psychological services for the Baltimore County, Maryland, Police Department; and Dr. Harvey Goldstein, Director of Psychological Services, Prince George's County, Maryland, Police Department. Collectively they became known as the Law Enforcement Behavioral Sciences Association (LEBSA). Although these mental health professionals were from the Baltimore–District of Columbia area, they recognized that the issues they discussed were very broad and had national implications. They agreed that their effort to share data and experiences, needs and aspirations, should be extended on a national basis.[54]

The psychologists active in LEBSA were also members of the APA. The APA affiliation was with Division Eighteen, Psychologists in Public Service. Division Eighteen brings together mental health professionals who provide assistance to public services, such as prisons and veterans' hospitals. In 1982, Dr. Harvey Goldstein, because of his involvement in LEBSA, provided the leadership necessary to form a new section within the APA's Division Eighteen, the Police Psychology Section.[55] With more than 150 members at the time of this writing, the Police Psychology Section is well–established and likely to grow.

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[54]Interview with Dr. Ellen Scrivner, Fairfax, VA, 6 December 1982.

[55]Interview with Dr. Harvey Goldstein, 17 May 1984, Quantico, VA.

While the debates continue concerning whether to hire a psychologist on a full-time or part-time basis, whether to have the office in the police facility or at an "off-site" location, and the many other considerations, police psychology and psychological services are being accepted by law enforcement organizations. Many argue that full-time programs will dominate the future. Others argue that the five functional areas of psychological activities in the criminal justice system, assessment services, treatment, training, consultation, and research[56] cannot possibly be done well by one person. Perhaps the future will witness a compromise of the two positions.

> Dr. Reiser was correct when he stated that the net result over time will be the diminishing of the perceived distance between the psychologist and the policeman. The birth of police psychology was unremarkable; there were no fireworks or parades. It developed slowly, out of infancy into childhood, and it obviously still has a lot of growing to do. But there is now a new specialty, with a small group of practitioners, a literature, and a future of unlimited potential.[57]

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[56]David Twain, Richard McGee, and Lawrence A. Bennett, "Functional Areas of Psychological Activity," in Psychologists in the Criminal Justice System, ed. Stanley L. Brodsky (Carbondale, IL: Admark, 1972), pp. 15-20.

[57]Martin Reiser, ed., Police Psychology: Collected Papers, (Los Angeles, CA: Lehi Publication Company, 1972), p. ii.

CONCERNS OF POLICE SURVIVORS--REACHING OUT TO AMERICA'S SURVIVING FAMILIES

Suzie Sawyer

When ten surviving families of law enforcement officers killed in the line of duty in 1982 traveled to Washington, D.C., on May 14, 1983, to hear the names of their loved ones read during the National Peace Officers' Memorial Day Service to be held the next day, little did they know that their informal gathering would be the beginning of a new movement to identify, study, and combat the trauma inflicted on the surviving families of law enforcement officers killed in the line of duty. One of the survivors suggested planning a seminar to coincide with the Memorial Service the following year. And what would we talk about?--DEATH and the trauma it inflicts on the survivors!

On May 14, 1984, 110 police survivors attended that first National Police Survivors' Seminar sponsored by the Fraternal Order of Police; and at the end of the day, these survivors voted to create their own separate organization to address specific needs of law enforcement's surviving families. That was the birth of COPS, Concerns of Police Survivors.

In 1985, COPS was the recipient of a grant from the National Institute of Justice that allowed COPS to do psychological research on the survivors, gather data on law enforcement agencies that had experienced line-of-duty death, and function as a national organization.

In our research (Stillman) with surviving spouses we found:

> A survivor's level of distress is affected by the police department's response to the tragedy.
>
> Spouses who were not notified of the death in person experienced additional trauma.
>
> 59% of the surviving spouses met the criteria for having Posttraumatic Stress Disorder.
>
> Younger women, especially if married for 10 years or less, had a more severe reaction to the death than older women married a longer period of time.
>
> The same level of distress is experienced by surviving spouses of officers killed accidentally and feloniously. There is NO difference in the sense of loss.

Major findings of our research with law enforcement agencies that lost officers included:

> 67% of departments surveyed lacked formal general orders addressing line-of-duty death.
>
> 58% of departments surveyed had psychological services units, but only 31% of those departments that had psychological services afforded survivors access to a staff psychologist.

80% of the departments kept records on spouses on file; more than 67% lack records on parents of their officers.

In 1988, COPS prepared a handbook, "Support Services to Surviving Families of Line-of-Duty Death." This handbook was based on the research findings in our survivors' study after hearing survivors discuss their concerns with the department's responses to the family immediately after the tragedy, during the funeral, and the weeks and months that followed. Major issues discussed in the handbook include:

1. Proper death notification.

2. Assisting the family at the hospital and acknowledging their right to visit the body before and/or following the demise.

3. Support for the family during the wake and the funeral.

4. Providing information and assistance on benefits to the surviving family.

5. Continued follow-up visits with the family.

6. Support for the surviving family during the trial.

7. The handbook provided a sample of a printed death benefits package that can be developed for each law enforcement agency to provide to the surviving family.

The handbook also calls attention to other areas of concern. There is definitely a need to secure or enhance educational benefits for the surviving children AND spouse. There is definitely a need to extend health insurance benefits to the surviving family at reasonable rates, perhaps continuing to have the department pick up the premium payments. Continuing the widow/widower pension even though the surviving spouse remarries is a sensitive issue for survivors; they feel that issue is ALWAYS a part of their history and that appeals, parole hearings, and other legal procedures continue to haunt their emotional recovery. It is the survivors' belief that these pension payments should not stop after remarriage.

There are several areas of concern for the living officers that are addressed in the handbook, too. There is definitely a need to debrief coworkers following a line-of-duty death or any traumatic incident that may occur throughout their career. We believe critical incident booklets should be developed and completed by officers and kept on file with the department or with their personal papers at home. Trauma teams are a must and those teams should most certainly have a police survivor as a member of that team. ALL departments should have general orders outlining their actions when line-of-duty death occurs. Law enforcement agencies should develop a system for timely review of beneficiary papers by each law enforcement officer. There is much work to be done with the law enforcement agency to sensitize it to the needs of the employees and their families.

The yearly major activity of COPS is the National Police Survivors' Seminar. The COPS Seminar in May 1989 in Arlington, Virginia, found nearly 500 police survivors attending sessions dealing with grief, anger and guilt, forgiveness, grief and addiction, helping children cope with grief, and many other topics. Police psychologists, grief counselors, peer-support personnel, and mental health specialists reaching out to survivors continue to make the COPS Seminars a tremendous success. One-on-one counseling was available to the survivors in addition to group discussions for surviving spouses, parents, siblings, adult children, significant others, fiances, and coworkers. Grief therapy sessions were conducted with the children attending the seminars during the morning hours and then the children were taken on tours of the Washington, D.C., area each afternoon.

COPS is now functioning through a grant from the Office of Justice Programs, U.S. Department of Justice. This grant allowed COPS to present the 1989 National Police Survivors' Seminar held May 13 and 14, and has afforded COPS the opportunity to have a staff of three employees and maintain a business office. COPS will be focusing on two major projects during the next year: (1) formation of an adaptable general orders policy addressing line-of-duty death and (2) development of a handbook for survivors telling them of the benefits due them and samples of letters they will have to write to various government agencies, creditors, and insurance companies following the death of their officer. COPS continues with its nationwide effort to organize local and/or state chapters and hopes to train survivors to be peer support volunteers. With peer support teams receiving more and more acceptance in law enforcement agencies nationwide, it is our goal to make these teams aware of the value that a police survivor can be when the next line-of-duty death occurs.

With over 150 line-of-duty deaths occurring each year in the Unites States, the resources for this national peer support network are definitely there--now all we must do is help these survivors heal and train them to reach out to the police surviving families of the future.

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PEER SUPPORT AND TRAUMATIC INCIDENT TEAMS: A STATEWIDE MULTIAGENCY PROGRAM

Eugene Schmuckler, Ph.D.

ABSTRACT

Although public safety agencies are beginning to accept stress as an occupational fact of life, recognizing the impact of traumatic incidents upon personnel still meets resistance. Organizational reluctance is expressed in statements such as "If they can't stand the heat let them stay out of the kitchen." Organizations refuse to deal with what it means for an individual to experience a psychological injury. This paper will describe the program developed by the state of Georgia to deal with these issues. It will address the resistance displayed not only from within the agency but also from what may be viewed as surprising sources. Furthermore, it will examine the means by which individuals from different types of agencies are molded into a unit.

INTRODUCTION

During the past fifteen years, stress and its consequences have been the focus of national and international concern. This concern does not stem exclusively from altruistic motives. The effects of negative stress have been identified as contributing to cardiovascular ailments, gastrointestinal problems, dermatological conditions, and a wide range of behavioral and emotional sequelae. The economic impact of stress is measurable in terms of absenteeism, accidents, substance abuse, and turnover.

Stress is of particular concern when the affected individual is a public safety officer entrusted with weaponry; the ability to make life-and-death decisions; and is charged with responsibility for the public's safety. Economic concerns draw attention to the fact that many stress reactions are costly to the employing agency in terms of increased liability risks and thus higher insurance premiums, loss of valuable personnel, low levels of morale, high absenteeism, reduced competency levels due to substance abuse, and increased public displeasure from those on the receiving end of physical or verbal abuse.

Recognition of the effects of stress has not led to a groundswell of stress management programs in the public sector. A number of factors contribute to this relatively low response. For public safety employees, helping professionals (psychologists, psychiatrists, social workers, EAP counselors) are viewed with suspicion. Many public safety officers question the professional's competency with statements such as, "He/she needs help more than I do." Sitting in waiting rooms in which they may encounter persons they have met in pursuit of their duties adds to the discomfort of seeking help. Officers may doubt the service's confidentiality. Officers cite the fact that they often know when one of their colleagues receives professional counsel within moments after the individual leaves the professional's office. Insurance claim forms can inadvertently become a matter of public record, further adding to the resistance to seeking help.

Many agencies are also reluctant to allow affected individuals to seek professional assistance. Senior officers are of the opinion that "They aren't making them like they used to." Allegedly able to handle any stressors they might encounter, they are unable to understand why their charges are not able to function in the same way. There is also concern that the public will lose respect for the agency if it becomes known that officers seek and receive assistance from helping professionals. Still another concern is that which deals with the ability of one who has been to a "shrink" to function in a line-of-duty situation.

All of these concerns were and still are present within the public safety ranks in the state of Georgia. The geopolitical structure of the state is another element that may frustrate an individual's ability to seek help. There are over 150 counties in the state, many of which are rural in nature. Mental health facilities may not be readily available. The majority of law enforcement agencies consist of less than 10 sworn officers. For an individual to take time off from work to seek help results in the agency functioning shorthanded.

Awareness of these circumstances, along with serendipity, is in part responsible for the program in Georgia. The efforts of several progressive law enforcement agency chiefs and a representative of the Georgia Department of Human Resources led to the writing of a proposal presented to a gubernatorial candidate, Mr. Joe Frank Harris. Upon his election, Governor Harris issued an Executive Order directing that the Georgia Peace Officer Standards and Training Council (POST) conduct a study "for the purpose of identifying the specific symptoms of law enforcement personnel distress." Further, the Council was directed to develop a program "to assist law enforcement executives in managing stress-related personnel problems within their agencies and to make recommendations to the Governor concerning the appropriate role of the state in implementing such programs." To assist in this effort the Executive Order directed POST to enlist the expertise of the Department of Human Resources, the Criminal Justice Coordinating Council, the Department of Community Affairs, law enforcement executives from both the state and local level, local government officials, academicians, and knowledgeable members of the general public to participate in this study. The Council in turn established a Law Enforcement Stress Task Force to be coordinated by the Governor's Office of Planning and Budget. By having representatives from all the above-mentioned agencies involved at the onset, the task of persuading the legislature to implement the recommendations became significantly easier.

During the course of the study it was found that some individual departments were already making attempts to provide services designed to help officers overcome the effects of negative reactions to stressors. In a majority of instances the programs focused on the use of a department chaplain who may or may not have had specific training in counseling peace officers. Only a few agencies maintained a referral relationship with a mental health agency or a mental health professional.

The completed study offered a number of recommendations. This paper will focus only on two of the categories. The first concerns the individual's stress-coping ability. Centered mainly in a didactic modality, the approach focuses on increasing the stress awareness of individuals. The second category is concerned with providing assistance to stressed individuals. The study stated, "In close relation to the self-help technique is the peer counseling where officers help each other. Peer counseling becomes a kind of first line of defense that does not replace existing programs such as AA or drug programs, but aids the affected officer in accepting that there is a problem and in finding appropriate assistance."

Armed with the results of the study, the Task Force went before the state legislature requesting a Project Coordinator be named to continue the program on a full-time basis. The combined support of all participating agencies was a major reason for the legislature creating the requested position.

THE GEORGIA PROGRAM

The position of Stress Management Supervisor became operational on July 1, 1984, and was housed in the George Police Academy. Placement within a training facility dictated that the primary focus would be on providing training as opposed to psychological services. It was further dictated that programs would not be restricted to law enforcement but would be available to all Georgia public safety personnel, i.e., firefighters, EMTs, and correctional officers. In 1987, the position was moved from the Police Academy to the Georgia Public Safety Training Center. This organizational change made the program more accessible to non-law-enforcement personnel. Initial course offerings provided training in stress awareness and management. Programs were tailored for line personnel, first-line supervisors, and for chief executives of public safety agencies. A special program was designed for members of the helping professions to make them aware of the specific stresses confronting public safety personnel. These programs are still an integral part of the stress program. In addition, specialized blocks of instruction on stress-related matters are included in most course

offerings. For example, the judgmental shooting class includes a block of instruction relating to postshooting trauma.

Child abuse and family violence classes deal with stress awareness and prevention of burnout. Inclusion of these instructional blocks provides stress management information and also makes class participants aware of the other programs available to them. It has been found that providing line officers and first-line supervisors with information concerning the stress programs leads to a high likelihood of agency acceptance.

Long-term evaluation of the stress management and awareness programs indicated that their effectiveness was of relatively short duration. Officers returned to a work environment or a domestic situation identical to that which they left. The sources of stress were still present. They sought out social and peer support as suggested in class but found it to be unavailable to them. Their receptivity to seeking help was frustrated.

The POST study called for development of peer counselor programs. A number of elements needed to be taken into consideration before this program could become operational. Many agencies are too small to have their own peer counselors. It is recognized that in spite of assurances of confidentiality, individuals might still be reluctant to speak to a member of his/her own agency. Also, the program needed to be available statewide to all public safety agencies. Serendipity again came into play. The Emergency Health Unit of the Department of Human Resources recognized the need to develop a traumatic debriefing program. At a steering committee meeting it was decided that a preliminary requirement for one to serve on a debriefing team was successful completion of the Peer Counseling Training Program. As a result of the strong commitment on the part of this group, it was decided that the Peer Counselor Program would be undertaken on a regional basis using the 10 emergency health regions. In this way it was assured that every part of the state would have a pool of peer counselors, and with additional training, debriefers would be available. The regional concept is an important one and has been an important element in the program's success. Each emergency health region has a regional coordinator and a training coordinator. This facilitates communication and mobilization and leads to a sense of program "ownership" in each region.

Individuals may attend peer counselor training either by self-nomination or through selection by the agency head. Classes are limited to 18 participants. Class makeup includes individuals from different services and functions. This fact is not made known to participants until the afternoon of the first day of class. The initial peer counselor training class was held in June 1987. To date over 300 peer counselors have been trained. The training is not unlike that presented in other peer counselor programs. The participants are advised that their role is that of a counselor and not of a therapist. They are encouraged to work with professionals and refer whenever possible. The training includes basic communication skills, group dynamics, dealing with resistance, and problem solving. Specific issues covered include assisting suicide survivors, substance abuse intervention, dealing with death, and domestic relationships. A large segment of the 40-hour training course includes practical experience. Sessions are videotaped for evaluation. In the main, the response of participants has been extremely favorable. Even individuals who choose not to become peer counselors at the completion of the training have indicated that the training has had a marked impact upon their lives. Of greater significance is the fact that in those agencies in which the program is supported by management there have been marked reduction of stress-related problems. When a peer counselor leaves one of those agencies, the chief executive immediately seeks to have another individual go through the training.

Having firmly established the peer counselor training, it was possible to go on to the second phase, developing traumatic incident briefing teams. As stated above, members of the team must have first completed peer counselor training. It is strongly felt that the communication skills taught in peer counselor training classes are a necessary first level for debriefers. Individuals who are to be trained as debriefers must first receive endorsement from their agency. Without this endorsement they are ineligible to attend. Another way in which debriefer training differs from that given to peer counselors is that the training is presented at a facility in the region as opposed to having debriefers attend class at the Training Center. This makes it

possible for agency heads to observe what they may expect should their agency have the misfortune of being involved in a catastrophic situation. Offsite training also encourages mental health professionals to attend. Finally, the regional emergency health service training coordinator attends and plans for follow-up training. As with peer counselor training, debriefer training includes an extensive amount of practical experience. A program has been initiated with the Georgia Emergency Management Agency (GEMA) to include debriefings as part of their disaster management drills. Hospitals in the state are required to conduct disaster drills, and debriefings are now included as part of those programs. As a result, debriefing is now considered something to be expected after a disaster and not an afterthought. By having local individuals serve as the debriefers, continuity of service is maintained. Having the program's overall supervision housed at the Public Safety Training Center provides debriefers with a readily accessible resident individual to contact should problems develop. This arrangement has also led to the inclusion of debriefings as part of First Responder, Extrication, and elements of State Patrol training. This "first generation" training is being met with a highly favorable response by the trainees and their respective agencies.

It would be nice to say that the programs are totally successful. Unfortunately, that is not the case. The programs require constant marketing efforts. Public safety agency executives do not always enjoy job security. Participation of an agency during the tenure of one chief does not necessarily assure the programs' continuation under a new chief. Stress is still a four-letter word to many public safety officers. The Supervisor of Behavioral Sciences (an expansion of function from the Stress Management position) addresses as many groups as possible. The dominant theme presented during the presentations focuses on economics such as lost productivity and liability resulting from stress and trauma-related problems.

The programs face resistance in subtle as well as direct ways. A number of private practitioners view the programs as something that infringes upon their domain. The concern voiced is not one of peer counselor competency, but the potential loss of income. As a result, peer counselors are encouraged to meet with private practitioners in order to allay the practitioners' fears. The experience has been that when practitioners understand that the peer counselor is a potential referral source for new clients, the resistance softens significantly. A surprising and distressing amount of resistance has been displayed by individuals associated with Employee Assistance Programs (EAP) and Community Mental Health Centers (CMHC). These individuals view the peer counselors as competitors, not for dollars, but for clients. This resistance is difficult to dissipate, especially on the part of EAP personnel. CMHC personnel are critical members of the debriefing teams, and once their roles are explained to them the resistance is usually overcome. When it is not overcome, the already existing schism between the helping professional and the public safety officer is widened. To further aid in dissolving the threat to the CMHC, a Stress Referral Directory has been published by the Public Safety Training Center. This directory lists every agency in the state, public and private, offering mental health services to the community. This directory has served to indicate to the centers that the Peer Counselor Program does not compete with but instead serves as an adjunct to their services.

CONCLUSIONS

Although still in their infancy, Georgia's programs have made a good deal of progress. The basic Peer Counselor Program has been expanded to include a very strong debriefing component. Following the model of the U.S. Navy Special Psychiatric Intervention Team (SPRINT), Georgia has developed the Traumatic Incident Group Emergency Response (TIGER) team. Members of this team have been called upon to serve their colleagues in a variety of instances. Examples include providing debriefings postshooting, death of an officer killed while directing traffic, a quick response EMS unit colliding with a civilian vehicle resulting in death to the civilians, and several calls involving deaths of youngsters. Having individuals trained as debriefers from a variety of different services greatly expands the pool of debriefers from which to draw. The early successes of the debriefers has led to an increased interest in the program. This is reflected in the number of inquiries and requests for services received. It appears that the battle to persuade the officer and the agency of the beneficial effects of the services peer cCounselor and debriefings) is being met. The battle to convince professionals in the public and private sector of the mutual benefits of the program is still being waged. The overall beneficiaries of the program are Georgia's dedicated public safety employees.

DUTY-RELATED DEATHS--FAMILY POLICY CONSIDERATIONS

James H. Shaw, Ph.D.

ABSTRACT

The process of recovery by the spouse and immediate family of a deceased officer is directly related to events that follow the death notification. The primary purpose of this paper is to offer insight and to suggest procedures that foster rather than inhibit the survivor recovery process. These procedures should be considered in the development of agency policies for use in the event of a duty-related death. The duties of law enforcement personnel contain many distasteful elements; however, the most negative is the death notification to the spouse of a police officer. The method in which this message is delivered and the agency support to the survivors have a significant impact on the bereavement process. Inappropriate actions can result in serious psychological consequences for both the spouse and the immediate family. The importance of a positive process was emphasized during the Concerns of Police Survivors Seminar by the survivors of deceased law enforcement officers.

PLANNING FOR DUTY-RELATED DEATHS

Advance planning and a written standard operating procedure are essential, as with other contingency planning, prior to an incident. It is not unusual for agencies to have procedures for dealing with fiscal and insurance issues in the event of an officer death, but seldom are there procedures for emotional support of the surviving spouse, children, and extended family.

