LAW ENFORCEMENT

Critical Incident Handbook

Information for Law Enforcement Officers Involved in Critical Incidents

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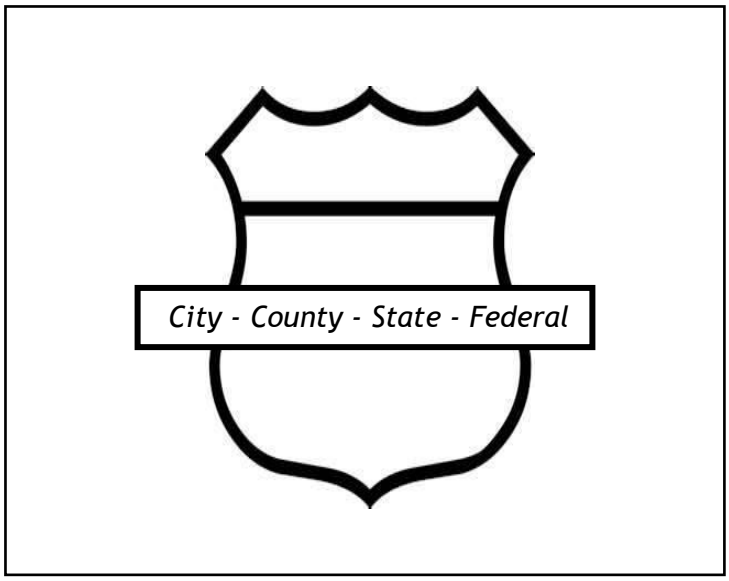

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LAW ENFORCEMENT
Critical Incident Handbook

Also by Jack A. Digliani:

Contemporary Issues in Police Psychology
Reflections of a Police Psychologist (2nd ed)
Stress Inoculation Training: The Police
Law Enforcement Critical Incident Handbook
Firefighter Peer Support Team Manual
EMS Peer Support Team Manual
Civilian Peer Support Team Manual
Law Enforcement Marriage and Relationship Guidebook
Peer Support Team Utilization and Outcome Survey

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Law Enforcement Critical Incident Handbook

The *Law Enforcement Critical Incident Handbook* is designed to provide concise and practical information to officers that have recently experienced a critical incident. It also includes information useful to spouses and police agencies planning to develop critical incident protocols.

If you are a police officer reading this and your department does not have a support program for officers that have experienced a critical incident, I encourage you to contact your administrators and initiate a dialog about creating a professional and peer support critical incident protocol.

The Handbook includes information from the *Law Enforcement Peer Support Team Manual*, *Reflections of a Police Psychologist (2nd ed.),* and *Contemporary Issues in Police Psychology*.

The topic items of the Handbook are designed so that they may be used independently of one another. Therefore, some information pertinent to the topic title may appear in more than one document.

The Handbook is intended to be a companion publication to *Reflections of a Police Psychologist* and *Contemporary Issues in Police Psychology*.

A two-sided print of the Handbook E-version is recommended.

To purchase a copy of *Reflections of a Police Psychologist (2nd ed.)* or *Contemporary Issues in Police Psychology* visit Amazon.com

For further information about police psychology and officer wellness, and to download the Law Enforcement Critical Incident Handbook, the Law Enforcement Marriage and Relationship Guidebook, the Law Enforcement Peer Support Team Manual, the Firefighter Peer Support Team Manual, and the Emergency Medical Services Peer Support Team Manual without cost visit www.jackdigliani.com

Law Enforcement Critical Incident Handbook

Contents

Introduction

Law enforcement officers have much in common. Most are committed to the ideals of "serve and protect" and will risk their lives in service to their community.

There is a proud history of law enforcement in America. It is a history of service and sacrifice. Every officer knows the dangers involved in policing. All too familiar to police officers is the fact that there are some persons that will intentionally act to harm or kill police officers. The dangers inherent in policing create the need for officer-safety procedures, self-defense weaponry, and self-defense tactics.

At times, police officers have no choice but to defend themselves. In self defense, many officers have had to utilize deadly force to keep from being seriously injured or killed. Although there are many kinds of police critical incidents, if you have had to use deadly force to defend yourself or someone else, you have experienced one of the most challenging types of police critical incidents. These can vary greatly in perceived intensity and can affect officers in a number of different ways.

For police officers there is an increased probability of exposure to critical incidents. This is because of the kind of work police officers do and the role that police officers play in our society. Police officers know and accept this unavoidable stressor of policing.

<u>During and following a critical incident</u>

A critical incident can produce out-of-the-ordinary perceptual phenomena. The experience of *vivid images* is one such phenomenon. Vivid imagery differs from hallucination in that there is an actual environmental stimulus involved in the perception. Consider the real-life case of Officer M. Officer M experienced vivid imagery during the incident and hallucination the following day:

Officer M responded to a call of a disturbance and found himself in a backyard, face to face with a seventeen year old suspect armed with a butcher knife. Officer M drew his weapon and ordered the suspect to drop the knife. The suspect did not comply and began walking toward the officer. As he was walking, the suspect began shouting "shoot me, shoot me!" Officer M, hoping to bring about a non-lethal resolution, began backing away from the suspect. By backing away, he could keep himself safe without having to shoot the young man. As the suspect continued his advance, the suspect unexpectedly drew the knife across his forehead. This caused profuse bleeding. Officer M could barely see the suspect's face. Officer M retreated until he was backed into a corner, between a fence and a wood pile. He continued trying to reason with the young man. When he could not withdraw any further, he advised the suspect that if his advance continued, he would have to shoot him. The suspect was now approximately seven feet from the officer, still holding the knife. Officer M began to pull the trigger of his weapon. It was pointed directly at the suspect's chest. Officer M recounted, "My thoughts were at Mach I, but everything else was moving super slow." He remembered seeing the hammer of his weapon cocking back in preparation for firing. At this instant, several things happened. (1) Although the suspect was wearing a shirt, Officer M saw the suspect as bare-chested. He also observed two bullet holes in the suspect's bare chest. This was despite the fact that the suspect was still wearing a shirt and Officer M had not fired his weapon. (2) Thoughts began to run through Officer M's mind. The first thought was "Why is this weapon not firing?" (3) He thought of his children. They were close to the age of the suspect. What would they think of their father killing someone so close to their age? About this time, the suspect stopped and

dropped the knife. He surrendered. To this day it remains unclear why. Maybe his anger and frustration had run its course. Maybe he realized that he did not want to die. Whatever the reason, the suspect had come very close to being killed by an officer who had literally run out of options.

Once the suspect surrendered, Officer M reported that everything snapped back to the present reality. His thoughts and perceptions returned to normal. The suspect was taken into custody, not shot and still wearing his shirt. The next day, Officer M was in the shower. He was thinking about the incident and the strange experiences of the day before. Suddenly and to his surprise, he again saw the image of the bare-chested suspect. Again, there were two bullet holes in the chest. The image was so clear that it was "like a photograph." He was instantly overcome by a "deep sadness." He remembered, "Feelings flooded my body like I killed him, like I had done a horrible, horrible thing." He thought "I'm a cop. I shouldn't be feeling this way." He wondered where this image and these feelings were coming from. How were they even possible? He could not get the image out of his mind. He recalled that he thought he was going crazy. He considered quitting policing.

Visual hallucinations and vivid images are more common than believed in traumatic situations. Although the exact cause of such experiences is unknown, there is some speculation that it is related to increased levels of *cortisol*, a stress response hormone. Many persons are reluctant to report hallucinations and vivid images for fear of being perceived as mentally ill or psychotic. If fact, they are neither. Visual hallucinations and vivid images are part of the brain's reaction to traumatic events. In most cases, they are short lived. For Officer M, the image and associated feelings disappeared soon after seeking professional treatment. Officer M returned to policing. (From Digliani, J.A.. *Reflections of a Police Psychologist (2nd ed.)*.

There are…

(1) There are many variables that determine how an officer is affected by involvement in a critical incident. Some of these are presented in *Critical and Traumatic Incident*.

(2) There are various possible responses to a critical incident. These are presented in *Critical Incident Information*.

(3) There are many things that police agencies can do to minimize the possible undesirable effects of a critical incident. Professional and peer support is important. Agency support should begin in the police recruit academy and continue throughout an officer's career. In addition to academy and periodic in-service stress inoculation support training, specialized critical incident support protocols should be established and written into policy. These policies must be in place before they are needed. Recommended agency protocols are presented in *Critical Incident Management and Return to Duty Protocol* and *Trauma Intervention Program*.

(4) There are many things that police officers can do for themselves. Most importantly, police officers can change the way they think about asking for psychological help. Associating "asking for help" with being defective or weak is dysfunctional and irrational. It makes little sense for police officers to physically survive a police career only to be psychologically undone by the stressors of a critical incident or the job itself. Some ideas about how officers can help themselves following a critical incident are presented in *25 Suggestions and Considerations for Officers Involved in a Critical Incident*.

Information other than that mentioned has been included because of its significance and possible individual-officer relevance. Best wishes for a *stronger and smarter* recovery…JAD

Critical and Traumatic Incidents

By their very nature *critical incidents* have the potential to overwhelm normal stress coping abilities. Simply stated, it is this potential that differentiates everyday incidents from critical incidents.