A planning and resource group should be established that includes a cadre of persons who will assist the agency and the survivors in the event of a duty-related death. These resources include:

1. The agency psychologist, legal advisor, fiscal officer and chaplain.

2. A member of the Concerns of Police Survivors organization.

3. A financial planning expert who is known to be reputable and who will donate his/her services.

4. A representative of the 100 Club and/or other law enforcement oriented community support service organizations.

The manual provisions should outline the process for the fiscal officer to notify the Bureau of Justice Assistance to process the death benefit in a timely manner, to process other job-related death benefits, and to determine procedures for payment of funeral expenses. The agency should determine, in advance, who has responsibility for payment. Involvement of the agency in the funeral often impacts the cost of the service and those costs should not be passed on to the spouse. In fact, it is recommended the agency pay all the basic funeral expenses.

As a product of this planning process, it would be helpful if each officer and spouse are furnished with a copy of the procedures along with a listing of all duty-related death benefits. This information will allow informed decisions concerning need for supplemental insurance coverage.

Police officers seldom consider their own vulnerability, and many times that issue is only focused upon at the funeral of a fellow officer. Often that concern is as much a reality confrontation for themselves as a concern for the slain officer and his/her family. Due to a preference to ignore the possibility of death, officers may not have prepared wills, considered adequate insurance needs, or addressed other death-related issues. Therefore, it is recommended the agency provide a mechanism to encourage the officer to complete a will and to discuss insurance needs. The legal advisor and agency fiscal officer can facilitate the procedure. There should also be a procedure to have the officers review their insurance beneficiary at least annually. It is all too common to have death benefits awarded to a former spouse instead of the intended beneficiary.

DEATH NOTIFICATIONS

The spouse often comments that the officer who delivered the death message was not a friend of the deceased, or the messenger was not held in favor by the slain officer or the spouse. Thus, the notification procedure may lack the compassion the survivors desire.

It is recommended the agency require each officer to complete a death notification form. The form should be maintained in a sealed envelope in each officers' working file where it is immediately available. The form should contain the following information:

1. A listing, in order of preference, the names of three officers who would deliver a message of serious injury or death.

2. A listing of who should be notified by the agency, giving home and work addresses, telephone numbers, and their relationship to the officer. This can become complicated with multiple marriages.

3. The names of officers who would serve as the liaison between the agency and the family. It is recommended both a male and a female officer be assigned.

4. The name of the officer who would clean out the deceased officer's locker and return issue equipment to the agency from both the locker and residence.

5. If clergy are to be involved, their names and telephone numbers.

6. Any special requests to the agency regarding the notification, pall bearers, funeral, burial or memorial.

In the event of a serious injury or death, immediate personal notification is essential. Many families have scanners and the media will pick up immediately on an injury or death of a police officer. Learning about the injury or death from a friend or the media can have a devastating effect upon the spouse and the family. It is also essential to protect the family from the media, which, on occasion, has shown an appalling lack of sensitivity.

When notifying the spouse, two officers should be dispatched--one to transport the spouse and one to remain at the home to be with the children, answer the telephone, etc. Often, the police chief makes the notification personally. His presence at the notification is not essential; however, personal contact by the chief as soon as practical is recommended. The family of the officer must never be allowed to feel the administration is noncaring. Further, the family should be provided continuous departmental support by liaison officers until after the funeral.

When the notification is made, it is obvious to the recipient it is not a social call. The spouse is aware the problem is serious and the use of any delaying tactics are not appropriate. Although it is natural for the

notification officer to attempt to help resolve the grief, well-meaning comments are often offensive to the spouse. The spouse should be provided with an accurate account of the events surrounding the incident and the current medical condition. There are few exceptions to this rule, as later the survivors will usually learn they have not been told the "whole story" and may feel angry and betrayed. Immediately after notification, the spouse will usually want to be taken to the hospital, and this request should be honored.

Sometimes well-meaning officers will want to protect the spouse from seeing the deceased until after the body has been prepared at the funeral home. If the spouse wishes to see the body at the hospital, this should be allowed. If the body is mutilated or burned, that fact should be presented; however, if the spouse insists upon seeing the body, the request should be considered.

From the time of the death until the funeral, the agency should offer continued appropriate support services such as child care, telephone answering, notifications, assistance in dealing with the response from the public and other agencies, meal assistance, and transportation. Some of the support services will be required for some time following the funeral.

It is essential for the family to be actively involved in planning the funeral arrangements and their wishes fully considered. A common complaint is that the agency determined the funeral to be their "event" and disregarded the wishes of the survivors.

Immediately following the death, two valuable outside sources of support are members of the Concerns of Police Survivors organization and the clergy. The COPS volunteers have first-hand knowledge of the needs of survivors following the death of a police officer. Experience has indicated the ability to recover from the death is enhanced when the spouse and family have a strong religious faith. Even if the spouse is not religious, appropriate support by the clergy can be comforting. Of course, if the survivors request the clergy not be involved, that request should be honored.

Officers dedicate a portion of their lives to the law enforcement profession and would like to believe they have had a positive influence in helping their community to be a better place in which to live. It is essential to convey to the survivors that the officer's life made a difference. It is necessary that the spouse and immediate family be assured that the death has some positive meaning, the officer was important to the agency, and the memory of the officer will be preserved. It makes little difference to the family if the officer died as a result of a shootout, was killed by a drunk driver, or died as a result of an accident on the agency firearms range. The important issues are that the officer was on duty and the duty was related to the mission of protecting and serving the public. Therefore, it is recommended that all duty-related deaths be acknowledged by a permanent memorial at the agency or other appropriate public area.

The average age for duty-related deaths is approximately 25 years. At this age there are often young children left without a parent. The parents of the slain officer are also intimately affected by the death. Following the death, there is often friction between the parents and the spouse, and it is not unusual for open hostility and competition to be present when the agency presents the officer's badge and/or memorial plaque. It is suggested the agency make a joint presentation to both the surviving spouse and the parents of the officer. This action is inexpensive, extends a measure of condolence and appreciation for the life of the slain officer, should go a long way toward eliminating the competition and friction that may be present between the parents and the spouse, and reduces the anger that may be directed toward the agency. If the officer is not married, but has a fiance(e), provisions should be provided to include that person in the memorial service.

Because many officers attempt to overcontrol their emotions, often there is a false belief the family knows the risks of the job and the survivors are emotionally strong enough to handle the death with very limited support and intervention by the agency. This view is not realistic with most law enforcement families, as their social support system is often directly related to the agency. Research has shown that spouses of deceased officers often develop symptoms similar to those included in the diagnosis of Posttraumatic Stress Disorder. Some of these symptoms may have developed because of improper handling of the details after the

death. Therefore, it is recommended the agency provide support services from the time of the death until several months following the funeral.

It is comforting for the widows to know there is someone they can call for assistance. Some widows express their appreciation that officers check with them on an ongoing basis to determine that no assistance is needed, or to assist them with requested tasks. However, the support can be overdone. For example, some widows have complained they were overprotected by officers who have run background checks on new male friends, have provided advice on who they consider to be appropriate companions, or who have attempted to protect them by not sharing pertinent facts with the family concerning the incident and/or legal proceedings.

Children are often neglected when it comes to postdeath counseling. They can have unresolved conflicts and feel personal guilt over the loss of their parent. Children need to be given the opportunity to express their concerns with the death or to resolve angry prior thoughts and comments concerning the deceased parent. For example, children, when they are angry, often think about or state that they wish their parent were dead. These thoughts and statements take on major emotional consequences when that parent is killed.

It is recommended both the surviving parent and children be encouraged to seek psychotherapy shortly after the funeral. The selection of a therapist is critical for the success of the bereavement. The therapist should be licensed by the state and also have an in-depth knowledge of the philosophy and workings of the agency as well as the typical interactions present in a law enforcement family. An inexperienced counselor can easily say the "wrong thing," thus increasing the difficulty of bereavement.

The children's therapist should be experienced in working with children who have lost a parent through death. This is a fairly specific specialty and it should not be assumed that the therapist who treats the surviving parent can also successfully treat the children. The police psychologist who advises the agency is usually the best referral source for locating an appropriate therapist.

FINANCIAL IMPLICATIONS

The surviving spouse is confronted with varied essential decisions shortly after the funeral, which includes the problem of investing death benefit funds. The $100,000 Department of Justice death benefit, pension funds, other insurance, and donations represent a sizable income that must be carefully invested in order to provide for the future. It is a common complaint from survivors that numerous persons representing various investment schemes begin calling shortly after the funeral. Most spouses do not have experience dealing with large sums of money nor the knowledge necessary to select an appropriate financial planner. The names of preselected planners who have been screened by the agency are greatly appreciated.

TRIAL

If a suspect has been charged in the death, a trial will be scheduled. During the trial process, it is important to keep the family advised. It is essential to provide the family with a complete briefing just prior to the start of the trial to ensure they will be aware of critical issues before learning of them through the media. If, during the trial, additional issues are to be raised, the family should be so advised, in advance.

The family will be making a decision concerning attendance at the trial. There is an absolute controversy as to the benefits of the survivors attending the trial. Attendance is an individual decision of each survivor as he/she may feel a need to represent the deceased spouse and/or to bring closure to the death. On the other hand, if they have been thoroughly briefed, they may not see the need to attend.

RESOURCES

The information for this paper was taken from actual incidents and concerns and recommendations related by surviving spouses of law enforcement officers who were killed in the line of duty. The spouses were attending the Concerns of Police Survivors annual seminar, held during the month of May in Washington, DC.

Agencies planning to develop or modify policies and procedures have several additional resources to contact for assistance. These include: The International Conference of Police Chaplains, the Psychological Services Section of the International Association of Chiefs of Police, and the Concerns of Police Survivors organization. Additional information can be gained from the following resources:

International Association of Chiefs of Police (1989, May), "Support services for survivors," Police Chief, pp. 20–27.

Stillman, Francis A. (1987, January). "Line of duty deaths: Survivor and departmental responses." National Institute of Justice, U.S. Department of Justice, Concerns of Police Survivors, Inc., Grant #85–IJ–CX–0012.

Concerns of Police Survivors. (1988, October). Support services to surviving families of line–of–duty deaths. Brandywine, MD: Author.

THE DEATH OF A POLICE OFFICER--SURVIVING THE FIRST YEAR

James H. Shaw, Ph.D.

ABSTRACT

The death of a police officer presents a living nightmare for the spouse. As with bereavement from any death, the manner in which the bereavement is undertaken can contribute to the effectiveness of the recovery process. This paper provides an understanding of some of the issues involved in recovery and may contribute insight and assistance.

When your spouse was killed, you may have felt all alone, but, in fact, you have the support of many members of the law enforcement profession and the members of Concerns of Police Survivors (COPS), whose membership came through the death of their police officer spouses. These women and men offer a unique and valuable support system.

The writing of this paper was assisted by two COPS members--Patty Nollmeyer, whose husband Craig was shot by a mental patient January 24, 1985, and Joyce Mavity, whose husband Alex was shot by a felon he was arresting on Valentine's Day, 1989.

Each death is unique, the subsequent events are different, and the bereavement issues will likewise differ. The purpose of this paper is to present some common events, to indicate some of the issues, to assure and reassure you that your reactions are normal, and hopefully to assist you through your period of recovery. The bereavement road from death to recovery is long and has some unexpected turns; however, with the assistance available to you, recovery can be timely and complete.

According to the Uniform Crime Reporting Program statistics, in the past ten years, 590,822 officers were assaulted, 204,584 were injured, and 1,525 feloniously and accidentally killed in the line of duty. During 1988, 161 police officers lost their lives. An officer dies every 59 hours. The average age of these officers is 25 years, which means they often leave young children.

These are statistics your spouse probably never discussed with you because officers do not like to look at their own mortality. To feel vulnerable is to make the job more difficult, and they do not want their families to worry about their safety. Nevertheless, you sometimes wondered, as he left for work, if he was going to return home safely. You tried not to be too possessive and usually kept your concerns to yourself. You sometimes had the premonition that something was wrong; however, you have had that feeling before and he has always returned home.

This evening, however, the doorbell rings; you answer the door and there stands the Chief of Police and your husband's Captain. They don't have to say anything--this is not a social call--and you know there is a serious problem.

The Chief has difficulty looking you in the eye when he advises you your husband was killed a short time ago. As he describes the circumstances, you are barely listening; your mind is racing and all this seems unreal. The Chief asks if there is anything he can do, assures you the Department will be providing assistance, and advises an officer will arrive shortly to stay with you and act as the liaison between you and the

Department. The Chief and Captain excuse themselves as they have to return to the Department to deal with the details of the shooting.

They leave and you feel all alone now. You can't believe this is really happening and think it must be a bad dream. You are in shock. A few minutes later you hear footsteps on the porch and check your watch. You feel an immediate sense of relief that it is your husband coming home and this has been all your imagination. You run to open the door and find your liaison officer, who cannot think of the right words to express his true feelings.

Your children are asleep. You think about going into their bedroom, hugging them, and telling them about their father, but decide to let them sleep. The next person at your door is the chaplain, who tries to comfort you, and as you listen to his words, you have difficulty concentrating. Friends and relatives begin calling and arriving now that the media is carrying news of the shooting.

The phone is constantly busy with persons concerned with your welfare. You are fortunate to have assistance with the phone so that you do not have to take all the calls.

Morning comes rapidly. There are still several people remaining and someone is in the kitchen making a fresh pot of coffee and you smell breakfast cooking. The whole scene seems unreal and you see yourself somewhat distant from the room looking in at yourself and others in the room. You notice that you feel numb, but not necessarily like crying.

At this time, your young children come into the room, see all the people, come running up to you and want to sit in your lap. They ask what is going on and you have difficulty telling them what happened. They do not seem to comprehend anyway.

People continue to come and go and the Chief returns and tells you about the Department plans for the funeral. As he reviews the details, your input is considered but perhaps not implemented. Food is arriving and the kitchen table and refrigerator are both full. You don't feel like eating, but try to be a good hostess and invite the others to eat.

The funeral is a real production, with officers representing departments from all around the area. It crosses your mind that you may not be an important part of the funeral, as so much attention has been devoted to protocol. The body of your husband is placed in the grave, you return home, and for the first time in almost four days, you and your children are alone. Returning home has caused you to think about the future, and you feel a real sense of emptiness, loneliness, and fear.

You are still somewhat numb emotionally and will learn this numbness is a form of shock that acts as a measure of emotional protection. Still you cannot help asking yourself, "why me?" and you are noticing an anger that is directed at the assailant, the Department, and even at your husband. You reflect on the unfairness of life, but it is hard to concentrate on any one train of thought too long.

You wonder where to turn now that you no longer have your primary support system. You have lost your best friend and confidant.

You consider yourself fortunate because of the support provided by his parents. However, it is not unusual for friction to develop between the spouse and the mother-in-law.

The Department attempts to assist you, and you cannot help noticing how uncomfortable the officers act around you. They often do not look at you directly, and their speech is awkward. Their behavior is atypical from the self-assured, highly verbal officers you are familiar with. You are uncomfortable with their discomfort. Later you are to learn that you are a reminder of their vulnerability, their mortality, and you are

living proof of that factor. They see their wives and children in you, and yes, they are indeed uncomfortable in attempting to deal with their own emotional reactions.

The Department has numerous papers for you to sign, and you are following their direction with a kind of numb, almost zombie–like obedience. They have arranged grief counseling for you, and you keep the appointment. You learn there are stages of grief, there is a healing process, the emotions you are experiencing are normal, and it is a relief to know you are not going crazy. You learn that bereavement is a necessary healing process and wonder when the numbness will leave and you will complete that process.

You are referred to a group for widows and it is helpful to hear others experiencing similar emotions. Shortly after the death was announced, you were contacted by a member of Concerns of Police Survivors––a police officer widow like yourself. That person recontacts you and suggests a meeting. Here is a person with whom you have some close identification, as her husband was also a police officer, and her experiences help you to cope with some of the issues not found in the widows' group.

You have taken some time to go through the letters and cards received following the announcement of the death and are surprised to receive so many cards from concerned citizens who did not know your husband, but recognized his sacrifice in keeping them safe, and their support is appreciated.

You are experiencing a unique set of emotions. You want to maintain emotional control as now you have the primary family responsibility and may find difficulty crying in front of others, but do find time to cry when you are alone. It is at this time when your thoughts go back to your husband: The good times, thinking about the last week before his death and the day he died. You remember the things you said and wished you had said, and deal with some "what if's" which, although fantasy, are common in attempting to deal with a situation over which you had no control. You later realize that it is okay to fully grieve, and until you do, the healing process is encumbered.

A police officer devotes his career to public service, and, if killed in fulfilling that duty, will be remembered. An appropriate memorial will be dedicated to his memory to assure that his devotion will not be forgotten. You attend the ceremony and are reminded of your emotions at the funeral.

You are aware that police officers' wives often go through a transformation during the first months of marriage. Police officers, being "take charge" people, generally marry very feminine women who tend to defer to their wishes. One of the officer's desires usually involves your handling the home responsibilities and the children. Their shift work, overtime, and often second jobs give you no choice but to take full charge. Now, however, you are somewhat disorganized and otherwise minor problems seem insurmountable. You often wonder how you will be able to cope. Support systems are helpful and you find friends who can teach you how to change the washer in the dripping faucet or what to do when the car needs to be serviced––projects that were the domain of your husband.

Although your husband liked "his toys," and there was usually not a lot of extra money in the budget, finances are not usually a crucial worry at this time. Personal, departmental, and Federal insurance will alleviate financial problems. Now you must face another decision; how best to deal with this fairly significant amount of cash, which has to be properly managed to provide for the years to come. You get lots of financial advice, but the decision is yours.

Sometimes, when people are depressed, it can be helpful to spend some money on themselves. You realize that the matching shoes and purse somehow, magically, make you feel a little better momentarily. Your grief counselor might suggest a trip for you; it sounds like a good idea and you leave. You are amazed at how valuable this trip is to get away where you can indulge yourself and actually do some good honest grieving. Without the home pressures, you can more objectively look at taking more control of your life.

When you return home, you realize decisions must be made about the house. What do you do with his clothes, guns, tools, and other personal effects? There are his favorite chair, footstool, and lamp, which renew emotional pain whenever you walk into the house. Then there is the matter of the bed. Difficult decisions are made over which items from the past must be discarded. New furniture is an obvious option, but what about the pictures--and the coffee table he made those imperfections in. They are now very special.

Let's be careful not to forget about the children. They often appear to be coping well, and although not openly showing grief, may in fact be having considerable difficulty. They may have been told, or believe, that not showing emotion is proper, that they now have responsibility to help mother, or "now you are the man of the house." They may not have a good understanding of the circumstances of their father's death and they do not have the answer as to WHY. They usually have considerable anger, but it is often internalized and not expressed. The anger later comes out in problems in school, interpersonal problems, withdrawal, and with the need for discipline. Children typically feel the same emotions as their mother, which include abandonment, guilt, anger, depression, frustration, and yet they do not know these feelings are normal or how to properly express them. They need to be given permission to talk about their father, to ask questions about him, express guilt ("if only I hadn't wished he were dead when he made me mad, he might be alive), and frustration that things are not as they were when he was alive. They may have no way to deal with these emotions and in fact usually need assistance and permission to grieve. Grief counseling should be started soon after the funeral and include both individual and family involvement. Children should be referred to a therapist who is experienced in assisting children in grief. Your child will usually tell you and the therapist when there is no further need to continue therapy.

The children need support from their mother and relatives that is ongoing. Sometimes, when we are absorbed in our own grief, we are not as sensitive to the needs of others, which includes those who are very close. Sometimes we tend to overdo the attention and affection shown the children, which is also confusing to them.

What about your role in attending the inquest and/or the trial of your husband's assailant? These are very formal and structured proceedings. If you feel an absolute need to know all the details of the death, then the inquest is one good opportunity to obtain that data. However, you may learn more than you wanted to know, and some of that information may well result in additional emotional problems that would not have otherwise been a factor. Other sources to obtain this information are through the police department or perhaps from the medical examiner or coroner.

If the death was felonious and a suspect was charged, there will be a criminal trial. The trial is different from the inquest. There exists an absolute controversy concerning the survivor's attendance at the trial. Many survivors believe their attendance at the trial will help them to understand what happened, to represent their deceased spouse, and to bring about closure to the death. On the other hand, during the trial, the defense attorney will often attempt to justify the taking of the life of a police officer. Generally after sitting through the trial, you will become angry and come away with a disillusionment of the system your husband gave his life to support.

If not attending the entire trial, the survivors may wish to make a short visit on one of the first days of the trial. Seeing that the deceased police officer, who is not now able to defend his actions, is a real person with a wife and children, has to have a profound effect upon the jury. Whether or not you decide to attend the trial, you should be sure to be thoroughly briefed by the lead trial prosecuting attorney immediately prior to the beginning of the trial so that you will not be surprised to learn of unknown issues through the media.

If you want to attend the sentencing of your husband's assailant, that may also be valuable. Until this person is sentenced, the death of your husband has not been dealt with, and closure of this part of your grieving has not usually been accomplished.

Shortly after your spouse's death, you received a lot of attention from the other officers who made certain you were okay. As they see you are "capable" they will come less often, but usually will remain available if needed.

As you progress in your recovery, you make new friends. Your old friends are very important, but you realize some of the police officers and their wives who used to be close friends don't come around as much. You become aware that as a police widow you make these friends look at their vulnerability, and if they cannot deal well with that possibility, they feel uncomfortable being around you with the reminder that "there, but for the grace of God, go I."

You may have also noted that you don't have the same attraction to men that existed before his death. You feel somewhat empty emotionally, not at all interested in a romantic relationship, and find a lot of support from other women and from those men who listen and are understanding. You wonder if you will ever be able, or want, to establish the type of close relationship you had with your husband.

As you are recovering, you understand that life can never be the same. You have been changed by this death and certain anniversaries take on a different meaning. His birthday, your anniversary, and the day he died take on new meaning. As the dates of these anniversaries approach, your thoughts go back and you relive some of the emotions that were so intense shortly after his death. Traditionally happy holidays such as Thanksgiving, Christmas, and Valentine's Day are now days for feeling melancholy. You reflect upon the past and are thankful for the support given by your faith, children, family, and others whose assistance has been so important to your recovery process.

In the year after the death of your husband, you are invited to attend the COPS seminar and the National Peace Officers' Memorial Day Service in Washington, DC. You have mixed feelings about attending, but upon your arrival are overwhelmed with the support system that exists for you. You soon become aware of the relationship and bonding that takes place between women who share the common bond of having lost their spouse, best friend, and last, but not least, a police officer who was killed making this world a better place. You leave the conference with a sense of hope and usually a strong desire to help other police officer widows.

You have survived the first year. As you review the events, you see that your support system has included your faith in God, relatives, friends, counselors, the Department, children, members of COPS, coworkers, and yourself. Some of your grieving has been completed and you're well on your way to recovery. However, as Patty Nollmeyer so succinctly stated, "The first year is only the rehearsal; the second year you live the loss."

CRITICAL INCIDENT TRAUMA AND INTIMACY

Patricia L. Sheehan, D.N.S.

ABSTRACT

Intimacy is probably the most sought after and feared phenomenon in life. People want a deep, honest, open relationship and yet tend to avoid or sabotage these relationships when they find them. My work with Vietnam combat veterans and other survivors of trauma has led me to believe that trauma tends to exacerbate fear of intimacy. In a recent study of Vietnam veterans (Sheehan, 1989), combat trauma was found to be significantly positively correlated with fear of intimacy. Police trauma, especially that associated with critical incidents, is very similar to combat trauma. This paper will explore some possible connections between police trauma and fears of intimacy.

Intimacy has been defined in various ways. In a historical review, Sexton and Sexton (1982) found that most cultures view intimacy as a two-person mutual sharing of innermost realities. Participants in my workshops on intimacy and trauma say intimacy involves honesty, openness, trust, sharing, vulnerability, caring, and acceptance. They also agree that intimacy is not sex; noting that it is possible to be intimate with someone and not be sexual--as with a good friend. It is also possible to be sexual with someone and not be intimate--as with a one-night stand. Most concur, however, that the relationship that is both sexual and intimate provides an opportunity for some of life's peak experiences.

The workshop participants also agree that although everyone wants intimacy, they also tend to damage and/or avoid intimate relationships. When asked why people do this, participants generally attribute intimacy-destructive behaviors to ignorance, pride, and fear. Ignorance stems from not learning to be intimate from one's family of origin. Pride involves trying to "look good" and/or to win at the other person's expense. Fear is the primary obstacle to intimacy. Larry B. Feldman (1979) developed a typology of five different fears of intimacy that are particularly useful in understanding relationship problems. The following is a description of my view of the five fears and rationale as to why police trauma could exacerbate those fears and thereby interfere with intimacy.

Fear of merger. Merging is the experience of losing oneself in another person--of not knowing where one's own body and self end and the other person begins. When lovers sexually abandon themselves with their intimate partner, the physical, emotional, mental, and spiritual merging of the two people can lead to a powerful spiritual experience. Both eastern and western spiritual and religious works note that sexual intimacy is the most common way humans get a glimpse of the ecstasy of being one with the universe or united with God (Callahan, 1969; Curran, 1972; Keane, 1977; Moss, 1981; Piper, 1960; Ram Doss, 1970; Thieleke, 1964; Watts, 1958; Westley, 1981). Most people find this very pleasurable. However, the power of this experience of lowering defenses and letting another person in may also result in a fear that the other person will have too much influence over them and thereby cause them to lose control over their own lives, lose their freedom, or lose their identity.

This fear is very common. The person may feel suffocated or overwhelmed. This fear manifests itself in power struggles over who controls whom and what. It may be expressed in several ways, e.g., "Don't fence me in"; I don't have to answer to you, you're not my mother/father"; "I don't want to be known just as Mrs. Joe Brown"; or "I'm not going to be henpecked." All of these statements reflect a fear of loss of identity and/or control over one's own life. The most difficult task in a relationship is to stay

true to yourself and also communicate and negotiate with the other person in a way that maintains the integrity and identity of both. Fear of merger causes people to avoid communication and negotiation. They fear that if they communicate and let the other person know them deeply, the other person will use that information to control them. This fear also leads people to refuse to negotiate; they fear "if I give an inch, you will take a mile." Their approach to conflict resolution is "It's my way or no way and if you don't like it you can hit the door" or "This is the way I was when you married me; take it or leave it."

The macho image of police does not promote emotional communication or easy marital negotiation and conflict resolution. This can be further aggravated by shooting trauma. One of the most common post-shooting emotional reactions is a feeling of lack of control and vulnerability (Lippert & Ferrara, 1981; Service Star, 1989; Solomon, 1988); the illusion of safety and invulnerability is shattered. This may prompt the officer to increase his defensive barriers to keep everyone out in an attempt to feel safe. This is sad because, in doing this, the officers cut themselves off from their lover's love and support that they need so desperately at this point in time.

Fear of abandonment. This is the fear of losing the loved one. As intimacy and connection increase in a relationship the lovers become more and more important to each other; the idea of losing the other person becomes intolerable. Nearly everyone has been through the experience of loving someone and then losing them--the broken heart; some never recover. If people try to form a new lover relationship before they have successfully recovered (which involves completing the grieving process), they tend to form unhealthy relationships. One type is the revenge relationship, in which they take revenge on the new partner for what the last one did to them; this can be conscious or unconscious. The other main type of unhealthy relationship people form as a result of an unhealed broken heart is the very clingy, jealous relationship in which they are constantly expecting and fearing that the new lover will abandon them as their previous lover did.

There are several potential sources of fear of abandonment in a critical incident situation. The stress of a shooting trauma may cause both the officer and the spouse to withdraw from each other. Unexpressed fears and anger build, causing more and more emotional distance; they may both feel abandoned. Vietnam veterans who lost friends in combat later tended to be extremely protective and worried that something would happen to their families. It is reasonable to speculate that the shooting trauma, which emphasizes the uncertainty of life, could also intensify this fear. The shattering of the illusion of invulnerability could also feel like abandonment--abandonment by God. The officers are left with the constant question, "Why did this happen to me?" (Service Star, 1989).

Fear of exposure. This is the fear that one's weaknesses and character flaws will be seen by the other person. Those with low self-esteem are afraid of being exposed as weak, bad, inadequate, repulsive, etc. They experience feelings of shame and inferiority. Everyone experiences this to some degree. Indeed, a hallmark of intimacy building is the sharing of mistakes, fears, and vulnerabilities. People share this information and then wait for a reaction--rejection or acceptance. If people truly believe no one could accept them, they will probably never do sufficient self-disclosure to build an intimate relationship.

Some of the common reactions to a shooting incident, e.g., a heightened sense of danger and vulnerability, fear, rage, nightmares, flashbacks, depression, guilt, emotional numbing/withdrawal from others, sexual difficulties, suicidal thoughts, and alcohol/drug abuse (Solomon & Horn, 1984) make some officers feel they are losing emotional control. They may begin to doubt their own competence and sanity. They may attempt to hide these reactions from their spouses, thereby increasing the feelings of shame and inadequacy and cutting themselves off, again, from one of their best sources of love and support.

Fear of attack. Attack can be physical or emotional. It can be obvious as in name-calling and hitting or it can be subtle as in put-downs and teasing. As intimacy builds in a relationship, people learn more and more about each other. They learn each other's vulnerabilities and sensitive issues. In healthy relationships, people do not use this information against each other. There is an unwritten agreement that

those areas are off–limits––there will be no teasing about those issues. Violation of this agreement is experienced as betrayal.

Attack is one of the main ways people reduce intimacy in their relationships. In response to a need to be introspective and alone after a shooting incident, officers may attack their partners to get them to back off; this can be a conscious or unconscious process. The healthier way to handle this is to tell the partner they need some time to themselves.

The hypervigilance and suspiciousness that is an asset in police work can also lead to misinter–pretation and overanalysis of the intimate partner's behavior, especially when one is feeling vulnerable after a shooting incident. The officer and partner's anger, confusion, and fear may provoke attacks on each other. Tempers flare and confusion reigns. Being told that this is a normal reaction to an abnormal situation may help them "cut each other some slack" and avoid escalating misunderstandings and conflicts unnecessarily.

Fear of one's own destructive impulses. This is the fear of one's own anger, rage, and willingness to hurt other people. Everyone has been disappointed in love relationships, and this disappointment frequently leads to anger. Healthy anger can be the energy that motivates one not to let oneself be used and violated––the strength behind one's "no." In healthy relationships, both partners express their anger and reconcile. Anger and rage are normal reactions to a shooting trauma for both the officer and the spouse. Unfortunately, they frequently take it out on each other. Both allowing them to vent their feelings and reassuring them of the normalcy of their rage will help to defuse the situation.

Most people do not have to face their ability to kill. Combat veterans and police involved in shooting incidents do. When killing has become part of a person's experience, anger and rage take on a new dimension. They know how far it can go; this, paired with the rage a person feels as a result of being exposed to the traumatic situation, could make the officers' doubt their own self–control. This could lead to a pattern of alternating between avoiding all conflicts and exploding.

In summary, there are good reasons to believe that shooting incidents could intensify officers' fear of intimacy and thereby cut them off from one of the most important sources of support during this critical time. Explaining this to the officers and their spouses or significant others could help avoid some of the misunderstandings and pain that surrounds this trauma. This information on the five fears could also help mental health professionals better assess and serve these people.

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THE DELIVERY OF MENTAL HEALTH SERVICES TO LAW ENFORCEMENT OFFICERS

Milton N. Silva, Ph.D.

ABSTRACT

Mental health professionals have been employed more frequently during the past decade by police departments across the nation and in other countries. The roles they have been asked to play within the organization are varied and, at times, conflicting. This paper touches on the traditional views law enforcement officers had of the mental health professionals. It explores problems in police personnel and their manifestations, among them cynicism and "gallow humors," and the difficulty law enforcement officers have with trust. Suggestions are given as to how mental health professionals can facilitate the development of trust in the counseling process. Some pitfalls in the delivery of mental health services within the police organization are considered.

INTRODUCTION

The utilization of mental health professionals in police departments across the nation, and in some cases, globally, has seen an increase during the past decade. In some departments or ministries of police where no budgetary provisions exist for the employment of professionals from these fields, the utilization of part–time staff, time sharing of them with other agencies or even the use of consultants on an as–needed basis, continue to escalate (More and Usinger, 1987).

Mental health professionals ("shrinks") were seen by some in the law enforcement field as the "sob sisters, softies, do–gooders" who appeared in court on behalf of the defendants. We are judged to be more forgiving, overly permissive, and less judgmental than those in law enforcement. Others in the police regarded us as sort of mind readers to be mistrusted since it is felt that we can be potentially threatening. Still others perceived us and our work as failures. They arrested our mistakes every Friday and Saturday night. Our successes usually go unnoticed as they never come in contact with the legal system.

Law enforcement officers have been furious with the "shrinks" and outraged because they saw the mental health system as a revolving door. The mental patients, the potential suicides, the combative, threateningly dangerous individuals––"we bring them to the emergency rooms of the hospitals and then you let them out a few days later." A young rookie for whom one of his first calls was to go into an apartment where a female was causing a commotion, entered to find the place covered with blood. The young woman had made a suicidal gesture by slashing herself with a razor. The resulting bleeding was more dramatic and impressive than the severity of the cuts. The officer, however, had never known personally anyone who had attempted suicide. He certainly had never attempted to disarm a deranged person who was threatening him with a razor. "A crazy person who kept yelling at me to stay away while slashing at her arms and chest with a razor." He finally succeeded in disarming the woman by wrestling the razor away from her and without sustaining any injuries himself. He transported her to the emergency room of the nearest mental health center where she was admitted for observation. "And three days later they let her out, back to her home. They let her out too soon. She'll try it again. I know she will try it again and it will be when I'm on duty and I will be sent out again to stop her and bring her back to the mental health center. And then you will let her out again right away."

Despite the mistrust and criticism by the law enforcement establishment, inroads have been made by mental health professionals earning the trust of police officers. Since Martin Reiser (1972) was appointed by

the Los Angeles Police Department in 1968 as the first full-time, in-house psychologist, others have joined the ranks. The tasks they are assigned are varied and range from screening police applicants psychologically, to training cadets and participants in ongoing in-service training programs, giving debriefings following critical incidents, and providing direct clinical services to officers and on occasion, to spouses.

The practice of a substantial number of agencies of employing professional mental health workers met originally with some resistance. It has now, however, become an accepted fact that the utilization of counselors provides an essential support system to the personnel of the agencies.

Occasionally, the department may place the psychologist in a difficult position. While providing ongoing psychotherapy to employees, the psychologist will also be required to do work-status evaluations and readiness to return to work assessments and gage fitness for duty: confidentiality problems, loyalties, trust issues, and intraorganizational conflicts may result. This places the psychologist in the unenviable position of being caught between warring factors: Union and management, patrolmen and administration, supervisees and supervisors.

TRUST

Trust, the most important component to the therapeutic alliance, is also the principal ingredient in the successful delivery of mental health services to law enforcement officers. Difficulty with trust appears to be an occupational hazard for those in public safety. It is frequently found among police, along with a strong sense of self-sufficiency and the insistence that they have the ability and wherewithal to solve their own problems. "I don't need to see a counselor."

The development of trust during the establishment of the therapeutic alliance depends greatly on the establishment of a mutuality between the counselor and counselee, on how skillful the counselor is in interpreting the counselee's emotions, reactions, and many nonverbal signals. The counselee, being able to feel at ease with the counselor, gains a sense of predictability from the other's behavior and finds comfort and pleasure from the interaction with him/her. Some counselors, because of their background and experience, have difficulty understanding what the law enforcement officer is all about, what that occupation entails. They may even have problems empathizing with those in public safety. The police officer in turn may be unreceptive, rigid, loose, skeptical, or untrusting. In that case, the officers must then be assisted to take reasonable risks. They must learn that paradoxically, it is safe to take risks. The risks they take must be reinforced in order to bring about success. They must also be helped to weather failure.

The counselor may be annoyed by what seems as lack of trust and the officer testing him/her. In reality, if all goes well, this is part of the process of forming the therapeutic real relationship. A response of annoyance or anger from the therapist will have a dampening effect and then destroy the incipient therapeutic alliance.

Two factors determine the level of trust in any relationship: The inclination and desire of all of the members to share themselves and the quality of the response they are given once they do participate and share themselves. No matter what the approach to self-disclosure might be, the ground rules must be clear from the start.

The ultimate goal in working with a law enforcement officer, if possible, is to train him/her to help other officers if and when the need arises. Most officers respond very well to peer intervention and help in time of crisis. The credibility of the therapist and general acceptance by members of the law enforcement community increases with the endorsement and recommendations of fellow officers. The basic skills of helping are also the basic skills needed for effective living. The helping process then comes to be most successful not only when it is used to learn to live effectively, but more importantly, when it is learned so well that the officer can now be of help to others.

To help develop trust the therapist must work at establishing a relationship based on mutual respect. Bear in mind that the counselee may not be able to purposefully change the nature of the relationship but the counselor may be able to find ways of doing so. The therapist must possess what Egan (1975) calls:

1. Accurate Empathy--when the counselor conveys his/her understanding of the counselee's background and experience, including occupation as well as feelings. The importance of understanding police work in its various aspects--what it means to be a police officer, how they see themselves and how others see them, interaction with other officers--cannot be emphasized enough.

2. Genuineness--the counselor must be genuine when working with police officers; that is, according to Truax (Egan, 1975) "without front or facade, openly being the feelings and attitude which at the moment are flowing in him. It means that he is being himself, not denying himself" (p. 100). If he/she is not, the officers will know or will find out, and whatever trust was developing will disintegrate. The counselor must avoid taking refuge in the role of the therapist. He/she must be spontaneous while tactful; free to be himself/herself while not impulsive. The helper must be nondefensive, particularly when being tested by the officer to determine if he/she can be trusted.

3. Availability--in an emergency the counselor must be accessible to the police officer or the department, as soon as needed or shortly thereafter. No promise that cannot be kept should be made. The counselor will be tested by officers who, as already pointed out, do not place much trust in mental health personnel. If the counselor does not or cannot live up to the promises made and is lacking a valid explanation for the inability to do so, damage beyond repair to his/her credibility will result. Trust will then be lost forever.

A psychologist offered a police department that he would be available to them as needed. He was contacted by phone when an emergency arose. Being available, he arrived in the precinct half an hour later to find that despite the bona fide crisis, the officers had timed the quickness of his response. The credibility of the psychologist was established and the department's good will earned.

4. Respect--the way in which the counselor deals with the counselee will show or demonstrate to the officer that he/she is respected. This transcends warm regards and good intentions. It is a unique way of viewing a person. It must start with prizing the individual because he/she is a human being and being a human is a value in itself. Committing to helping others is a value for the psychotherapist that must be translated into some type of action. Respect can be manifested in words or in actions, principally by the way the therapist orients himself/herself toward and works with the officer. It must be translated into concrete behavior so this value is communicated clearly to the officer. Respect is both tough minded and gracious.

The counselor must first and foremost be sincerely willing and interested in working with those in law enforcement. He/she must see the officers as unique human beings and support them in their uniqueness. The officers' self-determination must be honored. Counselees in general, and police officers in particular, do not like to feel that they are losing or have lost control in the therapeutic relationship. Critical judgment must be suspended by the helper. If the officers are going to believe that the counselor accepts and values him/her as a human being, that acceptance must be untainted by evaluation of behaviors, feelings, or thoughts.

5. Concreteness--the counselor must avoid overtechnical or vague language while talking to a police officer but at the same time not talk down to him/her. The image of the uneducated police officer is a dated stereotype. The majority of law enforcement officers respond favorably to a therapeutic intervention that is grounded in concreteness of feeling and behavior. The principal goal in counseling must be problem solving. Vague solutions to pressing problems or vague solutions to vague problems bother and dishearten police officers. Effective action invigorates them.

The first step in understanding those in law enforcement may lay not only on who and why people go into the law enforcement work, but on the unique interaction between the members of the force and the

public. The image of the "cop" is not created exclusively by the officer (Undercuffler, 1980). An identity is assigned to them the moment they pin on the badge. That image may be a stereotype, outdated, and inaccurate; nevertheless, it is the one the public has of law enforcement officers and believes. Police officers do not have to accept it. They can, instead, change it or even develop their own and live by that more realistic one. Police officers are told, and end up accepting, that they are marriage counselors and should investigate and resolve successfully family conflicts, and help the couple resolve the conflict and "live happily ever after." They are supposed to be paramedics and save the dying. They are supposed to be super sleuths and solve all cases. Although they can see how absurd those expectations are, they frequently run the risk of ending up believing them. If they are supposed to do all these things and do them well, is it surprising that they insist that they need no help when they have personal problems; that they can manage by themselves? Yet, no matter how successful they are at any or all of the above, they frequently find themselves in the no-win situation of someone always disapproving of what they are, do, or say.

New police officers soon discover that many people seem to react to them negatively in an almost automatic manner. The person wearing the uniform or behind the badge is not seen as an individual but rather as an amalgam of symbols. This highlights many issues about the dynamics underlying the role and functions of police officers when perceived by the public they have been sworn to help. The reasons behind these reactions to the uniformed officers include political, interpersonal, ethnic, racial, and socioeconomic factors as well as past experiences with other members of the police and exposure to the media, which has portrayed officers from the saviors of mankind to corrupt and evil members of society. Further, the officers are seen as the immediate representation of incarnation of the broader law enforcement system as well as of the criminal justice one. They can and are associated inevitably with the weakness of the system and criticized for it (Dufford, 1986; Band & Manuele, 1987; FBI, 1986; Neilson, 1988; Tuco, 1986).

The duties of the officers in the street are diverse and generally involve people. They are an authority because the city, county, state, or federal government says they are. That, unfortunately, does not guarantee that the officer possesses the personal qualities associated with the concept of authority: Positive self-esteem, self-confidence, flexibility, and tolerance.

It has been estimated that police officers spend 75-90% of their duty time in noncrime-related activities. Among them are mediating interpersonal conflicts and functioning as helping persons. Only 10-20% of their duty time then, is crime related. It is significant, though, that 90% of their training in law enforcement deals with crime work. Even though only 10% or less of their training focuses on service-related tasks, that occupies 75-90% of their duty time.

With these discrepancies and contradictions, with the double messages, and with the undermining of authority and self-image, it can be understood why police work is one of the ten most stressful occupations in the world; and why the possibility of burnout is highly significant and the help of mental health professionals is essential. They are charged with carrying out orders and daily operations with no identifiable solutions (Donovan, 1983; Violante, Marshall & Howe, 1985).

TESTING OF THE MENTAL HEALTH PROFESSION

When mental health professionals start to work with law enforcement officers, they soon discover that the officer is evaluating them as much as the professional is evaluating the officer. Law enforcement officers will frequently wonder and frequently ask of the mental health professional, "Why do you want to work with police officers? What is in it for you? Are you in this for money? How much do you charge? Who is paying you?" If you do debriefings with them after critical incidents, the question might be, "What are you going to do with this information, write a book?" Once they trust you, the question now might turn to a recommendation: "You should write a book about this so it can help other coppers."

Knowledge. The officers will want to know and establish the degree of familiarity of the professional with the police and police work; his/her opinion of police officers; what constitutes occupational stress for the officer; previous work experience with law enforcement officers.

If the mental health professional passes the initial test evaluation, the officers may go on to the next phase: Putting him/her through additional ones. They may also want to ascertain the depth and breadth of knowledge of the counselor in his/her area of specialization, "role-expertness," training and skills as a therapist, perhaps even success with other clients. "What type of cases?"