Critical versus Traumatic Incidents

When do incidents become critical? Incidents become critical when features of the incident lie outside the normal range of everyday policing and human experience.

When do critical incidents become traumatic? Critical incidents become traumatic when officers that have been involved in critical incidents experience some degree of cognitive, emotional, and psychological decompensation or discomfort associated with the incident.

Incidents can be "critical" – officers can be "traumatized." Another way of stating this is that *criticality* is a property of the event while being *traumatized* is a human experience.

The Transactional Nature of Critical Incidents

Whether an officer is traumatized by involvement in a critical incident depends upon many variables. These variables make a wide range of potential traumatization possible. This is why different officers can be affected differently during and following a critical incident. There are officer, incident, and environment variables.

Some Officer Variables

1. Personal history
2. Personality traits
3. World view and view of reality
4. Beliefs and aforethought
5. Assessment of threat
6. Assessment of performance
7. Assessment of options
8. Personal coping abilities
9. Stress inoculation training
10. Trauma management training

Some Incident Variables

1. Proximity
2. Sudden or planned
3. Blood and gore
4. Age of others
5. Personal history of suspect
6. Suspect or others behavior
7. Alone or with other officers
8. Circumstances of the event

Some Environment Variables

1. Perceived treatment by department
2. Perceived treatment by the press
3. Perceived treatment by peers
4. Family support

Critical Incident Information

Critical incidents:

are often sudden and unexpected
disrupt ideas of control and how the world works (core beliefs)
feel emotionally and psychologically overwhelming
can strip psychological defenses
frequently involve perceptions of death, threat to life, or involve bodily injury

It is not unusual for police officers to experience several out-of-the-ordinary perceptions and responses during and following a critical incident. These are normally of short duration and resolve over time without difficulty.

If you have experienced or are now experiencing distressing perceptions or responses following a critical incident you should contact an available professional resource.

Perceptual distortions possible during the incident:

slow motion
fast motion
muted/diminished sound
amplified sound
slowing of time
accelerated time
dissociation
tunnel vision
visual illusion or hallucination
heightened visual clarity
vivid images
memory loss for part of the event
memory loss for part of your actions
false memory
temporary paralysis
automatic pilot

Possible responses following a critical incident:

heightened sense of danger
anger, frustration, and blaming
isolation and withdrawal
sleep difficulties
intrusive thoughts
emotional numbing
depression and feelings of guilt
no depression and feelings of having done well
sexual or appetite changes
second guessing and endless rethinking of the incident
interpersonal difficulties
increased family discord
increased alcohol or drug use
grief and mourning

Posttraumatic Stress, Posttraumatic Stress Disorder, and Acute Stress Disorder

There are several stereotypical responses that follow exposure to a critical incident. These are common and include: (1) repetitive thinking or psychologically replaying of the incident, (2) disruption of normal sleep and dream patterns, (3) second guessing, (4) changes in appetite, (5) changes in sexual desire and function, and (6) temporary mood changes. Collectively, these responses are called *posttraumatic stress*.

Posttraumatic stress differs from *Posttraumatic Stress Disorder* and *Acute Stress Disorder:*

Posttraumatic Stress (PTS) – expected and predictable responses to a traumatic event. PTS normally resolves within one month of the incident. External psychological and emotional support systems are of great value for the timely resolution of PTS. Clinically significant distress or impairment is absent in PTS.

Posttraumatic Stress Disorder (PTSD) - a constellation of clinical symptoms which meet the specific criteria for the PTSD diagnosis (including clinically significant distress or impairment for at least one month). PTSD requires professional treatment to produce the most positive possible outcome. PTSD may be accompanied by some degree of depression or other mood disorder.

Acute Stress Disorder (ASD) – similar to PTSD however the clinical symptoms must be present for at least 3 days and last no longer than one month. An ASD diagnosis may be changed to PTSD after one month if warranted.

Following a Critical Incident

1. It is possible to experience no or very little posttraumatic stress.
2. It is likely that some degree of posttraumatic stress will be experienced.
3. Many officers will experience some degree of PTS and not develop PTSD.
4. It is possible that the criteria necessary for the diagnosis of Acute Stress Disorder or Posttraumatic Stress Disorder will be present.
5. It appears that police officers manage stress and recover from the normal effects of a critical incident much better if appropriate department and peer support protocols are in place and utilized.
6. Police agencies have a responsibility to assist involved officers with any post-critical incident difficulties that might arise.

Posttraumatic Stress Disorder

1. Has been a psychiatric diagnosis since 1980.
2. Is more likely to occur with increasing severity of trauma.
3. Changes the biology of the brain and the way in which the brain works.
4. May be mitigated by early administration of certain beta-blocking drugs.
5. Improves with appropriate psychological intervention.

Traumatic Stress: Shock, Impact, and Recovery

Various researchers have identified a somewhat predictable progression of personal experience following a critical incident. This progression can be reduced to three principle phases: *shock*, *impact*, and *recovery* (S-I-R). The shock, impact, and recovery sequence can vary in intensity, duration of phases, speed of succession, and stability of succession. The S-I-R sequence is commonly seen within the experience of *posttraumatic stress, posttraumatic stress disorder,* and *acute stress disorder*.

Shock—psychological shock (P-shock) is often the initial response to a traumatic incident. (The symptoms of physical shock, more precisely called *circulatory shock*, may also be present. Circulatory shock is a life-threatening medical condition and requires immediate medical attention). P-shock is comprised of a host of discernable reactions including denial, disbelief, numbness, giddiness, bravado, anger, depression, and isolation. P-shock reactions, although common following trauma, are not limited to trauma. P-shock can occur in response to any significant event. Football players who have just won the Super Bowl frequently respond to questions from sports interviewers by saying, "I can't believe it" (disbelief) or "It hasn't sunk in yet" (no impact).

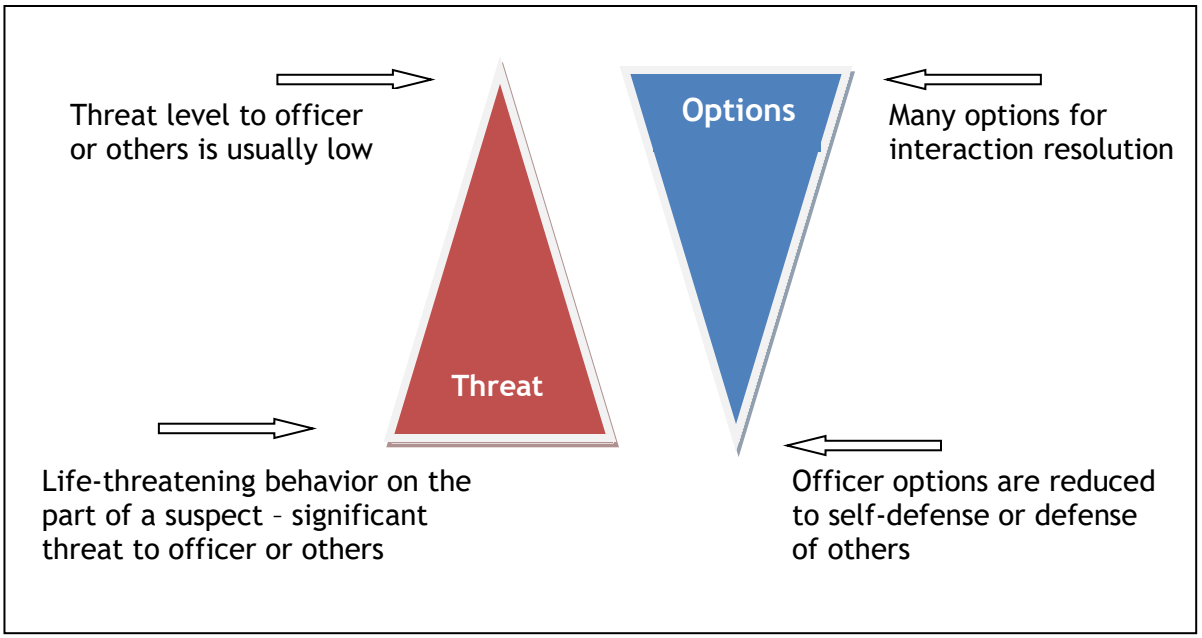
Impact—after the passage of some time, the amount of time differs for different people, there is impact. Impact normally involves the realization that "I could have been killed" or "This was a grave tragedy." These thoughts and the feelings that accompany them can be overwhelming. Officers should never be returned to full duty while they are working through any overwhelming impact of a traumatic incident. Police agencies should have policy directives which provide for administrative or other appropriate leave until an experienced police psychologist evaluates and clears the officer for return to duty.

Recovery—recovery does not follow impact as a discreet event. Instead, with proper support and individual processing, impact slowly diminishes. As impact diminishes, recovery begins. A person can experience any degree of recovery. No or little recovery can result in lifetime disability. Full recovery involves becoming stronger and smarter, disconnecting the memory of the incident from any enduring disabling emotional responses, and placing the incident into psychological history. Without recovery, persons remain *victims* of trauma. With recovery, they become *survivors*.