Confidentiality. Police officers, as any other counselee, fear having their trust betrayed. Self-disclosure is frequently intimidating to counselees because of the fear of what they may discover about themselves. More intimidating still is the fear that once shared with the counselor, the latter may hold the information against him/her or maybe worse, divulge it. "Do you know anyone in police administration?" "Will this information get back to them?" "How much of this do you have to report to the insurance company?"

The officers may subsequently, in the course of the sessions, expose the professional to cynicism and how cynical he/she can be. Cynicism not infrequently elicits in others avoidance and fear. They may barrage the professional with "mocking" disbelief of police work and the police system and dare him/her to agree.

Humor. According to Kaplan, Friedman, and Sadock (1980), humor is among the mature defense mechanisms. They define it as "an overt expression of feelings without personal discomfort or immobilization, and without an unpleasant affect on others" (p. 376). Humor permits the person to cope while at the same time focusing on what is too terrible to bear. Wit, on the other hand, always involves distraction or movement away from the affective issue.

Salameh (1986) in "The Effective Use of Humor in Psychotherapy," states that "as we travel through life with all its tribulations, the experience of humor comes to replenish and heal us" (p. 157).

Humor is considered to be emotionally therapeutic because it can assist a person in opening up to his/her feelings. It has been stated that in psychotherapy one of the principal goals is assisting the counselee to decongest emotionally. Humor can become the access or entry point into the mainstream of emotions. It has been hypothesized that if the counselor and counselee can laugh together, they can go on to share other more personal or intimate feelings.

Humor may also serve to bring a sense of balance and proportion to those instances in which the emotional world is chaotic, warped, or unduly stunted. Police officers are likely to deal with horror in their daily work; gruesome multiple deaths, as in freeway car pileups; investigation of macabre homicides by sadistic killers; physical and sexual abuse of children and the elderly; rape and torture cases; obnoxious and combative citizens. They are shocked and revolted by what they see. Their sense of humanity is assaulted. They are outraged and horrified by the cruelty of one person to another. A generalization of stimulus results and they start to doubt and mistrust anyone and everyone. Feelings of anger surface. They use humor to vent the anger. Some attempt to deal with the repeated emotional shocks through "gallows humor." Those outside of law enforcement see it as sarcastic or callous, insensitive, and unconcerned.

A well-accepted principle arising from studies of human behavior is that individuals are incapable of engaging in two incompatible responses at one time. It has been suggested that any condition serving to induce emotional states or responses that are incompatible with anger are effective in deterring or mitigating aggression (Kaplan et al., 1980). Many different responses may come to be inconsistent with anger or aggression. One, however, has been the subject of increasing interest in recent years: Feelings of amusement or humor.

For many officers, humor is the way of ventilating the aggression that the traumatic events to which they are exposed generate. Dollard, et al. (in Kaplan & Sadock, 1989), hold that whatever its nature, the performance of one aggressive act reduces the aggressor's tendency to engage in all other forms of aggression against the sources of their annoyance. Thus, for an angry person to engage in verbal or fantasy aggression may reduce the probability of engaging in direct attack of the source of frustration. A series of studies by Hokanson, et al. (in Kaplan & Sadock, 1989), have provided evidence for the tension-reducing properties of various types of aggression, including noninjurious forms. The performance of expressive, although noninjurious acts, can both lower the emotional arousal stemming from provocation and reduce the likelihood of other forms of aggression.

CONCLUSION

The delivery of mental health services to those in law enforcement is both old and new, as well as simple and sophisticated. A working model must integrate the best helping techniques into a goal-oriented systemic scheme. The helping model must ideally be goal-directed as well as action-oriented. It must not be ambiguous. Above all, it must be based on trust as well as on matching of personalities of the counselor and the counselee. The helper must have a thorough understanding of police work and the everyday stressors experienced by the officers in the discharge of their duties, as well as knowledge as to the composition of the police force and demographics of the patrol officers. They must also be familiar with the organization of the police department and its power structure. In addition to being knowledgeable and experienced, the helper must be skillful, genuine, empathic, respectful and, as important, available when needed.

It must also be borne in mind that each counselee is a prospective helper; therefore, they should be assisted and encouraged to acquire the necessary skills so that they can help other officers. Police officers, it has been demonstrated, respond better and can be helped more by other officers who have gone through experiences similar to the ones they are traversing or by peer support groups. Further, peer help proves frequently to be more effective than professional approaches to helping. It usually consists of less theorizing and analyzing and at a lesser financial cost.

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THE SECOND INJURY

John C. Snidersich

"Don't worry. You'll be all right." "You'll be out of the hospital in a couple of weeks and everything will be okay." "You'll be back on your feet in a couple of days and feel as fit as a fiddle."

These are some of the statements that are heard by an individual who has been seriously injured. At first, these phrases are believed by both the person saying them and the person hearing them. Yet within a few days comes the realization that those words, spoken in good faith, were uttered in sheer ignorance. Most people fail to recognize that we are made up of more than the physical. There is an emotional/psychological reaction to our injury as well. This is the "second injury," and for many, the more devastating and long-lasting one. I can best explain this by telling you what happened to me.

On August 3, 1979, I was a New York City Police Officer assigned to the Street Crime Unit, a specialized squad dedicated to the arrest of criminals involved in violent crimes-in-progress. That afternoon I was working a plainclothes undercover detail with my partner, Kevin Shay, in the Borough of Manhattan. Unbeknownst to us, an individual by the name of James Bel walked into a Chemical Bank located at 39th Street and Broadway. There he approached a bank guard and produced a sawed-off shotgun from underneath his jacket. He then removed a .38 service revolver from the guard, walked over to the teller, handed her a brown paper bag, and demanded that she fill it up. She did so to the tune of $7,500. Bel took the bag and exited the bank.

A young male teller observing this felt that this was wrong and chased after Bel with a lead pipe. He caught up with Bel on the street in front of the bank where he threw the lead pipe and struck Bel on the back of the head. Bel turned and fired one round from the shotgun at the teller.

As the small skirmish was being played out, I was in traffic in an unmarked police van witnessing this entire scenario. It was at this time that I witnessed one of the most terrible sights I had ever seen to date. As Bel produced the sawed-off shotgun from underneath his jacket to shoot the teller, the brown paper bag containing $7,500 went in front of the muzzle of the shotgun, and I witnessed $7,500 shot to hell. But he missed the teller.

Bel then turned and ran toward the subway station located at the corner of 40th Street and Broadway. I yelled to my partner, "We have shots fired! Shotgun!" I jumped out of the van and gave chase. I had seen Bel go down the subway station and as I got to the curb, I now observed him walk out of the subway station, walk over to the money lying on the sidewalk, bend over, and proceed to place the money into his pocket. I approached him from the rear and said all the technical things I had been trained to say, "Halt...Police...Don't move...Get your hands in the air...You're under arrest."

As I spoke to Bel, he turned toward me and I saw a cocked .38 service revolver in his left hand. I told him to put the gun down and that I did not want to hurt him. With this, Bel fired three rounds at me. I returned fire, striking him. We then stopped, ran parallel to each other for a few feet when we then engaged in a second round of shooting. This time Bel struck me three times. The first round hit my right forearm. The second round hit a Marine Corps belt buckle that I had on. The third round hit me dead center in the chest. Many asked what is it like to get hit in the chest. I can best answer that by saying that it is like getting hit in the chest with a sledge hammer. A few asked what is the first thing that went through my mind. And for me, this was the more devastating result of the shooting. My first thoughts after getting shot centered on my three-year-old son, who I realized I would never see again. The depths of my depression at that moment cannot be described in words. I then realized I had to get back to business.

My partner, Kevin Shay, was yelling at me, "Are you hit?" since he saw me standing with my hand clenched against my chest covered with blood. I responded, "Don't worry about me. Get the bastard." Bel had run toward 40th Street and made a left hand turn. Kevin gave chase. I ran after them. As I reached the corner, I collapsed, got up and attempted to reload my revolver. I then heard a challenge from two police officers from the Midtown South Precinct Anti-Crime Team, neither of whom had ever met me. Both officers had their guns drawn and pointed at me. One officer had his gun cocked. It seemed like an eternity until I was able to convince them that I, too, was a police officer. As they approached me, they then realized the severity of my wounds and led me to their unmarked police car. They took me to Bellevue Hospital where I was given Last Rites and was cut open without any anesthetic. The doctor needed to perform an exploratory operation quickly to assess the extent of my physical injuries. Finally, friends of mine from the Street Crime Unit came in and stood over me with tears in their eyes insisting that I would get better and that everything was okay. All in all, it was a lousy Friday afternoon.

The following day I woke up and as the old saying goes I wanted to stop and smell the roses. I was alive and thankful. I was capable of seeing my son and my wife. I was told that they had left the bullet in my chest, and that I was going to be all right. I was also told that Kevin had dispatched Bel to his greater reward.

As a few days passed, I found things happening to me emotionally that I had never experienced in my life. I found myself on a roller coaster with my emotions. When I was by myself, I would cry. When I was with friends, I was the life of the party. I found that when speaking to friends and relatives, I went into what I would call a mental limbo. I was not consciously thinking of any one thing in particular, nor was I following the gist of the conversation. A few moments later I would become aware of the person speaking and realize that I had no idea what he was talking about. I had never experienced a mental numbness before and it was extremely uncomfortable and disorienting.

I found that my short-term memory was almost nonexistent, and what frightened me most of all was my inability to concentrate and read. Get well cards were brought into the room by friends. By looking at the card I could determine whether it was humorous or not and thus respond accordingly. In one situation, my partner brought in the report of our shooting for my approval. I simply stared at the page for what I thought was an appropriate amount of time and then handed him back the report and told him it read well. It was approximately two weeks later when I discovered that there were a number of inaccuracies in the report. This forced me to admit to a supervisor that I was unable to read for a while after my shooting. For me this was a major humiliation.

A very good friend of mine by the name of Terry Braga visited me on the last night of my hospital stay and asked a very simple question, "I know how you are feeling physically, but how are you feeling emotionally?" Up until that time, no one had addressed this issue because no one saw any changes in me. I did everything I could to hide my fears. With Terry, however, I was capable of putting my fears aside and speaking for the first time of my problems. Terry had arrived at 6:00 p.m. and stayed with me until 8:00 a.m. the next morning. He offered me an avenue to vent where none had been provided before. He also assured me that what I had revealed to him would be kept confidential.

What magnified the second injury was the fear of telling anyone what I was experiencing. This was further complicated by the fear that the department would take some type of negative action against me.

What is the purpose of the war story? I am trying to give to you, the reader, the understanding that there is not just one stressful stimulus. Rather, the individual is being bombarded by any number of stressors. Mine ran the gamut from being physically shot to having to give directions to the officers driving me to the hospital, to being confronted by a newsman who managed to enter the emergency room in hopes of an exclusive interview. I feel it is important to note that the stress I felt and the reactions I had are not unique to shooting victims. I have personally met with and spoken to officers who have experienced similar stress-related reactions, both as a detective investigating violent crimes against police officers, and as a member of

a peer self-help group. In all situations, I have recognized that the officers experienced severe stress, and their stress reactions have taken various forms, including alcoholism, a general lethargy, and an inability to physically hold one's child.

If I have learned nothing else about the second injury, I have learned that the best way to bring hope to the officer and his family and assist in a speedy recovery is to address two issues. The first is the creation of a training program for officers who have already experienced the second injury. They then can go into the field better equipped to assist brother and sister officers in their recovery process. The benefit of having such officers is that they are perceived as trailblazers, and hopefully the lines of communication and trust can be established more readily. The second is to train psychologists/psychiatrists so that they understand police work and know what it means to be a police officer. Many police departments do not do this.

Recently, I visited with an officer who had received gunshot wounds to her stomach and had been interviewed by a department psychologist. One of the first questions asked of the officer was, "Didn't you realize how dangerous this job was?" The officer responded with her own question, "You're not a cop, are you? Because if you were, you wouldn't have asked such a stupid question."

It is incumbent upon the department to understand that just because a person is a professional psychologist/psychiatrist does not mean that he/she has an adequate understanding of the police officer's world. By giving the officer trained professionals to work with, the department is assisting in the injured officer's recovery by providing the best of both worlds: The peer support, which says in essence that "I have walked in your shoes and I understand your deepest fears because I have been there," and the professional who can provide a more structured therapeutic approach to the recovery process.

THE DYNAMICS OF FEAR IN CRITICAL INCIDENTS: IMPLICATIONS FOR TRAINING AND TREATMENT

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ABSTRACT

Fear is an automatic emotional reaction to perceived danger, an alarm response characterized by negative affect and arousal. Law enforcement officers have to know how to deal effectively with fear and life-threatening situations. Unfortunately, there is a paucity of information on coping with fear in the law enforcement literature. A linear model is conceptualized that describes how officers cope with fear and vulnerability during a critical incident. Implications for training and mental preparation for critical encounters are presented. The model's implications for treatment and critical incident stress debriefings are discussed and illustrated by case examples.

INTRODUCTION

Every law enforcement officer has to learn to cope with fear and vulnerability and usually has to do so alone. For many officers, talking about fear or feelings of vulnerability is taboo because it goes against the law enforcement image. It is crucial law enforcement personnel know how to deal with these feelings since coming face to face with one's sense of vulnerability, the nuts and bolts of critical incident trauma, is an occupational hazard. It is unfortunate that there is very little written on dealing with fear for police officers. This paper is an attempt to fill this gap.

Many police officers wonder what it will be like if they have a life or death encounter. "Will I survive? Will I be afraid? How will I react when I am scared?" Many officers deny fear, thinking, "It will never happen to me." For many officers who have been involved in critical incidents, things appeared to have happened automatically and instinctively. They are taught, and correctly so, they will respond according to their training. While good training is critical to survival, a much more active and complicated mental process is often involved during moments of peak stress that enables the officer to utilize the training for survival.

WHAT IS FEAR?

Fear can be defined as an automatic emotional reaction to a perceived danger or threat. It is an alarm response that is characterized by high negative affect (or emotion) and arousal. Many researchers have concluded that fear mobilizes one for flight (Barlow, 1988). Indeed, when one is scared, one's instinct is to get away. However, law enforcement officers are not allowed to act on this instinct. It is their role to respond to the danger. Hence, officers must be knowledgeable about fear, how it works, and how to deal with it.

Fear can be very useful. It cues us to be careful, to stay alert, and to mobilize for action. It is not an emotion to be second guessed or criticized, as so many officers do to each other because they do not consider it "macho." Fear is an automatic reaction and is beyond our control. It can, however, be focused. Moreover, it can be an important cue to action. We can still function, think, and process information under conditions of fear (Bandura, 1986).

Fear is different from panic. Panic occurs when one is overwhelmed by fear, and one responds by basic instinct--flight, fight, freeze (Barlow, 1988). Fear can mobilize great strength, the tremendous power

of our basic instinct to survive. Hence, fear can help us; it fuels tremendous response power and enables survival.

During moments of peak stress our minds and bodies rapidly mobilize for action. Our heart rate and blood pressure increase. Sugar is released into the bloodstream for energy. Acid flows into the stomach to get the nutrients out. Blood clotting enzymes flow into the system to minimize damage from wounds. More blood goes to the muscles and muscle tone increases. Capillaries close down and more blood goes to the internal organs to nourish them. The part of the brain responsible for conscious control of the muscles gets priority. Vision and hearing become more acute. Very quickly our body focuses all of its resources on survival.

The adrenaline flow and the other chemical changes caused by the "alarm" arousal often cause perceptual distortions that help survival. One may experience slow motion. One's thoughts are speeding many times faster than usual, so it seems time has slowed. Our ability to think and plan faster enables us to have more control over the threatening environment. For other people, time speeds up and one perceives everything occurring faster than usual, including their own actions.

One may experience auditory distortions. Sounds may diminish and we may not hear loud sounds (e.g., gunshots) that normally would disrupt our concentration. For others, sounds are louder, enabling a finer tuning into the danger.

Visual distortions occur that can help us. One may experience tunnel vision; an intense, focused concentration, usually on what is perceived to be the danger, with little or no attention paid to peripheral vision. Along with tunnel vision, and sometimes without it, there may be a heightened sense of detail. Under conditions of peak stress we can perceive more visual details more clearly than usual.

These perceptual distortions are normal and quite common during a critical incident, and help us survive. However, there are some costs to perceptual distortions. Due to tunnel vision, an officer may not perceive things (e.g., other threats) that are on the periphery. Later, an officer may be able to recall or describe only those aspects of the situation that were focused upon and be an unreliable witness for other aspects of the situation. An officer may not be able to give an accurate description of the time that transpired due to time distortion. Because of auditory distortions, an officer may not hear important details, such as how many shots were fired. It is important that investigators realize perceptual distortions are normal and occur automatically and unconsciously under peak stress conditions.

What are other psychological processes that officers go through when they come face to face with their sense of vulnerability that enables successful responding? The following discussion is what hundreds of law enforcement officers who have survived critical encounters have taught me about how fear works when one's life is perceived to be on the line. Keep in mind that the following discussion of a critical incident is an attempt to describe what takes place in split seconds. It is an artificial conceptualization designed to facilitate understanding of how fear works in a critical incident. Everyone is different and experiences critical incidents in individual ways. Some of the phases and concepts may apply to one person, but not to another. Understanding this process is more than an academic exercise, for it provides definite guidelines for training and preparation for critical incidents.

DYNAMICS OF FEAR

For purposes of discussion, a critical situation will be broken down into six phases:

I. HERE COMES TROUBLE: This is when we perceive that a situation is starting to escalate and realize the potential for threat. We become alert, physically mobilized (i.e., the "alarm" reaction), and

begin to focus our attention on the danger. Sometimes a situation is thrust upon us, with no warning, and the process begins with the next phase.

The next phase begins as one focuses on the threat and perceives that the danger is potentially life threatening. This phase is universally described by emergency workers in much the same way all over this country as "Oh shit!"

II. VULNERABILITY AWARENESS: At this point, one comes face to face with awareness of one's vulnerability and/or lack of control over the situation. One may experience a sense of shock and arousal, startle and surprise, disbelief and dread, and feelings of weakness and helplessness. One may have thoughts akin to, "Oh my God...this can't be happening...this is not supposed to happen...I (or someone else) may be seriously injured or killed...I don't know if I can handle this...I'm not in control here..." This is the essence of fear.

A general principle of human functioning operates at this point. When our focus is solely on danger and how vulnerable we are, we tend to feel weak and helpless (Bandura, 1986). We feel we have no control over the situation. This is a critical phase. Fear, or vulnerability awareness, may triumph and control our responses. Or, fear may cue survival responses.

For some officers, VULNERABILITY AWARENESS immediately leads to focusing on what they have to do to survive or gain control of the situation. This is especially true for the officer who has prepared for what can happen and what to do if it does happen. This officer immediately goes to Phase IV, SURVIVAL, and starts focusing on the danger in terms of his/her ability and capability to respond.

But sometimes we run into situations we do not expect or have never anticipated, or the perception of vulnerability and lack of control is particularly overwhelming. But, if one's awareness remains on vulnerability, there can be further intensification of arousal, fear, and distracting thoughts that can disrupt one's ability to respond to the danger (Barlow, 1988). Similarly, if one's attention remains focused on the physiological arousal, greater subjective intensity of the emotional experience may occur. Panic and mindless fight, flight, or freezing can result. One has to go through a transition phase that gets one focused on responding to the situation and SURVIVAL.

After VULNERABILITY AWARENESS, when one is aware of vulnerability and/or lack of control, one has to comprehend and make sense of what is happening and acknowledge the reality of what is taking place. One has to focus away from an internal awareness of vulnerability, with its consequent negative emotional arousal, to the external reality of the threat. One realizes something has to be done if one is going to survive and meet the challenge of the situation. There may be a phase of:

III. "I'VE GOT TO DO SOMETHING": The reality of the threat is acknowledged. There is no longer the shock, disbelief, and denial of what is happening. As one officer put it after literally saying "oh shit" when he saw a gun pointed at him, "It really is happening, and I've got to respond."

Another officer was shot in the shoulder. After thinking, "Oh my God, I'm shot," and experiencing a moment of shock and disbelief, he said to himself, "I am shot, now what am I going to do so I don't get shot again?" He crawled to cover, drew his weapon, and returned fire.

Some officers go through this refocusing phase, i.e., they shift their attention from their internal awareness of vulnerability to an assessment of what is happening externally and what they are facing. No longer are they denying the threat of the situation. Tuning into the external reality, instead of dwelling on the potentially overwhelming feelings of helplessness and fear, is necessary if one is to move from an emotional impasse to effective cognitive and physical action. Acknowledging

the reality of the threat is the transition from shock and startle to mobilization for survival. Such a transition enables thinking to focus on responding instead of helplessness.

Some officers have described a feeling of detachment during these moments. It is as if the situation is not real, even though they know it is happening. The have the experience of being on the "inside" looking out, or "watching" themselves in the situation. This detachment is an automatic psychological defense mechanism that dampens the feelings of shock and vulnerability. It is a disas–sociated state that allows overwhelming feelings to be distanced. This disassociation of emotions can facilitate functioning during overwhelming moments. Disassociation is characteristic of some people, but not of others. It is an automatic response that cannot be taught. Officers who react in this way need to know that it is normal in peak stress situations, and they are not going "crazy."

Many officers have thoughts that motivate the will to survive and propel them toward tactical thinking and action. For example, some officers strongly get in touch with how much they want to live. Other officers feel how much they want to see their families again. Some officers become quite angry (and survival will mobilizes) as they decide they are not going to let this guy take their (or someone else's) life or take them away from their kids. For other officers, the thought is, "How dare you do this to me." Indeed, anger serves to mobilize one for "fight." As with fear, anger can be an overwhelming emotion that disrupts behavior or it can be focused to aid survival.

It is amazing what thoughts we can have during these moments. One officer who was shot immediately flashed on a childhood situation where he was struck out during a baseball game, without taking a swing. He recalled his father telling him that if he is to strike out, then go down swinging. The officer then decided to "swing," and managed to return fire and kill his assailant.

As one realizes something has to be done if one is to meet the challenge of the situation and survive, one enters the next phase, SURVIVAL.

IV. SURVIVAL: One starts thinking about what has to be done to gain control of the situation; what one can do to survive. Commonly, officers describe that their previous training automatically comes to mind. Some officers think through several courses of action; others just find themselves responding. Such automatic responding is particularly displayed by officers who have used mental rehearsal techniques to prepare themselves for life–threatening situations.

One's perspective changes as one focuses on one's response to the situation. Where in VULNERABILITY AWARENESS one perceives the danger in terms of one's vulnerability, in SURVIVAL one starts looking at the danger in terms of one's ability and capability to respond to it and thinking about what to do. These thoughts can be quite rapid. Remember, thoughts speed up during moments of peak stress. The actions and options one thinks about in less than a second can take minutes to articulate verbally, given the slower speed of speech. Usually at this moment, feelings of dread and helplessness change. As one looks at and thinks about the danger in terms of one's ability and capability to respond to it, one feels more balanced and in control.

There is another important principle of human functioning here. When we view the danger or threat in terms of our ability and capability to respond to it, feelings of vulnerability and helplessness decrease, enabling coping and responding. (Bandura, 1986; Lazarus & Folkman, 1984). One feels more in control and is better able to maintain an external focus on dealing with the situation.

During SURVIVAL officers typically have a keen focus on what is happening externally. Quite often, the officer is experiencing tunnel vision, focusing solely on what is perceived to be the threat. There is an intense tracking of the threat and often continued reality checks as the officer affirms what is happening (e.g., "it really is a gun"), stays attentively attuned on what the suspect is

doing now (e.g., "he is not dropping it"), looks at the field of fire, decides on the target, anticipates options and their consequences, and so on, all in the flash of a second (or less). Indeed, an external focus is vital to survival, as an inward focus on one's sense of vulnerability can escalate arousal and interfere with one's ability to respond. Many officers describe a "moment of resolve" that comes once one commits oneself to a course of action, and one starts to do it. As one officer said when he committed himself to action (and an apt description of the next phase):

V. "HERE GOES": One starts one's response or finds oneself instinctively responding, with resolve.

This is an extremely strong moment--the moment between realizing what one has to do, committing to it, and starting to do it. This is the moment of survival, and one goes into a very strong, powerful frame of mind. Officers describe a sense of strength. There is a sense of control over this strength--though adrenaline is flowing and one's body is mobilized and aroused, one is in control of one's movements. Some officers describe a sense of calm strength once they committed themselves to action and started to initiate it. Though thoughts may be racing, they tend to be clear and lucid. There is often a sense of heightened awareness and a feeling that one is not going to over or underreact--just react. Many officers also have a sense of confidence at this moment. I call this the SURVIVAL RESOURCE frame of mind. In other words, focusing on one's ability and capability to respond, and not on one's feelings of vulnerability, leads to power. The resolve to respond when experiencing fear leads to tremendous strength. Fear can be utilized to get strong.

However, for many officers, there is no conscious awareness of the survival strength they had. They are aware of their fear and later recall how vulnerable they felt when responding. It is often later, upon deep reflection of the incident, when they tune into the part of them that enabled them to respond, that these officers realize how much in control and how strong they felt at this moment.

The sixth phase, once we have consciously or instinctively come up with a response that we have resolved to do and start to implement is:

VI. RESPONSE--We do it...and SURVIVE: One may be experiencing fear, but can still stay focused on one's tactics and actions.

LIMITS TO THE MODEL

Let us note that these phases can occur within a flash of a second. Quite often, we do not go through a conscious decision-making process during the incident--we just find ourselves responding. Some of the phases described above never enter into the picture.

The above model is a linear description of the best-case scenario and is most applicable to situations where action is possible. However, this scenario can be deflected into a loop of frustration, futility, and disruption, and a relooping to VULNERABILITY AWARENESS at any of several points.

One might see only with hindsight the cues that spelled HERE COMES TROUBLE. As a result, one finds himself thrust immediately into the VULNERABILITY AWARENESS phase. One may have misperceived the threat that caused the VULNERABILITY AWARENESS. For example, the officer who believes an individual is armed may mistake the "glint of metal" to be a weapon when in reality it was keys.

In the VULNERABILITY phase, an officer can easily become so focused on the internal feelings of vulnerability, focusing on fears of his annihilation, that he is unable to make the shift to the external world. Consequently, he is unable to plan any actions. This may be considered an "internal tunnel vision" phenomenon, insofar as the officer is aware only of his feelings of fear and helplessness and is unable to "see" his strengths and resources.

The I'VE GOT TO DO SOMETHING phase is a source of particular difficulty for officers when there is nothing obvious to do (e.g., when someone is dying despite the best efforts to save them by first aid) or it is obvious what to do, but one does not have the equipment, knowledge, or control to follow through. In such a case, the officer may fixate on an unattainable goal, leading to frantic, unproductive, or even counterproductive behavior. For example, at a multicasualty disaster site, the officer runs frantically from person to person, rather than lending his attention to a single person he could help. Under such circumstances, the officer must be prepared for a "fall–back" position. When he recognizes that the best possible choice is not an option available to him, he must ask, "What else can I do?" If he has not developed a "fall–back" position, he may endlessly loop back to trying to effect the most desired action, even with the knowledge that it is not possible. This loop ultimately produces frustration and VULNERABILITY AWARENESS. He is frustrated by his inability to perform the action that is desirable, and his inability to take that action makes him aware of his vulnerability. He may then attempt to solve the problem in the same way, determine that it is not possible, and become frightened, and so on....

The SURVIVAL phase where one plans one's response often requires the individual to coordinate two or more actions simultaneously or in a particular sequence. If the officer becomes fixated on a particular part of a multistate action, he may overlook other parts, with disastrous consequences.

The HERE GOES phase can be disrupted if one has made a poor choice of options. For example, an officer might attempt to overpower an unarmed man in the individual's kitchen, not having attended properly to the weapons available in the nearby knife rack.

Keep in mind the description of the phases is only a model of reality (and not reality itself) for purposes of discussion. However, some general principles can be gleaned about survival from this model that have important implications for dealing with fear and vulnerability before, during, and even after a critical incident when the emotional impact hits.

COPING WITH FEAR

The above framework gives us a model of how to cope with fear. Every officer should have ingrained in his guts that when we focus solely on the danger or threat in terms of how vulnerable we are, we feel weak, helpless, and out of control. When we focus on our ability and capability to respond to the danger, we feel more balanced and in control, and even RESOURCEFUL. Consequently, coping with fear is a matter of accessing and focusing on one's ability and capability of responding to the danger, and not dwelling on one's vulnerability. Of course, one must have the training and knowledge about how and when to respond.

One can understand panic as experiencing fear, but keeping focused on vulnerable thoughts and emotions. Staying in such a focus, where one's attention narrows on the arousal and strong emotions associated with vulnerability, can lead to further intensification of arousal, creating a vicious cycle of escalating fear that disrupts concentration and performance. One then has only basic instincts––fight, flight, or freeze––to rely on. One can break this escalating cycle by focusing externally on what is happening and the action one needs to take. Where fear can overwhelm one's ability to function if one stays focused solely on the threatening aspects of the situation (one's vulnerability) and the consequent internal arousal; fear can empower a person when attention is focused fully and completely on what one has to do and one has the knowledge of tactics for implementation.

Knowing one has the ability to respond to critical encounters is vital for optimal functioning. Competent functioning requires not only skills, but trust in one's ability to perform them; that is, believe in one's efficacy (Bandura, 1986). Lack of trust in one's ability to respond undermines effective use of the competencies one has. Research has shown that people who have a strong sense of efficacy more easily focus their attention and effort on the demands of the situation, and meet obstacles with greater effort than people with low self–efficacy (Bandura, 1986). The stronger one's sense of efficacy, the less disabling the

VULNERABILITY AWARENESS phase will be, the easier it will be to move to the SURVIVAL phase, grab hold of the SURVIVAL RESOURCE, and persevere. Several steps can be taken to enhance one's sense of efficacy and prepare for high-level functioning and coping during moments of peak stress.

1. LEARN YOUR SURVIVAL AND EMERGENCY TACTICS WELL. The more tactics and responses we know, the easier it is going to be to cope with fear. The more tactics we know well to the point of competence and confidence, the more we are capable of focusing on our ability to respond. Obviously, one needs to physically practice a variety of tactics and techniques to learn them well enough so that they are reflexive and second nature. But even that technique that is learned perfectly is useless unless one knows when, and in what context, to use it.

2. What facilitates tactics and motor skills becoming second nature is the utilization of mental rehearsal techniques, where one visualizes a dangerous or threatening situation and how one will respond to it. Mental rehearsal can help one learn tactics to the point they are reflexive and automatic. One should not only mentally rehearse for the gamut of situations that can occur, but rehearse a variety of responses to the same situation. One should give oneself more than one option and build flexibility to one's responding. Remember, although mental rehearsal is an adjunct to physical practice, it is not a substitute.

3. It is important that officers understand the psychological and physical effects of fear. Officers should be knowledgeable about coping with vulnerability, be prepared for perceptual distortions, understand the basis for physiological arousal, and what physical phenomena (e.g., "alarm" reactions) occur when fear is experienced. Unexplained arousal is aversive and can lead to more anxiety and arousal and further threaten one's sense of control (Barlow, 1988). Knowing what to expect and understanding what is happening can help one cope with fear and feel more in control.

4. It is crucial that one acknowledge the reality of what can happen NOW. Anticipating what can happen and what it will be like can take away some of the shock and startle value of a critical incident. This will facilitate moving from "VULNERABILITY AWARENESS" to "I'VE GOT TO DO SOMETHING" and facilitate "SURVIVAL" thinking. The quicker we can acknowledge the reality of a situation during moments of peak stress, the quicker we can start mobilizing ourselves to action.

   Mental rehearsal can help inoculate against shock if one makes the situations rehearsed as realistic as possible. One should not only make the situations as real as possible, but imagine what it will feel like when the situation is occurring. It can be difficult to cope with the anxiety generated by a realistic rehearsal. But it is critical that one rehearse as vividly as possible if the full "inoculation" effect of rehearsal is to be obtained.

5. It is crucial that one think about one's will to survive NOW and get the resolve to survive and live clear in one's head and heart. The tremendous strength of the SURVIVAL RESOURCE that comes with the resolve to take action can save one's life against overwhelming odds.

6. Utilize fear to become strong. Focusing on one's ability and capability to respond mobilizes the SURVIVAL RESOURCE, the frame of mind of controlled strength and clarity of mind that accompanies, and perhaps facilitates, responding under critical conditions. Research has suggested that the RESOURCE is an optimal frame of mind for responding to a critical incident (Solomon, 1988). One can build this frame of mind into mental rehearsals. Recall the RESOURCE as vividly as possible, what a moment of "HERE GOES" was like, and fully focus on the strongest moments. When doing mental rehearsal for future situations, one can incorporate this frame of mind. Research (Solomon, 1988) has suggested that utilizing the RESOURCE frame of mind can enhance performance.

7. Having a mental library of past successes enhances one's sense of efficacy. Rather than take successful responding for granted, it is important that officers think about their successes and learn from them as well as their mistakes.

IMPLICATIONS FOR TREATMENT

The emotional aftermath of a critical incident entails experiencing feelings of vulnerability, fear, and lack of control (Solomon & Horn, 1986). One has a tendency to focus on the VULNERABILITY AWARENESS phase of the incident and dwell on what is perceived to be the most vulnerable moments. The feelings of vulnerability and other reactions have to be acknowledged and dealt with, not denied or suppressed, which could lead to future emotional problems (e.g., posttraumatic stress disorder). Further, these feelings must also be acknowledged as normal.

However, one must also acknowledge the next phases of the incident, focusing on one's response. It is during the I'VE GOT TO DO SOMETHING, SURVIVAL, HERE GOES, and RESPONSE phases, where one responded to the danger and exercised control. Remember, when one focuses on one's ability and capability to respond to the danger, one feels more balanced and in control, relative to the VULNERABILITY AWARENESS phase. When the officer recalls and focuses on all the thought processes, myriad decisions, movements, and actions taken in response to the danger, one recaptures a sense of control.

The fundamental strategy of such treatment is to process the information comprising the emotional images or representations stimulating the fear and vulnerability to facilitate new learning and anxiety reduction. Lang (1979, 1985) elaborates on this "emotional processing" model of fear and anxiety reduction. I have found that the most effective procedure for going over the incident is to recall the incident moment by moment, perception by perception, "frame by frame." This not only facilitates ventilation, but helps the client to remember details and thoughts that were not previously recalled. This procedure should not be done immediately after the incident, when one is numb and exhausted. The next day, or within 72 hours is perhaps the best timing, when the emotional impact of the incident is being experienced.

I have found it particularly efficacious to help the officer focus on the HERE GOES phase, the moment of commitment, and recapture the sense of strength, control over this strength, heightened awareness, focused attention, and clarity of mind (the SURVIVAL RESOURCE). Quite often, officers are not aware of this frame of mind. They may attribute their survival to luck or say, "I guess my training came through, but I'm damned if I know how." They take no credit for their solid reactions, for their recall is stuck in the seconds of VULNERABILITY AWARENESS. When they recall the incident, they focus only on the fearful confrontation, not the successful resolution (e.g., they survived). They may focus on what was out of their control and discount that they were able to do something to influence the situation. Focusing on the SURVIVAL RESOURCE enables the officer to experience the strength, control, and power he had during the moments of vulnerability.

Getting in touch with the RESOURCE moments can reframe fear and one's perception of the incident. One can learn that fear leads to strength, or that one is capable of responding under conditions of fear. One can then recall the incident not only as a time of vulnerability and fear, but one of strength and control. Survivors come to realize that one is vulnerable; that is part of the human condition. BUT ONE IS NOT HELPLESS--ONE HAS THE ABILITY AND CAPABILITY TO RESPOND. One cannot always control a situation, but ONE CAN CONTROL ONE'S RESPONSE TO THE SITUATION. Such a reframe is vital for the officer, or any emergency worker, who goes back to the street and faces the possibility of another critical incident. All in all, one can learn and grow a great deal from a critical incident. Indeed, after coming to grips with one's sense of vulnerability, there is not a whole lot else in life to overcome!

There are times when the most appropriate response is a passive, yielding, or surrendering response. For example, an officer can be ambushed and be forced to give up his gun, or outnumbered and wisely make

the choice to back out of the situation without the person he just put under arrest. These are traumatic situations for officers who view their response as demonstrating weakness, or discount the appropriateness of their passive response. In these types of situations there is not active SURVIVAL RESOURCE action to look back upon, and the officer can get stuck in VULNERABILITY AWARENESS. The emotional impact can be particularly devastating for the officer who believes he should always be able to take action.

What must be realized is that in many situations the best response for survival is a passive response of that of doing "nothing" is often the best "something" one can do. The frame–by–frame procedure, with emphasis on the rationality and survival value of the decision to yield or act passive, given the circumstances, is still quite therapeutic. Further, in going through the situation frame by frame, the officer will probably find he was mentally active, not passive, and exercised control in choosing his response. There is still the SURVIVAL phase in thinking about what options one has (or does not have). The SURVIVAL RESOURCE is demonstrated in having the awareness to realize when one is outmaneuvered, realizing what options are realistic, and choosing not to act on "tombstone courage." There were probably a host of RESPONSES that one did in attempting to influence the situation (e.g., talking to the suspects, remaining alert and aware) that enabled survival. By going through the situation, one can realize one did the best one could given the situation, the perception at the time, and differentiating what was, and was not, under one's control.

CASE EXAMPLES

#1 The officer chased an armed robber who had just robbed a jewelry store into an alley. The bandit stopped in front of a truck and faced the officer. The officer positioned himself behind the truck, taking a covered position, yelling at the bandit to drop the weapon. The bandit fired a round at the officer. The officer ducked and then returned fire. The bandit fell to the ground, wounded. As the officer approached the bandit, the bandit again started to level the gun at the officer. The officer fired two more rounds, disabling the bandit. The emotional aftermath for the officer were flashbacks and nightmares of the incident and guilt. There was a pervasive sense of lack of control as the officer recalled the shot fired at him, and the bandit being able to bring his weapon to bear after being wounded.

Going back over the incident, frame by frame, the officer recalled his thinking during the chase. He was aware the bandit was armed and was keeping alert to his movements. When the bandit ducked behind the truck, the officer immediately started to position himself so the truck would provide cover. When he got to the truck, he recalled thinking about how to crouch so as to provide the best cover. He experienced a sense of controlled strength and clarity of mind when he fired his first round. When approaching the wounded suspect, he recalled his heightened awareness and focus on the subject, the caution he used in his approach, the necessity of having to fire again, the control he utilized, etc. In other words, he got back in touch with how he exercised control and realized that he had more control than he initially perceived. Not only was this relieving and therapeutic, resolving his fears helped him respond more competently when he was involved in another shooting a year later. He shot a bank robber who was attempting to run over him in a car. He felt a lot more in control during this critical encounter. He felt guilty about again having to shoot someone and had to deal with the reality that a cop can get involved in more than one shooting situation. But the positive resolution of the first incident facilitated optimal functioning in the second situation, and much less of a traumatic aftermath.

#2 A trooper was parked on the shoulder of a highway investigating an accident. One of the motorists was in the back seat of the car. The trooper saw an out–of–control truck heading his way, and seconds later it hit the squad car. The trooper was slightly injured and off work for a few weeks. The emotional aftermath were nightmares and flashbacks of the incident, a heightened sense of vulnerability, and a strong sense of lack of control. After all, there is not a whole lot one can do with a truck bearing down on you and no time to leave the car.

Going over the incident frame by frame brought out the complex and extensive thought process the trooper experienced. As he saw the truck coming his way and literally said, "Oh shit," he yelled at the passenger to duck. Along with thoughts relating to vulnerability and lack of control was a tracking of the truck's movement in the rear–view mirror as he readied himself for the moment of impact. He braced himself and remembered to keep loose to minimize injury. This process was quite comforting to the trooper. Focusing on all his thought processes and actions, noting all the different phases of activity after VULNERABILITY AWARENESS, helped the officer feel in control. He realized he was vulnerable and could exercise no control over the truck, but realized he was able to exercise some control and do something to minimize injury to himself and his passenger.

#3 The officer was involved in the fight of his life as he struggled with a suspect in a barroom fight. The suspect got the officer's weapon out of the holster and had his finger on the trigger. The officer started hitting the suspect continually as hard as he could in an effort to prevent the suspect from firing. After a few minutes, several bar patrons helped subdue the suspect. No shots were fired.

The officer suffered severe nightmares after the incident and experienced a deep sense of lack of control and vulnerability. His key moment of vulnerability was when he perceived the gun pointed at him. The officer, who was wearing a protective vest, recalled moving his chest in such a way as to have the vest directly in the line of fire and prevent the possibility of being shot in the side, where the was minimal protection. At this moment he fully realized he could get killed. However, he felt by entertaining such thoughts, and making such a movement with his chest, he was giving up and giving into the possibility of being killed. Though one can objectively see the officer made a survival decision to move his vest in the direct line of fire to minimize injury, the officer would not embrace this perception, and severe nightmares resulted.

Going through the incident frame by frame, the officer indeed experienced deep feelings of vulnerability when he saw the suspect's finger on the trigger and the gun pointing at him. But going beyond the VULNERABILITY AWARENESS phase enabled the officer to focus on his ability to respond. He recalled his thoughts about repositioning himself to minimize injury should the weapon fire. He realized he was reacting to the danger of the moment and his movement to reposition himself was a survival tactic, not a surrendering or giving in. He focused on his tactic of repeatedly hitting the suspect and realized his blows were effective in preventing the suspect from firing the weapon. He realized that along with fear and vulnerability thoughts, he was thinking tactically about how he could respond. He felt the survival RESOURCE strongly during several moments, which enabled him to give his actions credibility where before he was second guessing himself. After going through the incident frame by frame, he realized he exercised control, kept responding, and did not give up. His nightmares ceased after this session.

CRITICAL INCIDENT STRESS DEBRIEFING

The "dynamics of fear" model is also useful during critical incident stress debriefings. Dr. Jeff Mitchell (1983) offers an effective model for conducting a debriefing that is extensively used all over the world. In utilizing Dr. Mitchell's model for group debriefings, I have found questions like, "Did you experience a moment of 'Oh shit,' and what was it like?" to be useful. Emergency personnel know exactly what I mean. They tend to chuckle, and then go right to talking about the greatest moments of vulnerability. This question helps thresh out Dr. Mitchell's "Thought" and "Reaction" phases of the debriefing. Further, talking about the I'VE GOT TO DO SOMETHING, SURVIVAL, HERE GOES, and RESPONSE phases of an incident facilitates ventilation and helps to reestablish a sense of control as the tactical and survival thinking and action that took place during the incident are recaptured. I have found talking about the dynamics of fear to be useful to emergency workers during the "Teaching" phase of the critical incident stress debriefing. It gives participants a framework with which to think through and understand a complex process that is often difficult to comprehend and

articulate. The more one can understand one's thoughts, emotions, and reactions during an incident, the easier it is to work through the traumatic aftermath.

CONCLUSION

Training for police officers usually focuses on how to respond to high-risk situations. Seldom is there any discussion on dealing with fear and vulnerability. Officers should be given training about the dynamics of fear and vulnerability, what to expect, and how to cope.