Stronger and smarter: To become stronger and smarter, something positive must be found in every traumatic exposure. If you are exposed to a traumatic incident and something positive is not readily apparent, you must search the experience until something positive is found. To assist in your search, you must open the experience. You must look at the big picture. To focus on the worst of the experience is to provide it with power. Looking at the entire incident provides balance. It provides a more accurate and more realistic view. Even a traumatic experience with only a theoretical 3 percent negative outcome will feel 100 percent negative if 100 percent of the focus is on the 3 percent. When searching for the positive, remember, at the very least, you survived.

Option Funnel versus Threat Funnel

The idea of *option funnel versus threat funnel* helps to place traumatic events in perspective. When there are options available, the threat to officers or others is usually low. As the number of options decrease for officers, the threat to officers or others generally increases. Therefore, *option versus threat* is negatively correlated.



The Option Funnel verses Threat Funnel

At the bottom of the option funnel is *self-defense* or *defense of others*. When this is the only option remaining for officers, the threat level is dramatically increased.

Police officers can be brought to the bottom of the option funnel very quickly by the actions of another person. Lethal force may be necessary to defend and protect yourself or someone else.

Critical Incident Issues, Strategies, and Concepts

Critical Incident Considerations

When dealing with stressful or traumatic circumstances police officers should consider the following issues, strategies, and concepts.

- shock, impact, recovery
- concept of 2nd injury
- vicarious or "secondary" trauma
- retraumatization
- splitting of environments
- fear vs helplessness vs vulnerability
- role of reinforcement/conditioning
- second-guessing paradigm
- chronological history and psychological history
- the walk and talk
- surface lesson/deep lesson
- options funnel vs threat funnel
- the *2 and 2* - "I know what this is, I know what to do about it" and "stronger and smarter"
- survivorship vs victimization
- resiliency and recovery
- stay grounded in what you know to be true
- having the right vs is it right
- I'm in trouble vs I'm alive
- PTS vs PTSD
- intervention as the 2nd best option because time machines are unavailable
- involvement of professional counseling services
- peer support in conjunction with professional counseling

Information

- Police authority in America is intentionally limited.

- American society accepts a margin of risk for law enforcement officers. This influences the public acceptability of particular police tactical behaviors.

- The "seconds" of policing…

(1) Secondary danger – the police culture which reinforces the ideas of *show no weakness* and *asking for help is a sign of weakness.* Primary danger: the danger inherent in policing. (see www.jackdigliani.com)
(2) Second injury – psychological injury that results from how an officer was treated following a critical incident.
(3) Secondary trauma – trauma that occurs from the exposure to persons that have been directly traumatized. Also called *vicarious* trauma.

Incident Debriefing Information

It is possible to feel ok following a critical incident, participate in the incident debriefing, and come out of the debriefing feeling a bit unsettled. This is not overly concerning unless the feeling is uncomfortably intense. The unsettled feeling that can be generated by a debriefing is often related to the mild-to-moderate anxiety caused by psychologically revisiting the incident. This feeling usually diminishes within a few hours or days following the debriefing.

Information - Following a critical incident debriefing you may:

- feel unsettled; not quite "yourself."
- replay the incident over and over in your mind.
- wonder why you did or did not do certain things.
- wonder why others did or did not do certain things.
- wonder why you are having particular feelings.
- not sleep normally.
- have dreams, even nightmares, about the incident.
- have dreams that include incident-specific themes.
- experience appetite changes – overeating or no appetite.
- find yourself drinking more alcoholic beverages.
- notice a difference in your sex drive or ability to perform.
- feel less safe than prior to the incident.
- think more about those closest to you.
- have feelings that seem unusual or *out of character* for you.
- think more about life and death, or the meaning of life.
- worry more about your job, your welfare, and the welfare of your family.
- feel a bit numb, edgy, irritable, angry, anxious, or "down."
- experience gastrointestinal problems.
- feel physically uncomfortable – headache, fatigue, stomach upset, etc.
- wonder when your life will return to normal.*

Most importantly, you may not experience any of the above. It is not abnormal to feel ok following a critical incident; or to feel better following a critical incident debriefing.

Many of the responses that can follow a critical incident will diminish within a month. Significant improvement is often experienced within two weeks.

Rarely, thoughts of suicide or of harming others are present following a critical incident. If you have suicidal thoughts or thoughts about harming others, you should tell someone and seek professional assistance immediately.

Take care of yourself. For the next several weeks: (1) watch how you talk to yourself, (2) be patient with yourself and others, (3) engage in mild exercise, (4) practice self-care by doing things that are calming and rewarding, (5) stay connected to those that you care about and who care about you, (6) some alone time is ok but do not isolate yourself, (7) avoid alcohol as a means of coping, (8) engage your support resources.

* note that many of the possible debriefing responses are identical to the possible responses following the incident itself.

Danger, Unavoidable Stressors, and Confrontation

There is a primary danger in policing. This danger comes with the job and is comprised of the unavoidable stressors of policing. The primary danger and accompanying risk of policing exists because:

1. There are persons in our society that willingly engage in criminal activity, act in violent ways, and have little regard for the life and safety of others, and
2. The police are charged with the responsibility to enforce the law, serve and protect citizens, and ensure community safety.

Police officers attempt to counterbalance the risk inherent in policing by applying the three T's of policing—*Training*, *Tactics*, and *Technology*.

Dangerous environments, police officers, and the community

It is a sad commentary that American communities must be considered dangerous environments; however, this is a fact for police officers. This is true even in "safe" neighborhoods. Many police officers have been killed or injured in safe neighborhoods by "good" people. This is the unavoidable reality of policing.

Remaining mindful that even initially cooperative persons may become violent is a component of police officers' reality. It does not matter if the person is young or elderly, male or female, verbal or silent, attractive or homely, intoxicated or sober, all can become a threat. This compels police officers to live in an occupational world of *assumption of possible threat*. It is much different than most other workers who live in an occupational world of *assumption of safety*.

Confrontation

Police officers provide a vital service to their community. Much of this service may seem "routine" and unremarkable. However there is another side to policing, the side of *confrontation*. Confrontation is one of several unavoidable stressors of policing. Officers must have or must develop a means of coping with confrontation. Even when the police are requested to assist in particular situations, there is often at least one person who does not want officers present.

Some confrontations are mild and consist of verbal discussion or nonverbal posturing. Others are critical and may involve officers fighting for their lives. Like everyone else, police officers have a right to protect and defend themselves. Unlike others, police officers also have a duty to protect and defend others. This is true even if it means that officers must place themselves in jeopardy. There are consequences for officers that fail to meet this duty, including departmental discipline, employment termination, and civil lawsuits. This is different from most other occupations, and it increases the probability that officers will become involved in critical incidents.

Confrontation on a daily basis is one of the unique aspects of policing. Officers accept this feature of the job and endeavor to do their best even in the most unfamiliar, challenging, and sometimes life-threatening circumstances.

25 Suggestions and Considerations for Officers Involved in a Critical Incident

1. You're safe. No matter what type of critical incident you have experienced, do not forget that you are now safe.

2. Realize that your survival instinct was an asset at the time of the incident and that it remains intact to assist you now and in the future if needed.

3. Emotions following a critical incident are normally different or more intense than usual. This is due to the nature and intensity of critical incidents. Accept your emotions as normal and part of the incident survival and recovery process.

4. Accept that you may have experienced fear. Fear is a normal emotion and should not be interpreted as weakness.

5. Learn about or become acquainted with the features of normal post-critical incident responses. This will help you to understand that much of what you're feeling is a normal part of the recovery process.

6. Accept that you cannot always control events, but you can control or at least influence your responses. If you are troubled by a perceived lack of control, focus on the fact that you had *some* control during the event. You used your strength to respond in a certain way.

7. Talk to someone. Discuss your experiences and feelings with someone you trust. Seek a person with privileged confidentiality communication protections if necessary.

8. Try not to second-guess your actions. Evaluate your actions based on your perceptions at the time of the event, not afterwards. Remember that e*very cop, every day* has to make decisions based upon limited and sometimes faulty information. It is imperative to keep this in mind following a critical incident.

9. Understand that your actions during the incident were based on the need to make critical decisions for action. Some of these decisions had to be made within seconds.

10. Accept that your behavior was appropriate to your perceptions and feelings at the time of the incident. No one is perfect. It's normal to like and dislike some of your actions during and following a critical incident.

11. Focus on the things you did that you feel good about. Positive outcomes are often produced by less than ideal (especially in retrospect) actions.

12. Following a critical incident, officers are often more critical of themselves than they would be of other officers in identical circumstances. Do not become your own worst critic. Talk to yourself in the same way you would to another officer.

13. It is normal to have the incident play over and over in your head. Repetitive incident replay is a feature of the psychological process leading to recovery. Incident replay normally gradually subsides over a period of several weeks.

14. Take some time for yourself if needed but avoid isolating yourself physically and emotionally from your family and others that care about you. Avoiding isolation may be especially difficult if you are feeling numb or emotionally "flat". Do your best to progressively engage others. The numb feeling, if present, will gradually subside.