There needs to be more research and training on coping with fear and vulnerability. Though theoretical models are available in the anxiety and phobia literature, there is little information on fear in the context of emergency work. I offer my model as an attempt to fill this gap. I invite criticism of the model in the hopes more attention, thinking, and research is directed toward this vital area.

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THE PSYCHOLOGICAL PROCESSING OF TRAUMATIC EVENTS: THE PERSONAL EXPERIENCE OF POSTTRAUMATIC STRESS DISORDER

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Sudden, terrifying experiences that explode one's sense of predictability of life can have profound short-term and long-term effects on one's subsequent ways of coping. The syndrome of Posttraumatic Stress Disorder (PTSD) can follow such widely different stressors as war trauma, rape, muggings, shootings, explosions, accidents, heart attacks, family violence, and child abuse. The helplessness and rage that usually accompany these experiences can profoundly affect a person's self-concept and interfere with the subjective sense of relative safety and predictability that is essential for normal functioning. People seem to be psychologically incapable of accepting random, meaningless destruction and will search for any explanation to make meaning out of a catastrophe, including blaming themselves or their loved ones; helplessness asks for a culprit. This may be either turned against the self for having been unable to prevent the inevitable or against others.

Unable to process the experience with customary coping strategies, trauma victims usually first react with a feeling of numbness and derealization, attempts to deny the reality of the experience. This emotional paralysis alternates with waves of recollections of the catastrophic experience. Memories of the event may come back in a variety of ways: as thoughts and preoccupations, nightmares, flashbacks, waves of feeling, bodily sensations, or behaving in ways that would have been appropriate at the time of the trauma. Thus, PTSD has been described as phasic alteration between intrusive and numbing responses. This consistent pattern of hyperarousal alternating with numbing has been noticed following such a vast array of different traumas that it is reasonable to assume that this consistency is related to the biological reactions that accompany sudden terrifying experiences.

It is difficult to predict just who will and who will not develop PTSD; many people make a good readjustment after the symptoms of acute PTSD subside until weeks, months, or years later when, during subsequent periods of stress, they may suddenly develop intrusive memories of past traumatic experiences. If people live in a supportive environment and have a chance to talk about what happened; if the trauma does not devastate everything that is dear to them; if they have a well-developed sense of their strengths and weaknesses; if their past experiences have been relatively safe; and finally, if they are not blamed for their misfortunes, they are likely to either recover from the trauma or to delegate the feelings associated with the trauma to such a small area of their personal life that the scars are hardly noticeable. All these preconditions illustrate how vulnerable people can be to developing some long-term effects.

When people do develop PTSD, the trauma overpowered their capacities to make sense of it. This caused the images and feelings related to the trauma to continue, not necessarily in conscious awareness, but as actions, sensations, or feelings that were appropriate at the time of the trauma but are not relevant to current events. The unexpressed ideas and feelings related to the trauma are responsible for the continued reenactment of the trauma, until the victim learns to put them into words. Until then, they are likely to react to even minor irritations as an emergency. Thus, people who develop PTSD organize their lives around dealing with the aftermath of the trauma in one or both of two seemingly contradictory ways: They are dominated by recurrent intrusive, affectively overwhelming "memories" related to the trauma in the shape of visual images or somatic sensations, such as nightmares, flashbacks, or anxiety attacks and/or they show extreme avoidance of involvement in life, in fear that any intense feelings may trigger a reexperience of trauma. They can respond to ordinary stimuli in a rote manner, but when exposed to issues dealing with intimacy, trust, dependency, or anger, they often react to current situations as if they were traumatized all over again: With rigid, totalistic reactions appropriate to overwhelming situations--either with fight responses or with flight; they either blow up or withdraw, often both. Without conscious awareness of where these feelings come from, this forces them

to relive the past over and over again. Aware of the effects of their behavior on their surroundings, they feel guilty and angry and are prone to dull their feelings with overwork and/or alcohol.

THE TRAUMA RESPONSE HAS BOTH BIOLOGICAL AND PSYCHOLOGICAL COMPONENTS

Over the past few years, it has become increasingly evident that the intensity of the initial bodily response to the trauma is the most significant predictor of long-term outcome. The intensity of physiological arousal seems to depend, in turn, on how much terror was experienced at the time of the trauma; on a person's innate physiological reactivity; the stage of maturation of the central nervous system (CNS); and on the degree to which the person can feel safe that others will protect him/her to prevent a recurrence of the situation. A person whose body continues to go into a fight/flight/or freeze response at the least provocation keeps experiencing life as a continuation of the trauma and remains in a state of constant alert for its return. Many traumatized people who have consciously put the trauma behind them continue to experience increased autonomic arousal when exposed to situations reminiscent of the trauma or even to unexpected events such as loud noises.

In PTSD, the symptoms of hyperreactivity (with startle responses, explosive outbursts, nightmares, and intrusive recollections) alternate with diminished motivation, decline in usual interests, and emotional constriction. Chronic increased reactivity has been demonstrated in other civilian trauma victims as well. Studies of rape victims found persistent "generalized signs such as nervousness, tension and trembling . . . panic attacks and apprehension and dread. . . which leads to avoidance and escape behavior." In PTSD, this increased autonomic arousal is no longer a preparation for, but a precipitant of emergency responses that bear little relationship to the nature of the contemporary stimulus. This can result in further autonomic arousal, anxiety, and even disorganization of thought processes.

The immediacy with which trauma victims continue to react to stress is most striking: rape victims experience intense anxiety in situations reminiscent of the trauma; Vietnam veterans may misinterpret the movements of a sleeping bed partner as a Viet Cong attack and react accordingly; mild noises played into the rooms of sleeping people with PTSD may precipitate nightmares in which old traumatic occurrences are recreated in exact detail. An illustration of how autonomic arousal is associated with flashback phenomena was provided by a former parachutist who had a three-month period of symptoms of PTSD after his second parachute failed to open until he was a few hundred feet above the ground. Five years later, the only remaining symptom of PTSD is a flashback of this event upon exposure to another stressor such as a near car accident.

In addition to hyperarousal, traumatized people have repeatedly been noted to have an all-or-nothing response to emotional stimuli. They have trouble modulating the intensity of their emotional responses, be they anxiety, anger, or intimacy. This can, in fact, account for most long-term problems, such as the following.

1. The tendency to react to relatively minor stimuli as if there were a recurrence of the trauma: startle reactions and irritability, which prevent thinking before doing--in other words, which precipitate inappropriate fight, flight, or freeze reactions.

2. Visual and motoric reliving experiences: nightmares, flashbacks, and behavioral reenactments. Situations that cause physiological arousal activate these memories of the trauma.

3. Persistent hyperarousal leads to avoidance of all stimuli that may remind a person of the trauma resulting in emotional and social isolation.

4. Compulsive reexposure to circumstances reminiscent of the trauma may be related both to the fear of novel situations seen in traumatized people and to conditioned endogenous opioid release in response to reexposure to traumatic stimuli.

INFORMATION PROCESSING AND MEMORY STORAGE

Both a person's developmental level and the degree of physiological arousal affect the way in which information is processed and memories are stored. Developmental psychologists have identified three modes of information processing that bear relationships with the development of the central nervous system: Enactive, iconic, and symbolic/linguistic. As people mature, there is a shift from muscular to visual to symbolic and verbal ways of organizing mental experience. When people are stressed, they often revert to earlier modes of processing emotions: The essence of the trauma experience is that it leaves people in a state of "unspeakable terror," it does not fit into established meaning schemes, and it overwhelms people's usual coping mechanisms. Being unable to put the experience into words, the memory of the experience is stored on a somatic or visual level: As horrific images, visceral sensations, or as fight/flight/freeze reactions. Under ordinary circumstances, memories for these experiences are often difficult to retrieve, but they can be reactivated by bringing people back to the feelings or surroundings that were present at the time of the trauma.

Children are particularly vulnerable to physiological disorganization in the face of stress, and they rely principally on their caregivers to help them with the extent of their arousal. As children mature, they acquire broader cognitive schemata into which to fit a larger variety of experiences. These ever-expanding cognitive abilities decrease a child's reliance on his/her environment for soothing and increases his/her own capacity to modulate physiological arousal in the face of threat. Cognitive schemata serve as a buffer against being overwhelmed; e.g., a well-trained police officer is much less likely to react to physical trauma with a freeze or flight reaction than people whose cognitive frame leaves them unprepared for specific responses in the face of mutilation and death. Thus, the cognitive preparedness (development) of an individual interacts with the degree of physiological disorganization to determine the capacity for mental processing of potentially traumatizing experiences. When an experience is traumatic, i.e., overwhelms a person's coping mechanisms, the event will be stored in memory, but physical memories may dominate over verbal representation, and the events will mainly be remembered as a bodily experience--as anxiety and panic.

Children are much more prone than adults to react to trauma on a somatic and behavioral level and often have little verbal awareness of the origin of these reactions. However, both traumatized adults and children are prone to increased clinging, repetitive acting out of the trauma, and general loss of curiosity.

When adults are overwhelmed by generalized somatic and affective responses to terrifying experiences, they often regress to earlier stereotyped emotional and behavioral patterns, including infantile dependency, obsessive-compulsive behavior, and difficulties in modulating the intensity of aggression. Trying to forget the trauma rarely seems to be a useful psychological long-term coping strategy. We have known for a long time that if a person tries to run away from important events, he/she "is obliged to repeat the repressed material as a contemporary experience instead of . . . remembering it as something belonging to the past."

EFFECTS ON INTERPERSONAL FUNCTIONING

The shattered sense of predictability and safety, combined with the increased physiological arousal of traumatized individuals prepares them to react to subsequent stress with continued emergency responses. These impair the capacity to calmly size up the nature of current challenges, and, as a result, many traumatized people go immediately from stimulus to response, relying on action rather than thought to meet new challenges. These actions are more appropriate to the past emergencies than to the current stimuli. Not being able to react appropriately to the present further interferes with the resolution and integration of the trauma. The long-term psychological responses to traumatization, including spacing out, sensation seeking, emotional

constriction, and drug and alcohol abuse all make it difficult to recognize that it is the person's attempt to push away the memories of the trauma that underlies these reactions. When emotional constriction, with loss of conscious preoccupation with the traumatic event, only results in overinvolvement in work, emotional distance, and generalized irritability, it is even more difficult to pinpoint their origin.

OTHER EMOTIONAL EFFECTS

The other emotional difficulties that may accompany PTSD are: (1) continued feelings of depression and helplessness; (2) poor affect tolerance, impulsivity, and a tendency to experience emotions as physical states; and (3) compulsive reexposure to dangerous situations reminiscent of earlier traumas.

Depression and Helplessness

The loss of feeling that they can influence the course of their lives leads many trauma victims to position themselves at either extreme of the dependence–independence spectrum; i.e., they lose their capacity to modulate intimacy and dependency. In practice, this means that many trauma victims either become intensely dependent on their caregivers, which is accompanied by a loss of personal initiative, or they take a counterdependent stance, with lack of involvement with others, often accompanied by excessive involvement in work. Traumatized people generally have difficulty in modulating intimacy; they develop a disorder of hope. They often seem to have difficulties in knowing what are appropriate or inappropriate demands. Unable to appropriately assess their own and others' contributions to interpersonal tension, they often continue to see many social transactions as further victimization. Lack of emotional involvement in actual relationships diminishes the meaning of life since the trauma and thus further perpetuates the central role the trauma plays in their lives.

Poor Affect Tolerance

Traumatized people generally continue to have a poor tolerance for arousal. They tend to respond to stress in an all–or–nothing fashion and to react either with unmodulated anxiety, often accompanied by action, or with emotional withdrawal. This leaves traumatized individuals vulnerable to experience subsequent stresses primarily as somatic states, rather than as discrete historical events that require specific solutions. The tendency to experience stress as a somatic reaction may take the form of psychosomatic symptoms, panic attacks, rage reactions, or behavioral reenactments. Lacking understanding about the reason for the intensity of these reactions that are out of proportion to the severity of the current stressors, they are unable to use their mind to figure out what to do. Only after the intense somatic reactions are controlled with the presence of a safe relationship, psychopharmacological agents, and/or biofeedback can they begin to sort out the reality of their traumatic experiences in words and differentiate between past memories and current stress.

Fixation on (Addiction to) the Trauma

Some traumatized people remain centrally preoccupied with their trauma, at the expense of other life experiences. This may take the socially and psychologically useful form of sublimated preoccupation by being of assistance to other victims or of "bearing witness." However, other trauma victims continue to recreate the trauma in some form for themselves or for others. War veterans may enlist as mercenaries, incest victims may become prostitutes, victims of child abuse may grow up to become self–mutilators. These people experience a vague sense of emptiness and boredom when not involved in activities reminiscent of the trauma. Unless therapists actively focus on the effect of the trauma on current functioning, psychotherapy may at times reenforce preoccupation with and fixation on the trauma.

TREATMENT

Even after having suffered terrible trauma, people must somehow integrate those blows as aspects of their own lives in order to maintain continuity of a sense of self. The massive defenses that the mind initially created as emergency protective measures must gradually relax their grip upon the psyche so that aspects of experience do not continue to intrude into one's life experience and thereby threaten to retraumatize the victim.

The essence of traumatization is loss of safety and a continuation of psychological and physiological emergency responses. The first intervention needs to consist of making sure that the victim can retreat to a place of relative safety. This means both physical and emotional support, as well as a conscious avoidance of the natural tendency to "blame the victim."

After a traumatic experience that puts a person face–to–face with his or her helplessness and vulnerability, life can never be exactly the same: The traumatic experience somehow will be integrated in a person's life. Sorting out exactly what happened and sharing and comparing one's reactions with other victims have been found to be markedly effective: Putting the feelings and events related to the trauma into words is essential in the treatment of posttraumatic reactions. Traumatized patients are frequently very difficult to engage in psychotherapy. This probably is related both to a fear of attachment that reawakens the risk of abandonment and to reluctance to remember the trauma itself. After intense efforts on the part of the patient to ward off reliving the trauma, therapists cannot expect that the resistances to remember will suddenly melt away under their empathic efforts. The trauma can only be worked through when a secure bond is established with another person; this then can be utilized to hold the psyche together when the threat of physical disintegration is reexperienced. Failures to approach trauma–related material very gradually lead to intensification of the feelings and bodily states related to the trauma, leading to increased somatic, visual, or behavioral reexperiences. Once the traumatic experiences have been located in time and place, a person can start making distinctions between current life stresses and past trauma and decrease the impact of the trauma on present experience.

The process of remembering the past and putting it into perspective does not, of course, make the trauma go away or make the past not have happened, but reintegrating the sense of self in symbolic, reflective, and affective ways is the precondition for one's capacity to endure the seemingly unbearable experiences of life and the feelings that accompany them. Only when people are capable of separating the memories and feelings belonging to past events from current experiences will they be able to regain a sense of personal history with a past, a present, and a future.

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POSTTRAUMA VULNERABILITY: A PROPOSED MODEL

John M. Violanti, Ph.D.

ABSTRACT

The psychological assumption exists in most people that they are invulnerable from the dangers of the world and that bad things will not happen to them. When this assumption is shattered by a traumatic event, the ability to cope with psychological distress is affected. Police officers seem particularly affected by posttrauma vulnerability. From the moment an officer enters training, the police socialization process molds him/her into a myth of indestructibility. The effect of trauma on this myth is often devastating. Present methods do not allow for the measurement of vulnerability in individuals due to the complex interaction between human constitution and environment. It is therefore necessary to develop a model to measure **differential vulnerability** across groups. This paper: (1) outlines a proposed methodology for vulnerability measurement; and (2) discusses the correlates of posttrauma vulnerability. The model can be applied to the police and other groups, and may be useful in determining where treatment is most needed.

INTRODUCTION

The human psyche subjectively copes with the reality of life stresses. Individuals embody a psychological "assumptive world"; a strongly held set of assumptions that guide them through life (Parkes, 1975). In general, people operate consciously unaware of the postulates of these guidelines (Epstein, 1980).

A universal assumption seems to be that of invulnerability; a perception that harm happens only to other people. However, life events such as trauma, disasters, victimization, and severe stressors may shatter this assumption.

Police officers are particularly susceptible to posttrauma vulnerability. From the moment the officer enters police work, the socialization process molds him/her into depersonalized relationships and a myth of indestructibility. The effect of trauma, with its ensuing surge of emotions, devastates this myth. Officers expect **not** to feel vulnerable. When they do, it brings feelings of shame, fear, and a heightened sense of danger.

Regardless of the source of trauma, the result is generally an attempt to cope with ensuing psychological distress. Vulnerability may be one factor that affects coping ability, but we do not yet understand precisely what those effects are. We know that people experience differential vulnerability, as some cope satisfactorily with trauma while others do not (see for example Fowlie and Aveline, 1985; Frye and Stockton, 1982; Foy, Sipprelle, Rueger, and Carroll, 1984; Kessler, 1979).

An empirical model is necessary to assess the **differential impact** of vulnerability as it relates to traumatic stress. This paper provides such a model and explores constructs within the vulnerability process.

A MODEL FOR MEASURING VULNERABILITY

Exposure alone cannot account for the relationship between an individual's psychological distress and a traumatic event. There are many people so exposed who do not suffer psychological consequences and yet others who experience extreme reactions. What makes the difference is the **impact** of the traumatic event on the person. Vulnerability is thus defined as **the force with which trauma impacts on the distress of the**

the person. Vulnerability is thus defined as **the force with which trauma impacts on the distress of the individual** (Kessler, 1979). Perceived vulnerability after exposure to trauma may be a key factor in determining coping efficacy.

Since each individual has his/her own degree of vulnerability, the best strategy would be to assess on a personal level. However, due to the complex interaction of individual differences, environmental influences, and socialization factors, it is not presently possible to obtain an individual indicator of vulnerability. The best available measure would be a **vulnerability coefficient**, estimated as a constant across a group of individuals. Such coefficients can be statistically applied in each group and subsequently compared among groups.

Such a model for assessing vulnerability was proposed by Kessler (1979). When applied to trauma situations, the model is as follows:

Formula #1

$$D_i = V_i(T_i) + a_i$$

D = Posttraumatic Psychological Distress
V = Vulnerability coefficient
T = Traumatic Event
a = Residual effect

Explanation: If we think of a traumatic event (T) as being objective and potentially quantifiable and psychological distress (D) as some average symptom rating scale (e.g., impact event scale) (Horowitz, Wilner, and Alverez, 1979), we can estimate vulnerability (V) as a regression coefficient. Vulnerability may then be used to predict the **impact** of trauma on psychological distress.

Formula #1 does not necessarily infer that only one or several determinants make up the force of impact (vulnerability) on the individual. It is likely that vulnerability is embedded in a complex interaction of constitutional and environmental factors. An explanation might be as follows:

Formula #2

$$D_i = (V_{environment} + V_{constitution})\ (T_i) + a_i$$

This second formula may clarify the process, but we cannot use it to make the same estimation: there is presently no way to determine environmental and constitutional factors as **separate** entities.

A HYPOTHETICAL EXAMPLE

Let us assume that there are two groups of individuals exposed to a traumatic event: police officers and emergency medical technicians (EMTs). We want to assess the differential vulnerability between these two groups. Our first step would be the development of measurement criteria for the traumatic event and for symptom formation. Instruments are available in the literature for these purposes (see Horowitz et al., 1979; Langner, 1962; Macmillan, 1957). The next step would be to take our simple regression model and decompose it into four distinct components:

(1) The **impact** with which trauma affects each group;
(2) The **exposure** that each group has to the trauma;
(3) The **interaction** of vulnerability and exposure;
(4) the **residual** vulnerability that is unassociated with the present trauma.

In our imaginary experiment, we want to determine: (1) what the impact of trauma will be on police stress symptoms if they had the same vulnerability of EMTs; (2) what the expected change in police symptoms would be if they were exposed to the same trauma experienced by EMTs; (3) what the expected change in police symptoms would be if they were simultaneously exposed to trauma experienced by EMTs and had the same vulnerability of EMTs; and (4) what the residual differences in vulnerability would be unassociated with the present trauma.

In order to do this, we must first derive a separate regression equation for each group. A convergence of results from these equations can then be applied to the following formulation (Kessler, 1979):

$$D_{police} - D_{emt} =$$

IMPACT $\quad \text{sum } (V_{police} - V_{emt})\, T_{police}$

$+$

EXPOSURE $\quad \text{sum } (T_{police} - T_{emt})\, V_{police}$

$+$

INTERACTION $\quad \text{sum } (V_{police} - V_{emt})\, (T_{police} - T_{emt})$

$+$

RESIDUAL $\quad \text{sum } (a_{police} - a_{emt})$

Explanation:

IMPACT: Depicts the sum of the differences between police and EMT vulnerability scores across all independent variables. The outcome is then utilized as a coefficient of trauma experienced by police. This result represents the expected change in police distress symptoms if they were given the same vulnerability as EMTs.

EXPOSURE: Represents the sum of the differences between police and EMT trauma scores across all independent variables, then utilized as a coefficient for police vulnerability. Results show the expected change in police symptoms if they were exposed to the same trauma experienced by EMTs.

INTERACTION: Indicates the sum of the differences between police and EMT vulnerability scores across all independent variables multiplied by the sum of the differences between police and EMT trauma across all independent variables. Results will give the expected change in police symptoms if they were simultaneously exposed to the same trauma as EMTs and also had the same vulnerability.

RESIDUAL: Depicts the difference of police and EMT vulnerability that is not associated with the present trauma.

Together, these four components capture all of the influences on police/EMT symptom differences modeled in each equation. For illustrative purposes, let us say we obtain the following hypothetical regression scores:

Impact (vulnerability)	= 1.750
Exposure	= .001
Interaction	= .023
Residual	= .221

Such estimates would indicate that police officers are more psychologically vulnerable to trauma than EMTs. This is demonstrated by the impact coefficient, which shows a significant positive impact on symptoms among police even if they have the same vulnerability as EMTs. Exposure, interaction, and residual coefficients are small, indicating no significant impact on police symptoms.

The results of this hypothetical example can be summarized as follows: Police officers, because they are more highly affected psychologically (i.e., more vulnerable), exhibit greater psychological distress than EMTs when equally exposed to trauma.

CONSTRUCTS OF VULNERABILITY

Our hypothetical analysis provided a method to formally isolate the effect of impact on psychological distress, as we demonstrated how vulnerability can be measured differentially across two groups. To go one step further, we now need to look at some of the determinants of vulnerability.

As previously mentioned, there are many elements that affect vulnerability. First, there may be constitutional factors, including biological markers (Kauffman, 1987) that play an important part. Secondly, environmental factors such as social support can ameliorate the effects of traumatic stress (Solkoff, Gray, and Keill, 1985). Lifetime experience and the socialization process can also influence the perception of vulnerability.

Powerful influences on vulnerability are one's perceptions and beliefs. In our daily existence, we operate under an illusion that terrible things will not happen to us but to the other person (Janoff-Bulman & Frieze, 1983; Perloff, 1983). The experience of trauma, however, can alter this belief. As Lifton and Olson (1976) and Wolfenstein (1957) point out in their work on disasters, the involved person feels a sense of helplessness. . . an apprehension that anything may now happen to him or her; a sense of vulnerability. Solomon and Horn (1985) had similar results with police officers, who reported a heightened sense of danger after traumatic shooting incidents.

Shaw (1987), in his analysis of Israeli soldiers, discusses the development and importance of an individual's "illusion of safety." Effectiveness in battle depends on three psychological defenses: (1) a notion of personal invulnerability; (2) a belief that leaders are omnipotent; and (3) a feeling that the power of the group will provide protection for all members.

Shaw's analysis may certainly be applied to other groups. The police are an example. Police officers face danger, threats of bodily harm, and death on a daily basis. Much like the soldier, the police officer makes invulnerability an occupational necessity. As a result, police tend to develop a "superman" attitude and suffer extreme psychological harm when the myth is shattered by traumatic stress. This is likely to occur because of the unexpected suddenness (Modlin, 1960) of the traumatic event. As Rangell (1967) suggests, trauma deals a strong "blow to the ego," causing a feeling of lack of control, vulnerability, and of not being able to cope with future occurrences.

The precise point at which the illusion of invulnerability is shattered is a matter of debate (Mendelson, 1987). The "stimulus barrier," purportedly the point where stressors are experienced, is described by Gediman (1971) as a complex ego function measurable along an adaptive–maladaptive dimension. Others (Furst, 1979; Burchfield, 1979) have stated that the stimulus barrier has an innate biological component that is reinforced by maturation and life experience. Davidson, Swartz, Storck, Krishnan, and Hammett (1985) state that vulnerability may be reflected in family psychopathology. Opposing views are held by Fowlie and Aveline (1985) and Solkoff et al. (1985), who demonstrate that PTSD occurs in persons with no preexisting pathology.

Regardless of onset, the unmasking of vulnerability is a fearful experience for any person. Concerns of perceived failure, inability to prevent reoccurrence, shame, and loss of immunity to danger all affect the individual. Persons realize the true impact of vulnerability when they can no longer psychologically mobilize against trauma. Hopefully, this paper has clarified the process of vulnerability and will assist in further research and posttrauma treatment.

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A DEVASTATING EXPERIENCE: DEATH NOTIFICATION

Father William R. Wentink

ABSTRACT

You've got eight years on the Police Department. You're on patrol. You get an assignment from the Dispatcher. You pull up to the location, ring the doorbell, and wait. You know just what you're going to say. The door opens and there's a young woman in her late twenties with three little kids hanging onto her. You look into her eyes and the eyes of those three little children, and you know you are going to destroy their lives. You must deliver the painful fact that her husband is dead. You can't chicken out. You do a disservice to people if you don't deal with facts. In death notifications, the Officer or Chaplain is the stabilizing force in that person's life at that moment. This paper will deal with the proper way to handle notifications, personal experiences, and the importance of "doing it right."

You've served eight years on the Police Department, you're on patrol, and you get a call from the dispatcher. "Call for an assignment." As you go to the phone to make the call, a number of things run through your mind. "Why don't they want to put it out on the air? Probably somebody wanted on a warrant who has a scanner or maybe it's a bomb threat somewhere and they don't want to scare or alert everybody who listens to scanners." So you go to the phone, call the dispatcher, and get all the information you need. You return to your vehicle and start over to the location they gave you. You're thinking about some of the other calls you've been on during your eight years on the Police Department. How you've caught burglars in buildings. You think about searching buildings in the dark, about the times you've been scared. And you think about how you got through that by yourself. You're thinking about this call. You pull up to the location, walk to the front door, and ring the doorbell. You know just what you're going to say when they answer the door. The door opens and there's a woman in her late twenties with three little children hanging onto her side and she says, "Yes Officer, what can I do to help you?" And everything that you've prepared to say is now completely forgotten. You don't know what to say. You're moving back and forth on your feet, your palms are sweating, you have butterflies in your stomach. And she says again, "Officer, what's the matter?" And you reply, "Ah, um, ah, I'm here because your husband has been in an accident."

"An accident? What happened?"
"Well, I don't know. They just told me he's been in an accident, a real bad accident."
"Real bad?"
"Ma'am, it's a real, real bad accident. It's very serious."
"How bad is he? Is he at the hospital?"
"He's at the hospital, ma'am. It's real bad. It's critical."
"It's critical?"
"It's real, real bad ma'am."

You look into her eyes and you look at those three little children who are looking at you. And the wife finally asks you, "Is he dead?" You say, "Yes he is."

The entire time you were driving over there, the whole time you were standing there, you knew that what you had to say was going to destroy her life. And when it came right down to it, you didn't say it. She said it. She was the one who had to tell you, because when you arrived there and saw that woman and those three kids, you chickened out.

This incident was obviously handled wrong. In death notification it's very important to "do it right." This paper is based on my nineteen years as a Police Chaplain with the Rockford Police Department, my experiences during that period, and the training I have received from my membership and seminars with the International Conference of Police Chaplains.

There is no easy way to go to somebody's home and tell them that someone they love has been killed or died in a tragic way. Our police officers are the most valuable resource we have within our agencies, whether they are federal, state, or local. Because they are so important, police officers need to be physically, mentally, and emotionally healthy. Many of the things they handle take their toll on our officers. And one of the most difficult things an officer has to do is a death notification.

In death notifications, the person who delivers the news is the stabilizing force at that time. It's very important that notifications are made as soon as possible after the death occurs for various reasons: people might hear about it through the news media; in a traffic fatality, a relative or friend might drive by the scene, see the vehicle and call the people without any details. Speed is of the utmost importance.

Again I stress "do it right." The entire family should be told at the same time whenever possible, regardless of the hour. That's extremely important. Often parents feel it is best not to wake young children if it is late. They think the children should be told in the morning. It is vital that the whole family be told at once. When some family member is told at a later hour, he or she feels separated from the family. They feel that they were not important enough to be included. If the children are told with the rest of the family, they consider themselves a part of the group. They can begin the grieving and healing process with their family.

I find it is also important to recheck your information. Check with a neighbor to see if the person is going to be alone when you deliver your message. You also need to know if the person being notified has any health problems that might need to be considered. See if a neighbor will accompany you. Be sure of your information. Many times information will not be accurate when it passes through various jurisdictions. By the time it is relayed from officer to sergeant to communications and finally to you, inaccurate messages can be received. The best thing to do is call the agency back and speak to someone as close to the incident as possible. Try to get your information first hand.

When delivering the message, get people in a comfortable or relaxed setting. Get off the doorstep. Ask to come into the home. As a last resort, at an accident or fire scene, put the people in your vehicle. Let people act out their emotions as long as they don't injure themselves or anyone else. Start a support system immediately. The sooner a chaplain can be involved in the death, as a clergy, minister, or priest, the better he or she can help the people deal with their problems. As part of the support system, contact their own clergyman if possible. Also contact relatives or friends. Don't leave people without a support system.

Another important thing is to help people deal with the present. Many times it's "if only" and they want to deal in the past. Or they look to the future and deal with "what if." But I think one of the things we really have to do is deal with the present. As part of this, I believe it's crucial that the family be allowed to see the body, touch the body, and sometimes hold the body. There have been times when the body has been so mangled, that I prepare the family for this and then suggest that they see a hand or a foot. It's imperative that they see the body as soon as possible. Otherwise this death is not a reality. They think it's not true, and often they will hold out in their mind for years that this death really didn't happen.

One of the most difficult types of death notifications is a death with no body, such as a drowning in which the body has not been recovered. I think the real key here is to keep the people informed as to what type of recovery operations are being done, how the body might be recovered, and how long it might take. Again, deal with facts. Never say, "I don't know." Instead, use statements such as: "I will find out for you"; or "It's under investigation."

It has been my experience in notifications, that after presenting the facts, it is best to say no more. Sometimes hysteria follows. Let people act out their own personal feelings. Don't rush people. Give them time to absorb the information and work it through. Your presence is important. Stay there. Make calls for them if they request it. Encourage talking about the deceased. Include and comfort the children. They must not be excluded. They also need to act out their grief. Listen to people. Listening is so important.

When you make a death notification, you have no idea how people are going to respond emotionally. My experience has been that about ten percent of the people are going to be physically violent. They might kick, scream, or shove. I've even been sprayed with a can of mace. I've seen people pick up chairs and break them, throw things through windows, throw glasses, etc. Let them experience these violent emotions as long as they do not physically hurt you or themselves. I'm not advocating letting them harm you. But if you, as the authority figure, make them repress their emotions, these feelings will seethe within them. Whereas if you let them act out their violence, it will pass in five or ten minutes.

Another ten percent of the people show absolutely no emotion. They say "Thank you very much for coming, my daughter has been killed. You can go now." Don't leave these people without a support system.

It's necessary to use words such as killed or dead. My experience has shown that this is the way it should be done: I knock on the door, identify myself as a Chaplain with the Police Department and say that I want to come in and talk with them and their whole family. Most of the time when a person of authority appears, people will comply. I then sit down with the people and relay the information. For example, "There has been an accident involving your son, John. He has been killed in an accident." It is only fair to the family to get the facts out as quickly and accurately as possible. If you don't do that, you are doing a real disservice to people.

A death notification is compounded when it's a police officer who has been killed. This is because the person making the notification, often another officer, knows the family. It's much more emotional and difficult to do in cases like that.

In conclusion, I again stress the importance of "doing it right." Your initial response will stay with people the rest of their lives. Death notification must be done in a professional, caring, and understanding manner. If the notification is done properly, the healing process can begin sooner. Death notification is one of the most dreaded assignments a police officer can receive. But if it's "done right," you can be the biggest support at the most devastating time in a person's life.

COUNSELING DISABLED LAW ENFORCEMENT OFFICERS

Tom Williams, Psy.D.

ABSTRACT

Law enforcement officers traditionally become part of the "Fraternity of Blue" and have difficulty adjusting to civilian life upon leaving their profession. This is especially true of officers who, due to physical injuries, emotional disability or law violations, must change professions. Twelve disabled officers met in a therapist-led peer group therapy setting for over one year. This paper discusses selection of therapists, selection of clients, group process and common themes. Comments on inpatient counseling with former police officers are included.

INTRODUCTION

In the fall of 1986 our clinic, the Post Trauma Treatment Center, received a call from a police officer who was a patient at a nearby private psychiatric hospital in Denver. He had been looking for specialized help for nightmares, panic states, homicidal/suicidal, impulses and fears of going crazy. He felt his problems were similar to those of Vietnam veterans, and was referred to us by both the Veterans Administration and Army medical centers.

He was from a remote, small city police department. After handling a homicide of a citizen, with whom he had a contact just prior to the shooting, he became dysfunctional. He reported acute anxiety states, with visions of that death and others. His homicidal/suicidal feelings were intense. He was hospitalized, evaluated by a police psychologist, diagnosed with posttraumatic stress disorder and transferred to the Denver hospital. In the hospital he found little understanding from either staff or other patients for his police-related stress responses.

We evaluated him and suggested a treatment plan to his psychiatrist. Our suggestions included a police officer support group, but none existed in the Denver area. We were seeing a few police officers and former police officers for treatment or for worker's compensation evaluations and decided to start a group for police officers who were no longer working in law enforcement.

A search of the professional literature on police group therapy or social support groups for disabled or former officers yielded no citations, so we were on our own. We nonetheless felt confident that we would be successful. We had vast experience with Vietnam veterans groups, another traumatized population who didn't trust civilians, especially "shrinks." We are a private practice group and do not work specifically for any one police agency.

With help from the peer support coordinator of Adams County Sheriff's Department and a former police officer client we started the group. Admittedly, our police friends used bait and switch initially. They would invite a disabled officer to come to a meeting with Tom Williams, a private practice trauma specialist, and other officers to talk about police stress. The meetings were attractive to the officers, as they found a forum to air their problems and jointly seek solutions. Twelve former police officers went through the group in a period of 14 months. One returned to duty, one became a police department records clerk, one a drug and alcohol counselor and administrator, one a limousine operator, one a truck driver (soon to return to law enforcement or corrections), one owns his own security firm, and one is a pastor.

PLANNING--STRESS RECOVERY

Seven of the twelve had diagnosable posttraumatic stress disorders (PTSD) (APA, 1987) from shootings or accidental deaths. The remainder had a diagnosable set of symptoms without a single, identifiable stressor. They instead had a long series of subcriteria stressors, a phenomenon that we labeled a "stair-stepping" into PTSD. For most, separation from active police work precipitated an expected series of symptoms.

The theoretical PTSD model we use was adapted from Horowitz's model (1986). In this model are three main phases: symptom free, intrusion with anxiety, and denial or avoidance with depression.

In the symptom free phase there is a period in which a person appears to be free of symptoms. Upon closer examination there may be some relationship problems and sleep disturbance. The officers have feelings of being misunderstood and live a life altered by their police experiences. In the absence of high levels of current stressors, reminders of a traumatic event, or new traumas, the officers can remain in a symptom free phase for an indefinite period of time.

Normally the next phase is intrusion, where old painful memories intrude on the consciousness. This can be done by nightmares, flashbacks, daytime unstoppable thoughts, and psychological distress. The mood is anxiety and its accompanying sleep disorders, fits of rage, memory impairment, hypervigilance, and exaggerated startle response. These last two symptoms are characteristic of police officers anyway and tend to resist treatment. Nobody wants to sit in a group with his/her back to the door. This phase is frequently complicated by alcohol use. Alcohol is available, acceptable, cheap, and effective to combat anxiety. Much of the overuse of alcohol in police is related to self-medication for anxiety.

The next phase is denial and the mood is depression. "Go away, leave me alone, that stuff doesn't bother me" is a common response. The avoidance symptoms of PTSD are usually also present. The quantity of sleep is high, but the quality is poor, so they are fatigued most of the time. Many people are drawn to law enforcement by the excitement. When that excitement is withdrawn they often seek other forms of excitement used to ward off depression. These may include motorcycle driving, auto racing, sports parachuting, mountain climbing, or numerous sexual encounters. Obviously some behaviors are adaptive, others not.

Most officers who do not consistently overuse alcohol eventually return to the symptom free mode of PTSD. Others don't, and these are usually suffering from some type of survivor guilt. Cobb and Lindeman (1943) discovered this concept when studying the survivors of the Beverly Hills Supper Club fire. The survivors said they felt guilty that they are alive and others died. Officers who have lost a partner in a shooting or traffic accident often have these feelings. The type of guilt we most often deal with is content survival guilt, where the person feels guilty because of something they did or neglected to do in a trauma situation. The self-doubts and self-criticism remain, and the officer remains stuck between the anxiety and depressive phases of PTSD. The group provides real understanding about police related incidents and the various conflicting pressures the officer is under during a traumatic event.

PLANNING--GOALS

In planning the group our eventual goal was to help the disabled officers to return to work or reenter civilian life in a meaningful way. Intermediate goals included attaching to the group, symptom reduction and development of positive attitudes in planning for the future. We were cautious of overidentification, or developing overdependency to the group. Our job was to make the group obsolete, so we wanted a time-limited experience to avoid dependency.

The group did not have an orientation to pathology because the officers would not come. The group provided support through the aftershock of trauma. In some cases the worst trauma was losing the way of life

as a law enforcement officer. Being an accountant may be but a job. Law enforcement is a way of life, 24 hours a day, 7 days a week, that affects all aspects of one's life. A loss of that life is potentially devastating.

Education on the physiological and psychological responses to police work, stress and trauma was vital to help normalize their individual responses. Written information was provided to the families as well (Williams, 1987).

The officers needed an arena for resource sharing. They needed to exchange information on PPA, FOP, retirement benefits, lawyers, job possibilities, worker's compensation, and other matters.

We wanted a safe environment so they could try new behaviors and be validated by their peers.

PLANNING--STAFF

To meet these goals we decided on a "therapist-guided peer group" philosophy since we have assisted in a peer support system in a law enforcement agency and are familiar with the necessity of this approach. The peer concepts of dealing with police stress of officers on duty (Williams, 1987; Jones, 1989) are equally valid for disabled officers.

The group was led initially by a police officer with peer counseling experience and a police psychologist. When the police officer's shift changed, a new co-leader was brought in. She was a psychology graduate student who also worked half time at the Victim Assistance Unit, Denver Police Department, and had extensive ride-along experience. She was validated by both the outgoing police officer/co-leader and by the continuing police psychologist/co-leader. Previous experience with officers and agencies was vital, as was an equalitarian approach. Testing occurred before final acceptance.

The leaders were low-key but kept the group focused in a positive direction. Without some control the sessions tended to become gripe sessions, gossip sessions, or coffee break talk. Police officers are not used to talking about feelings and expressing emotions, and therefore tend to talk about other things. Cop talk is important but not the focus of the group.

Having civilians as co-leaders helped to dilute the "police only" focus of the group. As the police began accepting the co-leaders, they had a better chance of accepting other civilians. This includes other health care providers, potential employers, future friends, etc.

The leaders monitor the emotional well-being and the crisis potential and may intervene as appropriate. They may suggest individual therapy as well. While all applicants were initially screened for appropriateness for group, some needed special attention at times. Confidentiality is very important, and some matters are better discussed individually. Only very experienced co-leaders should see an officer individually and also in group. Minimal, if any, records should be maintained.

PLANNING--ATMOSPHERE

To help defuse the fear of loss of confidentiality, we decided to not charge fees. We did not want them to see themselves as patients in need of therapy. Many were financially destitute, as they previously had developed a life style based on a reliable income.

The group room was available for social time at least one-half hour before and after group. Since we considered coffee and donuts as a benign link between them and their former work, a coffee pot was in the room for them to make the coffee. They were encouraged to bring donuts, most of which they paid for.

The rule has been in our clinic that only police officers may bring weapons. We extended this policy to former officers who had concealed weapons permits.

We used a group room with a conference table. We felt that since these officers were suspicious of "touchy–feely stuff," sitting around a conference table would be less threatening than sitting in a circle in bean bag chairs.

The group was small (4–7) to allow plenty of time for all to interact. Groups were two hours long, and the group set the time and way of the meetings. The pace was slow and comfortable. We chose an open format to allow the flexibility of bringing in new members and allowing members to leave when they got jobs without overly affecting the group process.

GROUP COMPOSITION

We had officers referred for a large variety of reasons. They had lost their jobs due to law violations, accumulated job stress, shootings, medical reasons or politics. Three were combat veterans. Two were women. Three were from large city departments, one small city, two from rural areas, and one former state trooper. One also had extensive undercover experience. They ranked from a patrolman with three years' experience to a retired chief. The average time in law enforcement was eleven years.

Having such a variety of jurisdictions represented prevented "department bashing" and helped the group focus on the commonalities of the stressors. Their varied backgrounds, especially the chief's, made the group a fund of knowledge about the various medical / legal / compensation / retirement systems with which they were involved.

The group, after its beginning, approved or rejected new applicants after acceptance by the co–leaders. The primary reason for rejection was a law violation. Sex offenders were not allowed into the group.

THEMES

The overall theme was years of good service forgotten the moment the officer became disabled or separated. The resultant feelings of rejection by the department and eventually even by their former colleagues were hard to overcome. They often felt that their former officers saw them as "diseased." If the working officer accepts the reality of police disability it seems to make them feel vulnerable and unsafe, feelings incongruent with being confident on the streets. The working officer would rather blame the disabled officer than the job. The group members felt penalized by their former peer group.

The loss of power base, mystique, respect, ability to control others, and instant deference left many feeling impotent, powerless, and confused. There is no employment or retirement hobby that can replace the authority and responsibility that they had in law enforcement. Most had wanted to be cops all of their lives and could not envision themselves in any other occupation. Many times their families also were invested in police work.

Years on the streets hardened officers. They usually joined law enforcement with an attitude of helping others. While this did not disappear entirely, constant contact with bad people and bad situations resulted in an us–them mentality. Some of that feeling was adaptive as it supported officer safety. They could not trust people initially. As the us–them continued, the people they associated with most were other officers. While this is a poor stress management technique, police are not known for managing stress well. What had been a major source of support was withdrawn upon separation from police work. The former officer became a "them."

If the family remained intact through the officer's employment they could be a source of support for the transition to civilian life. Often the family was not intact or could not tolerate the additional stress of changing ways of life. It was not unusual that the spouse also worked in law enforcement.

Most officers in the group had been the focus of media attention. The press is rarely friendly to law enforcement, and their seeming disregard for accurate facts often infuriated the officers. The officers, by training and experience, have high regard for facts. The group allows a sympathetic forum to vent their displeasure at the way their cases were covered in the media.