15. Prepare yourself for some negativity. There are few police critical incidents that are not criticized by someone, especially if you had to shoot to defend yourself. No matter how necessary the use of lethal force was, it seems that there is at least one person who will say things like, "They didn't have to shoot him", "These cops are out of control", or "He (the suspect) would not have hurt anybody, the cops overreacted". You must *stay grounded in what you know to be true* to minimize the damaging effects of unjustified and uninformed private or public opinion.

16. Some people will force police officers to shoot them. If your critical incident involved a *suicide by cop*, it is natural to experience a broad range of emotion. These can vary from feeling sorry for the person to intense anger for involving you in their wish to die. It is also possible to experience several, seemingly contradictory emotions in reference to the suicidal person. Do not forget that he or she removed all your other options and you had to defend yourself from their potentially lethal behavior.

17. Sleeping can be difficult for awhile, and you may have unusual dreams during the time that you are sleeping. This is normal. Unusual sleep and dreaming patterns, if present at all, usually return to normal within a few weeks.

18. Avoid using alcohol as a primary critical incident stress management strategy. Although alcohol might "relax" you and help you to fall asleep if you're having trouble sleeping, it will not help you to maintain restful sleep.

19. Maintain your exercise routine. If you do not have a routine, start some daily light exercise. Walking is excellent. Even mild exercise or other physical activity helps to dissipate stress and aids in sleep onset and maintenance.

20. Keep caffeine consumption within your normal limits. It's ok to lessen caffeine consumption for a few days, especially if you're having difficulty sleeping.

21. Do not take the activities of the systems personally. Keep the needs of the various systems (DA's office, administrative investigation, criminal investigation, the press, etc) in perspective. In terms of the investigations, *remember that an officer's best defense against false accusations is a thorough and complete incident investigation*.

22. Try to be patient. Do this on two levels: (1) be patient with yourself - it takes time to psychologically work through a critical incident, and (2) be patient with everything else – your spouse, your department, incident investigators, the DA's office, etc. Even though you will want some things completed swiftly, most things will take more time than desired.

23. Assume responsibility for your positive recovery. Many police departments have professional and peer support protocols in place to assist officers involved in critical incidents, but many do not. Do not hesitate asking for the help you need. Do not become a victim of the *secondary danger* of policing (See page 8).

24. Be especially aware of any personal suicidal thoughts or feelings. Although rare, suicidal thoughts have been known to occur in officers following critical incidents. Keep yourself safe. If you are having suicidal thoughts, contact a responsible person immediately. Remain open to appropriate intervention. Suicidal thoughts following a critical incident are normally of short duration and respond well to appropriate support intervention.

25. Do not allow the incident to damage you, your family, or your career. Take care of your family and let them take care of you. (See *Officers and Spouses: Critical Incident Information*). Take advantage of available support resources.

Remember, police critical incidents happen because you are a police officer and there are circumstances beyond your control, not because of who you are as a person.

Positive Recovery

Keep in mind that you are naturally resilient. If you do not feel good now, allow yourself some time to process the event. You will feel better over time. Positive recovery involves the following:

1. Accepting what happened. You will accept any experience of fear and any feelings of vulnerability as part of being human. Vulnerability is not helplessness.

2. Accepting that no one can control everything. You will focus on your behaviors and the appropriate application of authority. You will keep a positive perspective.

3. You will learn and grow from the experience. You will be able to assess all future circumstances on their own merits. You will become stronger and smarter.

4. You will include survivorship into your life perspective. You may re-evaluate life's goals, priorities, and meaning. You will gain wisdom from your survivorship.

5. You will be aware of changes in yourself that may contribute to problems at home, work, and other environments. You will work positively to overcome these problems.

6. You will increase the intimacy of your actions and communications with those you love. You will remain open to the feedback and care of those who love you.

Getting Help

No one can work through the aftermath of a critical incident for you, but you do not have to go it alone. Keep an open mind. Allow your family, friends, and peers to help.

Seek professional assistance if you get stuck, if you do not "feel like yourself" or if your friends or family notice dysfunctional emotional responses or behavior. Do not ignore those who care about you. Stay connected to your loved ones.

This page adapts and includes information from the *Colorado Law Enforcement Academy Handbook* and *Reflections of a Police Psychologist (2nd ed.)* (Digliani, J.A., 2015).

Suicide by Cop

There are those who seek to be killed by the police. *Suicide by cop* (SBC), *victim-precipitated suicide*, and *decedent-precipitated suicide* are contemporary terms for this too frequently observed phenomenon.

Persons intending to be killed by police officers act in ways that compel officers to defend themselves. In the majority of cases, persons so disposed will point a firearm at police officers. Many of these people are armed with functioning, loaded weapons, and a percentage of these persons will not hesitate to kill police officers or others in their effort to die at the hands of the police.

Some persons intending SBC are in possession of air, pellet, BB, or replica weapons. They use these to threaten officers. Others have no weapon at all but act as if they do. These persons posture or "draw" to make officers believe that they are armed.

Some persons indifferent to life will sometimes engage in SBC behavior. They may point a weapon at an officer or otherwise threaten officers and let "fate" decide the outcome. Persons in this frame of mind do not care whether they live or die. They do not comply with officers' orders, threaten officers, and may compel officers to defend themselves.

Some persons that attempt suicide by cop want to die and have chosen firearms as the means. However, because they do not have a firearm, they choose the police as their instrument of death. In these cases, subterfuge is common.

Many of those seeking to be killed by the police are suffering from depression or other mental disorders. Some have recently undergone a "last straw" life experience.

What about those persons who wish to die by firearms and possess loaded, functional weapons but choose SBC? Why do they not shoot themselves? Several factors are suspected in these cases, including:

1. Social concerns - there is still a social taboo against suicide.
2. Suicide by cop allows suicidal persons to die without actually killing themselves.
3. Fear - an inability to follow through with suicide.
4. Religious prohibitions against suicide (SBC as a religion "loophole"?).
5. Concerns over life insurance policies.
6. Wanting to go out in a blaze - Wanting to make the news.
7. Punish, embarrass, or make a public statement to someone.
8. Anger against the police, particular persons, or society.
9. A desire to confront or harm police officers.
10. Psychological inability to kill oneself.

Officers must remain aware that persons considering suicide by cop may be willing to kill police officers or others to fulfill their wish to be killed by police.

You cannot bet your life on the probability that a suicidal person is not homicidal. *If you have been involved in a suicide by cop, you must remember that the person took away your options to handle the circumstances in any other way.*

Witness to Suicide

Police officers are frequently called upon to assist persons that have become suicidal. In a significant majority of these cases officers are successful and the person considering suicide receives the appropriate professional intervention. However, not all "suicidal person" calls end this way.

Some persons will kill themselves in the presence of police officers. When officers witness a suicide, the experience can trigger a cascade of emotions. These emotions range from intense anger to feelings of guilt and sorrow. This is especially true if the officer is acquainted with the person or the officer has come to know the person during the time spent trying to keep the person from killing him or herself.

Some factors in police officer emotional response to witnessing a suicide:

- Second guessing - "Did I do something that I shouldn't have, did I not do something that I should have?" This type of second guessing can lead to unjustified feelings of guilt. *You are not responsible for the person's behavior*.
- Proximity to the person
- Instrument or means of death
- Body damage, gore, blood, and death scene
- Efforts at resuscitation - failed rescue attempts
- Perceived personal danger
- Content of officer/person interaction
- Actual circumstance of the incident
- Interaction with the person's family
- Actions of other officers
- Your personal and family history (For example – If there has been a suicide in your family or if you lost a close friend to suicide, the incident may reactivate feelings of grief associated with your loss and the past event)

If you have witnessed a suicide:

- Accept your feelings. It is traumatic to witness the death of another person.
- Do not blame yourself. It was the person who made the decision. We are all limited in our ability to make others act as we desire, regardless of effort.
- Do not forget that there is no perfect way to interact with a person considering suicide. All you can do is manage the interaction in the best way you can.
- Understand that you did what you thought was best to help the person.
- Take some time to process the incident before returning to shift duties.
- You will likely experience some degree of *posttraumatic stress* (See page 5).
- Manage posttraumatic stress as suggested in *25 Suggestions and Considerations for Officers Involved in a Critical Incident* and *Recovering from Traumatic Stress*. Avoid alcohol or other drugs as a primary way to manage your feelings.
- Seek support: Talk to a trusted peer, supervisor, friend, or family member about your experience and feelings. Initiate contact with your department's peer support team, chaplain, or other available support resource.

Loveland Police Peer Support Team, Tim Brown, LPC LPD, and Jack A. Digliani

Exposure to Injury, Death, and Death Imprint

Exposure to the injury or death of others is an unavoidable stressor of policing.

Injury exposure

There are many circumstances that bring police officers into contact with injured persons. The injuries observed by police officers range from minor cuts and abrasions to life-threatening body damage and dismemberment.

It is not difficult to understand that interacting with some injured persons might emotionally distress an officer. Depending upon the actual circumstances, police officers may experience varying degrees of posttraumatic stress as well as posttraumatic stress disorder following such interactions.

Emotional response and the Death Exposure Response Spectrum

The *Death Exposure Response Spectrum* is a hypothetical continuum that specifies the possible emotional reactions to death.