While some officers were still able to carry concealed weapons, others were not. This symbolic castration discussed by Ayoob (1984) leaves many angry at the department, but most importantly leaves them feeling vulnerable and exposed. To some it is symbolic of a change of life style that they don't want. Their attitude about weapons became a barometer to measure their adjustment to becoming a former police officer.

GROUP PROCESS

The group used the before and after time to socialize and exchange information. Several carpooled, adding to the bonding and to the supportive atmosphere. In group it was a continual task to keep them focused on more difficult subjects. The co-leaders were initially tested by personal questions, such as why are you doing this? How much street experience do you have? and Can you keep this confidential?

New members were brought in by their sponsor, a group member. They were assured that all they were expected to say was their name, organization, and reasons for coming. There was no pressure to participate more, but all did. Bonding was almost instantaneous. Old members validated the co-leaders.

Traumatic events were discussed in police-like detail, to include drawing diagrams. Newspaper articles, shooting board reports, and other information were often brought to group to help process events. PTSD mini-lectures were given to normalize the stress reactions and symptoms. Self-disclosure by older members helped newer members feel free to enter discussions and also disclose. Older members helped provide role models for not only disclosing but for entering civilian life.

The group attended police events such as funerals and award ceremonies. This continued connection with police seemed to be positive and the members did not feel as distant from their former colleagues. We encouraged extra-group social activities that did not involve drinking.

As members became employed, busy with hobbies or school, or moved, the group stopped meeting. The graduates in Denver maintain some social network. Some of them remain on low levels of antianxiety medication and are therefore seen individually every few months for check-ups.

HOSPITALIZATION

Four of the group members had been hospitalized for emotional problems, three for chemical dependency, and one for PTSD. All had PTSD, but none received specialized treatment for it. All were considered successful cases upon discharge, but the "chemical dependent" cases neglected aftercare. Two of the chemical dependent officers were actually addicted, the other was not.

The hospitalized officers did and said what was expected of them. They followed procedures, rules and met staff expectations and therefore were considered as successfully completing the inpatient stay. None had their stress disorders addressed. They did not mix with the normal private psychiatric population.

They had a distrust of mental health professionals. Some of this distrust had been earned by the mental health system's inability to deal effectively with the psychotic citizens brought in by police. Another reason was the lack of a formalized PTSD program within the hospital setting. The programs did not address the way of life of law enforcement officers.

In an effort to provide help for these distressed officers we designed and implemented a specialized inpatient program for law enforcement officers that focuses on their life style, PTSD, and overuse of mood altering chemicals. One of the group members and three other officers from our clinic have successfully completed the program and remain functional to date. One is still a patrol officer.

SUGGESTIONS / CONCLUSIONS

Prior experience with police officers and administration is vital to successful provision of services to officers forcibly separated from active law enforcement work. We feel that our lack of formal ties to police agencies allowed the officers to feel confident that all information would remain privileged.

Don't work with this population if you have emotional reactions to weapons designed to kill people. When assessing suicide potential remember that they have weapons, and they all have known or heard about an officer who has "eaten his gun."

The "therapist-guided peer group" philosophy is appropriate in working with this population that doesn't trust mental health workers and has an us-them response to civilians. The group members are responsible for outreach to possible members, with professional screening prior to entering group.

While there are individual issues, most time is spent putting law enforcement attitudes and behaviors behind and becoming civilians. This often includes dealing realistically with past traumas.

The support, recognition and acceptance of the other group members helped many former officers establish new lives for themselves and their families.

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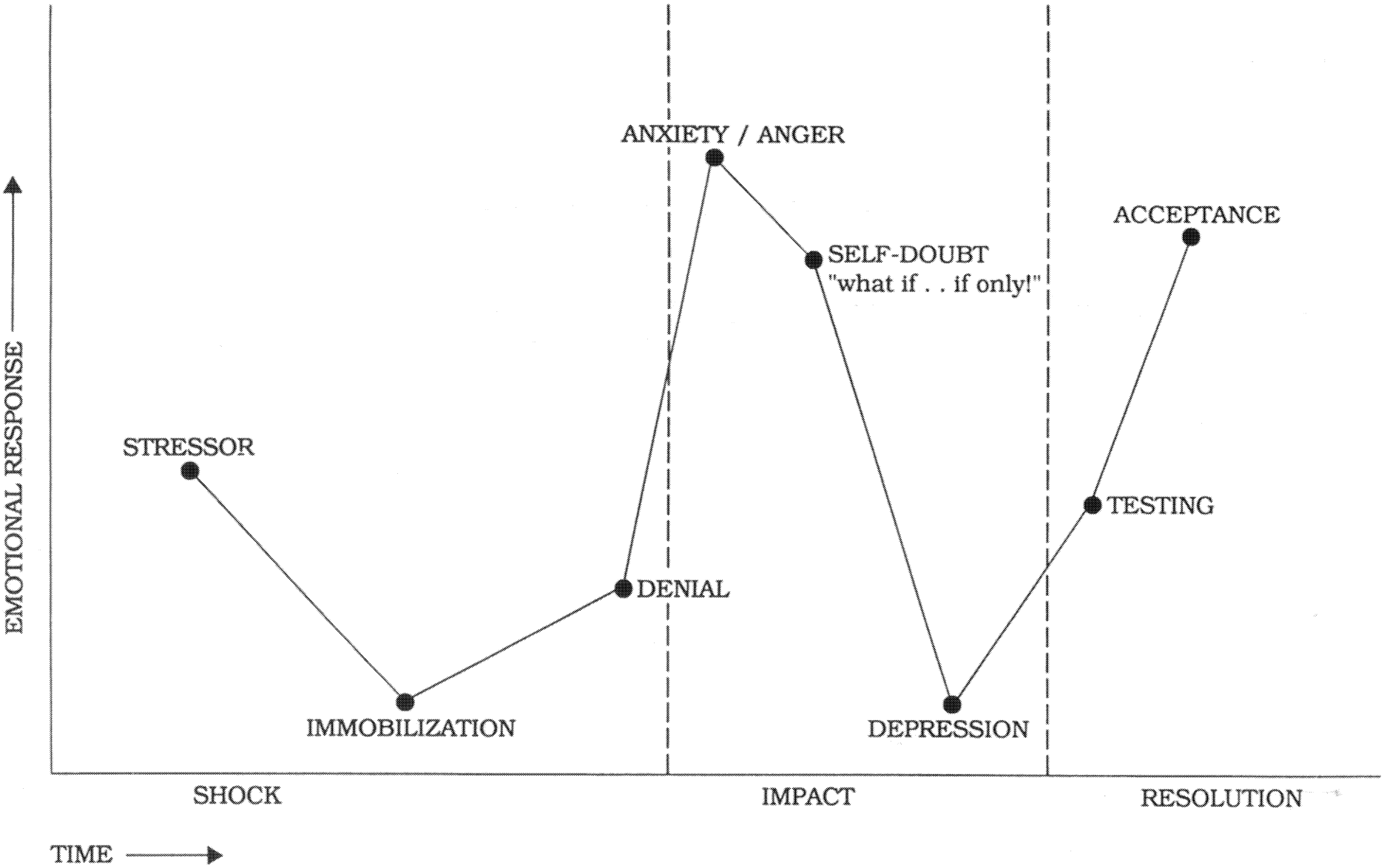

FIGURE 1

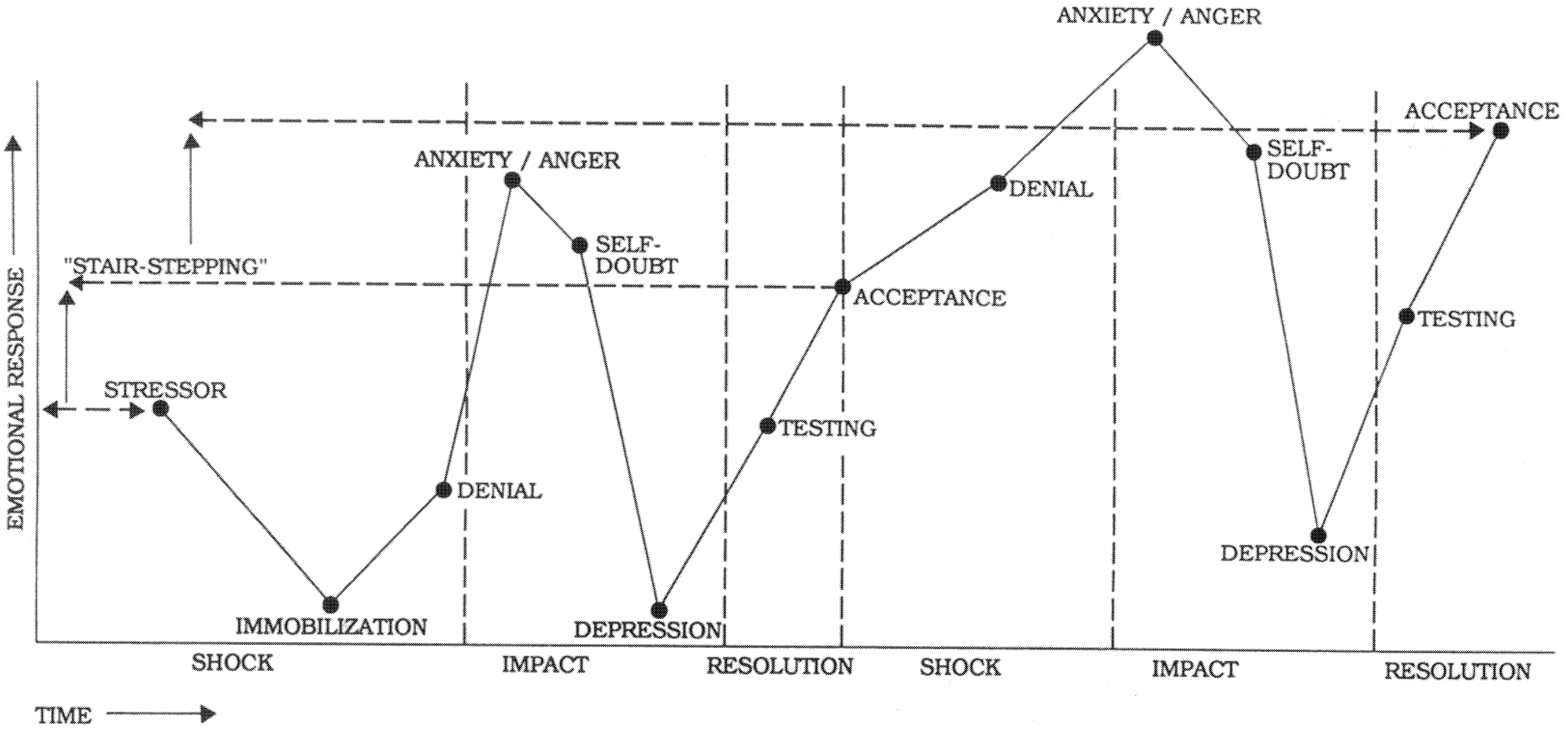

FIGURE 2 — ACCUMULATION OF STRESSORS

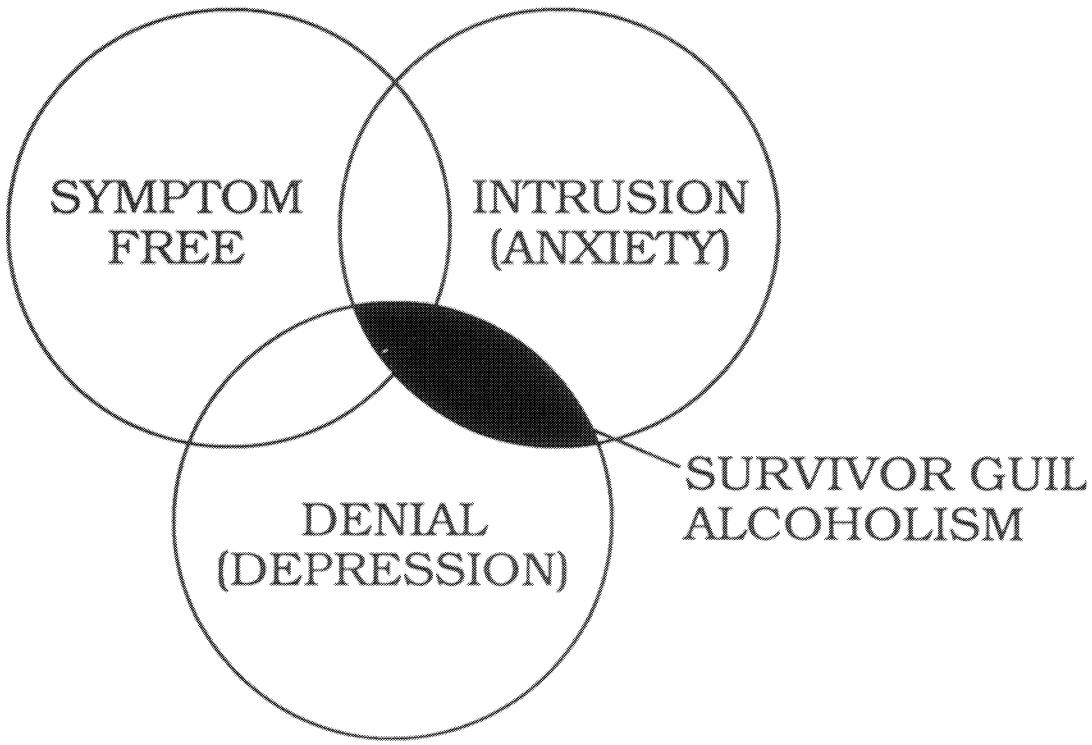

Figure 3 Chronic Post-traumatic Stress Disorder

POSTTRAUMATIC STRESS DISORDERS AND THE ROLE OF THE FAMILY

Roger G. Wittrup, Ed.D.

Significant issues have been addressed regarding posttraumatic stress disorders, to include the individuals involved in the incidents. After the incident is over and the publicity has subsided, however, the family members of the individual involved find themselves in a unique position. They now have to comfort and learn to relate to this person, as well as assisting him/her to grow. This tremendous burden includes such issues as the individual's changes in perception. An example of this would be a police officer who is now seen as much more mortal than his/her previous family role would suggest.

In the large number of interviews that we have conducted with persons involved in airplane crashes (such as Northwest Airlines Flight 255 in August 1987), barricaded gunmen situations, and mass shootings, we have seen that the entire family unit, as well as friends, undergoes a tremendous transformation in interpersonal relationships and issues of independence within those roles. The concentration of the media on the incident, sometimes involving 40–50 replays of a plane crashing and crumbling, continues the fear and depth of consternation experienced by the family members. Historically, there has been very little attention given to family members. They are treated in much the same way as experienced in hospital settings. Hospital professionals see the family as people that must be dealt with, but do not necessarily consider them significant with regards to caring for the patient. It is my thesis that the family is not only essential, but is one of the critical issues with regards to posttraumatic stress disorder.

We have interviewed approximately 2,800 individuals involved in critical incidents over a ten–year period. In addition, we have interviewed family members and conducted studies involving various groups throughout the state of Michigan. We are beginning to understand the vibrating quality of the incident throughout the system within the family unit. For example, we are aware of the anniversary syndrome for the individual involved in the incident, but very little attention has been given to the effect of the anniversary syndrome on the family members, who frequently wish that everything would return to normal and there would be no problems associated with a holiday such as Christmas or Thanksgiving. The result is a role similar to the enabler in codependent situations who wishes and tries and when the effort falls short, blames himself or herself or becomes exceedingly angry. Older children frequently become involved in their social or academic concerns or act out as a way of dealing with the incident itself, almost in an anger that such an incident has put the family into the spotlight. The younger children we have seen have trouble with the concept of finality or even change and frankly do not have the language to describe their pain and continued fear of ongoing separation. We have to remember that children under eight years of age experience separation at the same level they understand the concept of death. The continuing issue for children concerns the question of who, in fact, is the protector when both the parent who is involved in the trauma and the spouse have great emotional difficulties handling the situation. In short, the protective umbrella of the family has been removed or at least torn, and the family needs to be revitalized.

Initially, I believe that we must parallel the work done so admirably by Judith Wallenstein of California. We must understand that the family members need some kind of emotional advocate to deal with various issues from the media to simple logistical items like food and money. This advocate can assist in temporarily "shoring up" the family unit. This is not in any way an attempt to involve a legal advocate, but rather to advocate on behalf of the family members who are temporarily having difficulty with the demands upon them. I believe that there should be consideration of including someone to assist the spouse and an additional person to assist the children and extended family members because of very different issues involved. For example, if one is driving the spouse to the hospital as the advocate to get into the ICU, it is very difficult to be an advocate for the children who remain home and provide care, meals, and assistance to get to school.

The advocate could be a volunteer group such as a survivor organization that provides the understanding and support and calm listening ear to children and family members as they reexperience and wish to retell what it was that they saw and felt themselves. The training program varies, and I will leave it to the professional to determine the kind of program that he or she would like to institute.

One of the important roles belongs to the hospital in which there needs to be someone who can encourage and insist upon the children seeing the absent parent recovering and be allowed to visit. Many hospitals keep very stringent rules of visitation as a way of protecting the quality of medical care, but I think it is important to educate as well as assist the hospital administrators and medical staff in making changes so visitation rights become policy and can be written into the orders by the physician. Also, programs are often provided by funeral homes or hospitals to educate members of the community about what happens at funerals or at the hospital. Children may have a special need for this exposure and explanation of what can be very mysterious and frightening.

Qualifications to be an advocate are primarily sensitivity and participation in training programs, so that the individual may assist the family in the areas most needed. A grandmother and maid at St. Luke's Presbyterian Hospital was Kubler-Ross' first assistant in the grief treatment program. She had the sensitivity to work with people as patients.

It appears to be a rather American behavior to be reactive rather than proactive in dealing with those individuals involved in disasters, including the extended family. In July 1987, three officers were killed very violently in a suburban motel in the Detroit area. After the officers were killed, there was a stand-off for several hours, involving Federal, state, and some 15 local departments, until the three hostage takers gave themselves up. We were fortunate to have had a community mental health program manned by some community social workers who began calling in a variety of emergency services. The debriefing of officers and families began within hours and continued for several weeks. The funeral for the three officers was attended by an estimated 1500 police officers from all over the world. Their police cars brought to a halt the six-lane highway in front of the church.

Approximately four weeks later, Northwest Flight 255 went down, killing several hundred people and shutting down the major international airport in Detroit and Interstate 94. Many of us went to the scene and began debriefing and doing intervention with the family members of the dead as well as the with the police officers, EMS technicians, and dispatchers. The grieving experience was great and this was carried on at clinics and other sites. It was one of the times that I deeply appreciated our close working relationship with the Michigan Police Chaplain's Association and the Medical Chaplain's Association and area clergy. They provided tremendous help in assisting family members. Various psychiatric programs were superb, and we concentrated on the two to three sessions of debriefing with referral, without a lot of competition and problems.

We explained to the children about the normal reaction to a very abnormal situation, and that their parents who had been involved in the rescue operation and cleanup would be dealing with things in a certain way familiar to mental health professionals. We relied on such things as teddy bears, drawings, role playing, and parallel talking to help parents understand what the child was saying. We also had various children tell what they were experiencing. Our job was essentially to teach the family to recover and to help itself, not to replace the parenting role that must go on despite what had happened. We encouraged family members involved to be a part of the healing process, if by doing nothing more than taking coffee or donuts or other items to family members. Several set up a temporary shrine at the point of impact on I-94 and had a prayer service under the care of one of the chaplains. We encouraged extended family members, neighbors and friends, and members of the congregation to create a loving, safe place for the family members as well as the individual involved in the rescue work.

We have learned so much through people such as Judith Wallenstein and her Center for Families in Transition in terms of parents and divorce or death, in which no one spoke for the children. The assumption

was wrongly made that someone was speaking for the children, and I think that in death, divorce, and situations such as this, no one is really speaking for the children and their needs. It is appropriate for children to be concerned about attending proms, football games, and other events, which, for them, is a way of dealing with their hurt and pain.

The role of the professional is to speak and to give guidance during the transitional stage to the individuals involved in the rescue; to protect the children from what amounts to second injury; and to permit and give permission for the grieving to take place within the family unit. This can be done both in groups and as family therapy; with a select group of just children or just adults.

I believe that in the future, response aims must mobilize people to stay with sleeping children and then awaken them and take them to where needs can be cared for, provide babysitters, etc. Meals, transportation, and financial support for necessities must also be raised by various kinds of community efforts. There are those who would perceive the community support as unnecessary intrusion, but in talking with many of the family members, it was one of the times they felt better about being a part of society. For example, we encouraged members of the community to help provide meals by making double their normal recipe and providing one to the family in need. We also recommended that restaurants provide catered meals. We encouraged provision of guaranteed child care, totally done by close relatives, neighbors, and friends who were trusted and known to the family. Schools must be included to deal with the various issues by allowing the social activities of the school to contribute to the growth of the children through such a transition.

In brief, to quote Dylan Thomas, who was 38 when he spoke to his father, who was dying, "Do not go gently into that good night, old age burn and rave at the close of day; rage, rage against the downing of the light." We have discovered time and time again that it is, in fact, the family members who do the teaching—often the youngest or the victim. We remember John Gunther, the famous historian who wrote Death Be Not Proud about his son's battle against terminal brain cancer. The son taught his father about the meaning of life and the joy of working hard against the pain and difficulty caused by an inoperable brain tumor. Many of us have been fortunate enough to learn from the dying as well as those having gone through PTSD about the survivability of great tragedies and the difficulties faced. It is through that experience that it is possible for professionals to teach, to love, and to comfort those going through similar experiences. It is when the giant arms of the all-encompassing extended family grasp around the family at its greatest point of need that the real meaning of family becomes evident.

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