At one end of the Death Exposure Response Spectrum lie the emotional responses of sensitization and traumatization. Such traumatization frequently includes the experience of death anxiety, fear, and depression. At the other end of this spectrum lie emotional numbing, indifference, and insensitivity, resulting in an almost robot-like response to death. In the middle of these extremes are the more psychologically healthy responses to death.

For police officers, death is a more-than-usual topic for thought. For one thing, police training encourages officers to think about death; their own as well as others. Every police officer is trained to recognize circumstances wherein self-defense or defense of others becomes necessary. In some of these circumstances, officers may need to use lethal force.

Police officers are also encouraged to think about death by the very nature of their work. Street and investigative experience exposes officers to death in various ways, including criminal homicide, suicide, natural death, auto crashes, pedestrian accidents, fires, and industrial accidents.

If a police officer has not been personally exposed to the experiences described above, he or she certainly knows of other officers that have. This creates a type of vicarious death exposure. Either way, direct or indirect exposure to death seems a common aspect of the psychology of police officers.

Death exposure, the police officer, and the job

Regardless of how officers encounter death, it is possible for them to develop feelings of having seen too much death. This is especially true if there is a high frequency of death exposure. It can become more difficult if the deaths involve children, “didn’t have to happen”, or appear “meaningless”.

Some degree of death-coping ability is necessary for police officers. If death exposure is managed in a functional way, it can result in a psychological perspective which enhances officers' death-coping abilities. In turn, this allows officers to work in their assignments without a great deal of distress or death anxiety. However, no matter how officers conceptualize death or how well an officer copes with death, there is the ever present risk of *death imprint*.

Death imprint

When officers experience anxiety about death, it often involves thoughts about their own death, the death of loved ones, the inevitability of death, the identification of a deceased person with still living loved ones, the future loss of loved ones, and memories of those that have already died. The actual degree of experienced distress varies and is dependent upon the intensity and duration of the generated anxiety. However, even officers that have found a way to cope with death exposure can be emotionally overwhelmed. This can occur (1) due to the circumstances of a particular case, (2) when a particular case causes a *tipping point* in an officer's ability to manage death anxiety, (3) when a recent death reactivates feelings about a historical loss, or (4) gradually over time with continued death exposure. Regardless of the cause of death anxiety, the result of this emotional decompensation is sometimes referred to as "the experience of *death imprint*." Death imprint becomes possible when our psychological coping defenses weaken. This allows the normally suppressed anxiety and depression associated with thoughts of death to reach some degree of expression.

Death imprint is frequently an issue following the experience of a traumatic incident. It is a component of posttraumatic stress disorder. There does not have to be an actual death for a person to be effected by death imprint. Near death or serious injury that might have resulted in death is enough to trigger death imprint.

Keeping yourself healthy

Critical incidents involving death can challenge your normal coping abilities. If your coping abilities are overwhelmed you will begin to experience the responses consistent with the extremes of the *Death Exposure Response Spectrum* (Also see *Signs of Excessive Stress*).

All you can do is what you can do. This may sound like a redundant statement of the obvious but there is some wisdom in this old saying. Remember this when your best efforts fail to save someone.

No one in any environment can prevent the possibility of death. Although police officers have saved countless lives by protecting others, applying first aid, administering CPR, and completing rescues, there is no way to eliminate the possibility of death.

Death imprint is an occupational hazard for police officers. No one is immune from death imprint. If you feel that you are experiencing elements of death imprint or distress related to a death incident, talk to someone. Contact a friend, a member of your peer support team, the police psychologist, or another support resource.

Death, Loss, and Survivorship

For police officers, some critical incidents involve a personal loss. Officers experience personal loss upon the death of someone known to them, such as a family member, friend, acquaintance, peer, or other co-worker. Interestingly, police officers may experience similar feelings upon the death of those previously unknown to them, including those killed by police in self-or-other defense.

Summary of issues involved in death, loss, and survivorship:

1. Learning of the death. Shock and denial are common initial responses to death, especially if the death is sudden and unexpected. Disbelief and confusion are frequently experienced.
2. Reactions to death. Many factors influence how intensely we feel the loss. Among these are the nature of attachment, spiritual views, the age of the deceased, how the person died, the similarity of the deceased to those we love, and the extent of the void that the person's absence leaves in our life. The death of another can also trigger our own fears of death and memories of previous traumatic events or losses.
3. Grief and mourning. Grieving takes time. This is important to remember because American culture is not readily accepting of lengthy grieving or mourning periods. Instead, there is the idea that a person needs to put the loss behind them and get on with life. There is no correct way to grieve. People deal with loss in different ways for different periods of time. The public expression of grief is mourning.
4. Coping with loss. It is common to experience powerful emotions. Confront emotions openly. Strong emotion may feel overwhelming. Breathe through it.
5. Specific reactions to loss. There are many possible reactions to loss. Common and normal reactions include sadness, crying, numbness, loss of appetite, inability to sleep, fatigue, anger and frustration, finding it difficult to be alone, or wanting to be alone. Utilizing your support system is the best way to deal with the pain of grieving.
6. Stages of grief. Many clinicians have identified what they refer to as stages of grief. Although such stages differ in terminology, the basic structure of the stages involve (1) an initial shock and denial, (2) a subsequent impact and suffering period, followed by (3) some adjustment and degree of recovery (similar to exposure to any traumatic event). However, grieving is a complex process; it does not progress clearly from one stage to another. It is normal to once again have feelings long thought to have disappeared.
7. Healing. Acknowledge and accept your feelings. You may experience seemingly contradictory feelings such as relief and sadness (for example, relief that a burden of care or the person's suffering has ended, and sadness due to the loss). This is normal. Keep in mind that your emotional attachment does not end upon the death of someone you care about. Remember, bereavement is the normal process by which human beings heal from loss.
8. Surviving the loss. Surviving the death of someone you care about involves honoring the memory of the person by acknowledging what the person contributed to your life. From here, you can further honor the person by reengaging life. It is important to remember that similar feelings can follow the death or loss of pets, non pet animals, and even plants and inanimate objects that have acquired some special meaning (like losing a family heirloom). Brain studies show that the same neural pathways of grief are activated regardless of the loss.

Critical Incident Management and Return to Duty Protocol

Preparation and Stress Inoculation Training: Officers should receive instruction in agency procedure & critical incident stress inoculation, and participate in the *Psychologist And Training/Recruit Officer Liaison* (PATROL) program prior to working independently (See *Reflections of a Police Psychologist,* Chapter 2, *Field Training and PATROL,* 2010. Digliani, J.A.).

Concept of *second injury - s*econd injury occurs when an officer is treated poorly following a critical incident, even if unintentionally. Second injury is especially likely to occur if the poor treatment comes from the officer's department. Remember, it is as true for agencies as it is for individuals: *you don't have to intend harm to do harm*.

Critical Incident Management

1. Remove from scene/controlled environment/away from suspect's family/not isolated/gatekeeper and peer support (See *Officer-Involved Incident Protocol)*
   Officer notification of spouse, family/notification by policy if incapacitated
   On-scene support (peer support team, psychologist)/confidentiality
   Contact from top administrator (chief or sheriff). *Ongoing* admin/staff support
   Replacement of weapon (if taken as evidence) with like weapon/return of badge if clothing is taken and badge is not evidence/replacement badge if badge is taken as evidence
   Issues of officer blood sample – voluntary, probable cause, or policy
   Police vehicle considerations if vehicle is assigned
   Administrative leave pending processing of incident/press releases/telephone, email screening/officer and officer's family security
   Trauma Intervention Program – initiation into psychologist support program

2. Recognition of personal risk – recognition of officer's perceptions, conceptions, emotions, effort, and actions – appoint department contact officer
   Attorney for officer if requested without negative consequences for officer
   Clear distinction between criminal and administrative investigation: Miranda advisement? Garrity advisement?

3. Family involvement: spouse/children (immediate support, security, nature of incident, issues of vulnerability, peer reactions, work, school, released press information, extended family responses, etc)
   Prepare for possible negativity: press, segments of community, family members of suspect, other sources

4. Debriefing if appropriate, other support interventions if debriefing is unwarranted. Debriefing: voluntary, invitation of participants – consider support persons, dispatch personnel, other agency personnel/individual follow-up/peer support team member reach-out, timeframe (see *Guidelines for Conducting a Police Critical Incident Debriefing* and *Peer Support Team and Debriefing Issues*)

5. Expedite criminal and administrative investigations, district attorney, review boards, etc - expedite closure for involved officers

6. Consider scheduled court hearings and assigned off-duty work/evaluated on an individual case basis – Consider any other incident-specific factors

RETURN TO DUTY

1. Return to scene – often accompanied by investigators during walk-through, but need experiential perspective. Officer is accompanied by staff psychologist and experience is processed. Consider spouse or others if requested by the officer. *Caution considerations*: Issues of retraumatization or vicarious traumatization.

2. Firing range if shooting incident – shoot loaner gun if actual weapon is still held as evidence, shoot actual weapon when returned. Psychologist or PST member accompanies officer at firing range during weapon firing if needed. Otherwise, range experience psychologically and emotionally processed in later meeting with staff psychologist.

3. Officer Wellness Assessment (OWA) - conducted as part of the Trauma Intervention Program by the staff psychologist. The OWA is designed to determine the optimal timing for the initiation of the graded re-entry to duty (#4). (See *Fitness for Duty Evaluation, Officer Wellness Assessment, and the Trauma Intervention Program*)

4. Graded re-entry – program design: modified duty (uniform/non-uniform), buddy officer partner (may be selected by involved officer from anywhere within the department, contacted by officer and/or psychologist), consider off-duty work and specialized assignments during reentry (normally restricted), alteration if needed as program progresses. Important that officer works the assigned shift during reentry. Upon successful completion the officer is returned to full duty. Throughout process: mechanism of *safety net*, periodic contact with psychologist and additional psychological support if necessary. Peer support.

5. Follow-up - scheduled appointment(s) subsequent to completion of graded re-entry. Timing and number of follow up appointments vary as deemed appropriate (for baseline follow up: after two, four, and eight weeks of full duty – beyond eight weeks as needed). Family members scheduled for appointments as needed. Year of *firsts*, peer support team and departmental reach-out. Peer support team member assigned (selected by involved officer) for one year.

Trauma Intervention Program

The Trauma Intervention Program (TIP) is comprised of several components designed to support and assess police officers exposed to potentially traumatic circumstances. Ideally, the first step in traumatic exposure management is previous training in stress management and stress inoculation, as well as participation in the PATROL program. However, whether or not an officer has received such training or participated in the PATROL program, the TIP is initiated following the exposure to a potentially traumatic incident.

The TIP is initiated within the conceptualization that it is the person/incident transaction which determines the degree, if any, of actual individual traumatization. It is possible for an officer to experience no appreciable traumatization following an event which would normally be considered a police "critical" or "traumatic" incident.

The TIP summarizes and includes elements of the *Critical Incident Management and Return to Duty Protocol*. It is primarily comprised of the following features which are implemented in situation-specific appropriate sequence:

1) previous stress management training and participation in PATROL
2) on-scene support
3) initiation into a counseling program
4) assessment and appropriate intervention
5) psychological visit to the incident location
6) firing range and processing
7) reintroduction to equipment
8) officer wellness assessment
9) graded re-entry to duty
10) appropriate follow-up

- On-scene support is provided by the peer support team and when necessary, the staff psychologist.
- The involved officers immediately become clients of the staff psychologist. This establishes the relationship necessary for privileged communication. A supportive counseling program is initiated.
- As part of the counseling support program the incident site is revisited and the events/location/actions are psychologically and emotionally processed. Timing is important. The site visit is conducted when assessed appropriate.
- If the incident involved the use of firearms, involved officers shoot a non-qualifying course of fire for the psychological experience of shooting. Following this, they shoot a qualifying course of fire. The psychologist accompanies the officer at the firing range if needed. The experience is processed.
- There is a reintroduction to equipment including firearms, sound of police radio traffic, uniform, police vehicle, and other work items or experiences associated with the incident.
- The TIP OWA is initiated. (See *Fitness for Duty Evaluation, Officer Wellness Assessment, and the Trauma Intervention Program*)
- A graded re-entry to duty in the form of a *Return to Duty Protocol* is designed and implemented.
- Appropriate follow-up is arranged.

Fitness for Duty Evaluation, Officer Wellness Assessment, and the Trauma Intervention Program

The officer wellness assessment (OWA) associated with the Trauma Intervention Program (TIP) is different from a fitness for duty evaluation (FFDE). For the most part, officers undergo a FFDE following some identified problem. The problem that prompts a FFDE usually involves a perceived difficulty in the officer's state of mental health and emotional stability. Fitness for duty evaluations utilize one or several assessment instruments or "tests", performance and personnel records reviews, psychological and physical history review, clinical interview and assessment, and mental status examination.

FFDEs are conducted independently of any existing counseling program. This means that if an officer is in counseling, the psychologist (or therapist) that is providing counseling services does not complete the FFDE (even if qualified to do so). The reason for this is the ethical prohibition of *dual-relationships*. This prohibition is based upon the premise that a psychologist involved in a therapeutic relationship with an officer cannot be fully objective during a FFDE. Therefore, any FFDE of the officer must be completed by a second, independent, and qualified psychologist/evaluator.

In the OWA incorporated into the Trauma Intervention Program, the *primary goal* is to assess whether there is a newly developed incident-related clinical disorder that would prevent the officer from returning to duty (See *Stressor Related Disorders-DSM*). The OWA includes ruling out an incident-caused exacerbation of any preexisting psychological condition.

The primary goal of a TIP OWA assessment is made possible by the fact that the majority of officers involved in duty related critical or traumatic event were not experiencing psychological or performance difficulties prior to the incident. Therefore, most officers assessed in the TIP OWA come from a history of health, not a history of dysfunction. This, coupled with the fact that most officers perform professionally during critical incidents (in compliance with their training, state statute, and departmental policy), makes a FFDE unnecessary. Under these circumstances, any ethical concerns inherent in *dual-relationship* are managed without difficulty. This means that even if the officer has a counseling history with the staff psychologist, the staff psychologist may complete the OWA.

An officer should not be made to undergo a traditional FFDE simply because he or she performed as trained and as expected during a critical incident (See IACP below).

In the TIP OWA the staff psychologist completes a mental status examination, clinical interview and wellness assessment over several meetings with the officer. During this process, pre-incident psychological difficulties (if any) are assessed and sub-clinical psychological issues are addressed. In the TIP OWA psychological tests are used only when indicated and are not routinely applied.

TIP OWA: If there are no circumstances which would prevent the officer from returning to duty, the officer is returned to duty in accordance with the TIP and the specifically designed Return to Duty Protocol. If the TIP OWA suggests any type of clinical impairment resulting from or triggered by the incident, continued psychological and any other appropriate intervention is indicated.

If during the TIP OWA there is an assessed need for a FFDE, the FFDE is completed by an independent evaluator. The results of the FFDE are then integrated into the TIP therapeutic effort, whether or not the officer is assessed as fit for duty.

The need for a traditional FFDE during the TIP has been the exception much more than the rule. The TIP OWA has proven itself completely adequate in an overwhelming majority of incident-related circumstances wherein the TIP has been initiated.

International Association of Chiefs of Police (IACP)

In their effort to continue to best serve the policing community, the IACP has defined "Psychological Fitness-for-Duty Evaluation" and provided guidelines for the use of FFDEs following an officer-involved shooting.

Psychological Fitness-for-Duty Evaluation Guidelines:

"A psychological FFDE is a formal, specialized examination of an incumbent employee that results from (1) objective evidence that the employee may be unable to safely or effectively perform a defined job, and (2) a reasonable basis for believing that the cause may be attributable to a psychological condition or impairment. The central purpose of an FFDE is to determine whether the employee is able to safely and effectively perform his or her essential job functions."

Officer-Involved Shooting Guidelines:

"It should be made clear to all involved personnel, supervisors, and the community at large that an officer's fitness-for-duty should not be brought into question by virtue of their involvement in a shooting incident. Post-shooting psychological interventions are separate and distinct from any fitness-for-duty assessments or administrative or investigative procedures that may follow. This does not preclude a supervisor from requesting a formal fitness-for-duty evaluation based upon objective concerns about an officer's ability to perform his or her duties. However, the mere fact of being involved in a shooting does not necessitate such an evaluation prior to return to duty."

IACP information from: www.theiacp.org

Critical Incident Protocol –The Police Officer Involved

(formerly *Officer-involved Incident Protocol*)

The Eight Judicial District *Critical Incident Protocol* (CIT) was originally developed in 2005 and revised in 2012 and 2018 by the various Judicial District law enforcement agencies and the District Attorney's Office.

The CIT specifies the recommended course of action for officers involved in a critical incident.

The following text is quoted directly from the Protocol and specifies the role of THE INVOLVED POLICE EMPLOYEE when the Protocol is initiated.

THE INVOLVED POLICE EMPLOYEE

1. Calm Down and Ensure All Threats to your Safety are Over

- ☐ Notify Communications and request a supervisor if one is not already on scene
- ☐ Broadcast lookouts
- ☐ Request backup and related support services
- ☐ Assign responsibilities to responding units based on priority

2. First Aid

- ☐ Request an ambulance, two if needed
- ☐ Render aid

3. Secure Scene

- ☐ Secure your weapon in the holster. Do not open, reload, remove shell casings or in any other manner tamper with involved firearms.
- ☐ Should you become separated from your weapon during the shooting, the weapon is part of the crime scene and should not be moved (assumes a tactically stable situation)
- ☐ Secure any shoulder weapon in the trunk or gunlock of your vehicle
- ☐ Secure any part of the scene that might be destroyed or damaged in the first few seconds (e.g. evidence kicked away or washed away by rain/snow)
- ☐ Secure the perimeter and protect evidence
- ☐ Identify persons leaving the scene
- ☐ Identify witnesses and request cooperation

4. Absorb What You See and Who You See

- ☐ Take notes of what you deem important
- ☐ If practical, begin taking photographs of the scene activity

5. **A supervisor may ask you what happened in order to locate suspects, witnesses, victims and evidence. These questions will generally focus on public safety and scene management.**

   ☐ If you are an involved or witness employee, do not talk with other witnesses or involved police employees about the incident.

6. **Once the situation is stable, you will be transported away from the scene to a designated location free from the distractions of the investigative process. You can expect the following:**

   ☐ An officer or supervisor will be the "gatekeeper" and restrict access to you.
   ☐ Investigators will photograph you in your police attire, as well any injuries or anything else of evidentiary value. Your uniform or clothing may be taken, depending upon its evidentiary value.
   ☐ If there is a question as to whether a particular officer fired a weapon during the critical incident, a Gunshot Residue Test (GSR) will be conducted as soon as practicable, if not completed at the scene.
   ☐ Your entire gun belt, with gun in holster, will be retrieved by investigators and a replacement weapon/leather issued to you.
   ☐ An opportunity to provide toxicology samples (blood/breath/urine) will be provided.
   ☐ Peer support personnel who are not involved in the incident or its investigation will be made available to you.
   ☐ You may contact family members and within reason have them with you.
   ☐ You will be given the opportunity to contact any legal representation that you desire.
   ☐ A command officer will personally contact you to express concern and support during this stressful time. They will not question you about the incident.
   ☐ Expect a lengthy delay prior to your interview. If you wish, use this time to make notes about the incident. Every attempt will be made to provide an estimate as to when the interview will take place.

The CIT also includes recommendations for:

- the supervisor at the scene
- incident investigators
- investigative supervisors
- the peer support team

In this way, the CIT may be useful to officers and agencies outside the jurisdiction of the Eighth Judicial District.

Recovering from Traumatic Stress

Recovering from traumatic exposure takes time. The most difficult challenge for action-oriented officers is to be patient in recovery. If you are exposed to a traumatic event, accept your feelings. Depending on actual impact, the intensity of your emotional experiences may surprise you. Many officers have reported crying like a baby following shootings and other traumatic incidents. They describe the experience of strong emotion as *having lost it*. They are talking about feeling as if they lost control—control of their emotions.

In fact, they have not lost anything. Instead, they have *found* something. They have found the emotion that underlies their traumatic experience. When strong feelings surface, let them in, let them fade. Experience and explore the emotion. It is a natural part of recovery. Imagine intense emotion as an ocean wave. It will come, and it will go. Although it may feel overwhelming for a brief time, you can manage it. You know what it is: it is the healthy expression of strong emotion. You know what to do about it: you breathe through it.

Keep in mind that physical symptoms sometime accompany strong emotion. These will normally subside as recovery continues. Additionally, remember that family members may not fully understand your experiences. Try not to become angry or frustrated. They cannot know what it is like for you. Be patient with yourself and with your family. Maintain your family connections. Keep your lines of communication open.

What if I develop posttraumatic stress disorder after a critical incident and my symptoms persist? Can I be disabled by posttraumatic stress disorder?

Unfortunately, yes. If you develop PTSD after a critical incident, and the symptoms are severe and enduring, you can become *totally* or *occupationally* disabled.

Total disability occurs when the severity of the symptoms renders an officer incapable of engaging in any employment. Occupational disability occurs when an officer experiences disabling symptoms in the policing environment, but remains relatively symptom free in other work environments. This renders the officer incapable of returning to policing, but able to perform other work.

Occupational disability can occur following a critical incident because traumatic experiences have the power to "split" environments. That is, whereas officers are normally symptom free in their work environment prior to the traumatic incident, following the incident their work environment transacts to produce significant posttraumatic stress disorder symptoms. In such cases, the officer cannot safely return to the type of environment that produced the traumatic event. In essence, work environments have been split into symptom and non-symptom producing environments.

Fortunately, most police officers do not develop PTSD after a critical incident, and many of those that do are successfully treated. They are then able to return to work and continue their police career without significant difficulty.

Positive Side of Critical Incidents

There is a positive side to critical incidents, a side that is seldom discussed. It has to do with becoming "stronger and smarter" following a critical incident. Becoming stronger and smarter following a critical incident involves several variables including (1) finding something positive in the experience and (2) placing the event into psychological history.

This aspect of critical incident survivorship was well-expressed by a British police officer that, although much rarer in England than in the United States, was involved in an incident several years ago wherein he was compelled to shoot a suspect that had taken a hostage. The suspect was killed. He knew he did was what necessary to protect the hostage but like many police officers, it took him some time to psychologically and emotionally process the event. He described part of his experience this way:

"…I am also aware how having come through both the incident and the aftermath, that I changed in a positive way too. I believe that dealing with the incident made me more resilient, able to cope better with problems and difficulties (based on a mind-set that goes something like "If I can deal with all of that, I can deal with anything that life throws at me"). The incident also reinforced my personal levels of professionalism (and my expectations of it in others). Over time these positives have, I believe, come to the fore, whilst the negative reactions have faded." (May 19, 2015)

Positive outcomes can result from critical experiences. We do not have to focus on the undesirable or challenging responses which are sometimes generated out of unpleasant or unwanted experiences. We have an ability to examine the other side of such experiences. We have an ability to achieve a better mental balance. To the degree this can be accomplished, we can move forward, through any aftermath of any critical incident. In this way, we become stronger and smarter.

Resiliency

"Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress — such as family and relationship problems, serious health problems or workplace and financial stressors. It means "bouncing back" from difficult experiences. Research has shown that resilience is ordinary, not extraordinary. People commonly demonstrate resilience.

Being resilient does not mean that a person doesn't experience difficulty or distress. Emotional pain and sadness are common in people who have suffered major adversity or trauma in their lives. In fact, the road to resilience is likely to involve considerable emotional distress.

Resilience is not a trait that people either have or do not have. It involves behaviors, thoughts and actions that can be learned and developed in anyone." (From http://www. apa.org)

Trauma: Chronological History and Psychological History

Officers who have experienced critical events want to place the incident behind them and move on. The difficulty for many officers is that the incident continues to impact their lives in less than desirable ways. This is because the incident, while in c*hronological history*, is not yet in *psychological history*. The incident is in chronological history the instant that it is over. However, this is not the case with psychological history. When thoughts and other stimuli associated with the incident evoke powerful distressing responses following the incident, the incident is not in psychological history.

Placing the incident into psychological history involves disconnecting the memory of the incident from the gut-wrenching or negative emotional responses experienced during or immediately following the incident. When an incident is in psychological history, conditioned responses are minimized. Thoughts of the incident may produce emotional responses, but they will not be disabling. The person will be able to move forward, no longer being psychologically stuck in the incident.

A major component of critical-incident trauma recovery is placing the event into psychological history.

The ability to place experiences into psychological history is also important in everyday life. This is especially true of functional interpersonal relationships. In functional interpersonal relationships persons are able to emotionally move beyond the memory of minor transgressions and prevent such memories from continually exerting an undesirable influence on the relationship.

According to psychologist Albert Ellis, PhD (1913-2007), author of *Rational-Emotive Behavioral Therapy* (REBT) there are 12 primary irrational ideas that cause and sustain psychological difficulty. Irrational idea number 9 is presented here because of its relevance to "placing the event into psychological history" and as a reminder of what can be accomplished:

REBT Irrational Idea Number 9: *The idea that because something once strongly affected our life, it should indefinitely affect it* – Instead of the idea that we can learn from our past experiences but not be overly-attached to or prejudiced by them.

Ellis, A. (2004). *Rational Emotive Behavior Therapy: It Works for Me--It Can Work for You*. Amherst, NY: Prometheus Books.

Officers and Spouses: Critical Incident Information

Many officers have asked about how much incident information should be provided to their spouses. There are several factors that should be considered. Two of the most important are (1) is the officer retraumatized by recounting the information and (2) how much information is desired by the spouse. For some officers, talking about their traumatic exposure is not problematic. They can recount the event and their experiences without difficulty. For others, this is not possible. For them, each recounting of the incident is retraumatizing. In the latter cases, responding to a spouse's repeated request for more information may be detrimental to the officer.

Following a critical incident, some spouses want to know every detail. They want to see photographs, read case reports, listen to dispatch tapes, and so on. Other spouses desire or can tolerate only a broad description of the incident. For these spouses, providing more than general information may result in vicarious traumatization. This is especially true if the incident details involve blood, body damage, and gore. To keep officers from being retraumatized and spouses from being vicariously traumatized, a healthy balance must be struck between how much information officers can provide without detriment to themselves and how much information is desired by spouses.

A particularly difficult circumstance arises when the officer's need to talk about the incident exceeds the capacity of the spouse to listen. Capacity may be overwhelmed by the nature of the incident or the sheer number of times that the spouse has heard the story. Even if the officer is still struggling with the incident and feels better after talking about it, at some point most spouses will become *incident-info saturated*. They want to move past the event and get back to normal. For these spouses, like the spouses that cannot tolerate much incident detail, further exposure may result in vicarious traumatization.

If your spouse becomes incident-info saturated, limit further discussion of the incident with him/her and initiate or continue to process the incident with alternative support resources. Also, if not already started, consider that it may be helpful for your spouse to engage in counseling support services.

<u>After a critical incident</u>

Although things generally improve with time, there may be no getting back to what was previously normal. Some traumatic events will change persons and relationships forever. The officer and spouse (the entire family) must find a *new normal* and live on from there. The new normal may be better than the old, but the opposite is also possible. Some police officer relationships do not survive traumatic incidents. The incident either creates new and unbearable difficulties or intensifies previously existing problems. Some relationships collapse under the strain, and the couple separates. Other relationships appear to be strengthened by the pulling together of couples following traumatic exposure.

Do not become a critical incident statistic. Seek appropriate professional assistance if your relationship becomes troubled following involvement in a critical incident.

Police Spouse Anxiety and Critical Incidents

Some police spouses that have not experienced anxiety about the risks of policing prior to a police critical incident become anxious following a critical incident. This is because prior to the incident, three primary psychological defenses mechanisms function sufficiently to keep police spouse anxiety in check. These psychological defenses are known as *rationalization*, *intellectualization*, and *denial*. Together they create a protective buffer against policing-related anxiety. For police spouses, these psychological defense mechanisms work something like this:

(1) Rationalization – I am confident that *my* police officer has the skills to survive any work circumstance and return home safely after every shift. Therefore, I do not have to think or worry about it.
(2) Intellectualization – the chances that *my* police officer will be harmed or killed in the line of duty is a slight and unlikely theoretical possibility. Therefore, I do not have to think or worry about it.
(3) Denial - if a police officer is killed or seriously injured it would not happen here, and if it did it would not happen to *my* police officer. Therefore, I do not have to think or worry about it.

Psychological defense mechanisms

Rationalization, intellectualization, and denial are three of several hypothesized psychological defense mechanisms. In general, psychological defense mechanisms operate below the level of conscious awareness. Another way of saying this is that we seldom recognize the role that defense mechanisms play in our psychological life. Psychological defense mechanisms are normal components of our psychological composition. However, when over-developed they can create a myriad of problems, including relationship, family, occupational, and social difficulties.

Police spouse anxiety and psychological defense mechanisms

Following a critical incident, especially those in which the officer could have been killed, some spouses come to realize the true dangers of policing. The dangers of policing now feel much more "real" and generate officer-safety anxiety. In such cases, the reality of the critical incident has overwhelmed the psychological defenses which previously protected the spouse from the anxiety associated with the risks of policing.

Police officers, police spouse anxiety, and psychological defense mechanisms

It is important to know that the critical incident does not have to involve actual death or serious injury, nor must it involve the officer of a particular spouse. Spouses can be affected by what happens to officers that are not their husband, wife, or partner. Spouse anxiety following a police critical incident can be mild and temporary, or become chronic and so problematic that some officers have chosen to leave policing. Police officers involved in critical incidents can help lessen spouse anxiety by openly discussing the dangers of policing and how they managed the risks or threat of the actual incident. It also helps to discuss the three T's of policing (*training*, *tactics*, and *technology*) and how they help to counterbalance police occupational dangers.

Not surprisingly, the psychological defense mechanisms of rationalization, intellectualization, and denial are also employed by police officers. Like anyone else, police officers too can have their psychological defenses overwhelmed.

Foundation Building Blocks of Functional Relationships

1. **Emotional Connection**: all relationships are characterized by feelings or the emotional connections that exist between or among relationship members. Love is one such feeling. Feelings and the emotional connection frequently alter or influence perceptions and behaviors.

2. **Trust**: is a fundamental building block of all functional relationships. Trust is related to many other components of functional relationships including fidelity, dependability, honesty, etc.

3. **Honesty**: functional relationships are characterized by a high degree of caring honesty. There is a place for "not hurting others feelings". However, consistent misrepresentation to avoid short-term conflict often results in the establishment of dysfunctional patterns such as long-term resentment, invalidation, etc.

4. **Assumption of honesty**: with trust, we can assume honesty in others. A relationship in which honesty cannot be assumed is plagued with distrust and prone to suspicion. Such relationships are characterized by persons trying to mind read and second guess the "real" meaning of various interactions.

5. **Respect**: respect is demonstrated in all areas of functional relationships – verbal communication, non-verbal behaviors, openness for discussion, conflict resolution, etc. Without respect, relationships cannot remain functional because problem-resolution communication is not possible.

6. **Tolerance**: the acceptance of personal differences and individual *preference*s are vital to keeping relationships working well. A degree of mutual tolerance makes relationships more pleasant and less stressful.

7. **Responsiveness**: your responsiveness to others helps to validate their importance to you and reflects your sense of meaningfulness of the relationship. This is especially important in hierarchical relationships.

8. **Flexibility**: personal rigidity frequently strains relationships and limits potential functional boundaries. Highly functional relationships are characterized by reasonable flexibility so that when stressed, they bend without breaking. Many things are not as serious as they first seem. Develop and maintain a sense of humor.

9. **Communication**: make it safe for communication. Safe communication means that others can come to you with any issue and expect to be heard. Listen in a calm, attentive manner. Allow the person to express thoughts and feelings without interruption. Communication factors: *content-message-delivery* (Content - the words you choose in the attempt to send your message, Message - the meaning of what you are trying to communicate, Delivery - how you say what you are saying. Delivery includes nonverbal behavior and defines the content message). Remember: Protect less – communicate more. *Confrontation guidelines*: a caring manner, appropriate timing and setting, present your thoughts tentatively, move from facts to opinion.

10. **Commitment**: long-term functional relationships are characterized by *willingness* to work on problems, acceptance of personal responsibility, attempts to see things from other perspectives, conflict resolution, and the ability of members to move beyond common transgressions. Life is complex. People are not perfect. You must decide what is forgivable. If forgivable, put it in the past and move on. *Psychological history and chronological history*.

Remember: All of us have *special status* people. Spouses, significant others, etc. are special status people. It is ok to do some things differently for those with special status. For instance, comply with their wishes at times even though it's not your preference. They will return this courtesy, resulting in an improved relationship. Do you really need to assert dominance in every circumstance? Do you need to win every argument? Can you see things from viewpoints other than your own? These are important issues in functional relationships and *Life by Default - Life by Design*. (See *Trauma: Chronological History and Psychological History* and *Life management: Life by Default - Life by Design*)

Foundation reinforcers of functional relationships: (1) the assumption of good faith in your partner and (2) the absence of intentional harm.

When talking or otherwise interacting with special status people (especially your spouse), *do not forget with whom you are interacting*. Remaining mindful that you talking to or interacting with a special person in your life will help you to moderate your behavior and maintain a MOB (Mindful of Blocks) mentality. This will help you to remain calm, respectful, and measured in potentially emotionally charged interactions. As a result, you will avoid behavior that you may later regret. For example, have you ever found yourself apologizing following a conversation with someone you care about by saying something like "I'm sorry, I shouldn't have spoken to you that way"? If so, you did not maintain a MOB mentality during the conversation.

Conceptually, the relationship is supported by the foundation blocks, while the foundation blocks can be damaged or repaired by the relationship they support.

It is a sad fact that some police officers talk and interact more politely and less contentiously with co-workers, strangers, and offenders than they do with their spouse, family members, and other loved ones.

Issues in Interpersonal Relationships and Family Systems

- Rules and myths
- Generational boundaries
- Alliances and coalitions
- Function and dysfunction
- Homeostasis and Underflow

In combination with *Some Things to Remember* and *Gottman's Marriage Tips* the *Foundation Building Blocks of Functional Relationships* provide an excellent framework for those wishing to improve their marriage and other personal relationships.

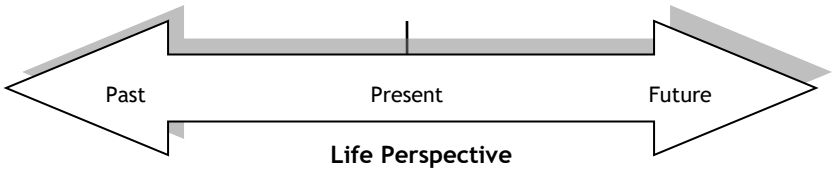
Life Management: Life by Default – Life by Design

Life management can be considered from one of two primary life perspectives: *life-by-default* and *life-by-design*. These perspectives are conceptual constructs and describe a continuum along which a person can engage life. It is unlikely that anyone lives life totally by default or by design. Most people live sometimes or most times by default, and sometimes or most times by design. Life-by-default differs from life-by-design in that life-by-default is what you get if you do not practice life-by-design. Not much thought or effort goes into life-by-default. Persons who are oriented toward life-by-default often feel powerless. They subscribe to the "This is my life. What can I do about it? It is what it is. What will be, will be" life position. This is very different from the life-by-design philosophy of "taking life by the horns." Life-by-default does not mean that life experiences are or will be undesirable. Quite the contrary, life experiences can default to very desirable circumstances. It is a matter of probability. The probability that life will default to something great and wonderful is less than the probability of desirable outcomes in life-by-design.

Life-by-design is best described by a single word: *intention*. Persons oriented toward life-by-design act intentionally and accept responsibility for their decisions and behaviors. Life-by-design persons are not passive observers of life. They do not wait for life to simply unfold. They feel empowered and they act in ways to direct their lives. In life-by-design there is no illusion that all things can be directed, controlled, or even influenced. Instead, there is respect for what might be changed and what must be accepted. There is recognition of the influence of personal values, societal values, and cultural influences.

Life-by-design persons do not blindly accept the values of their childhood. They consider all values and evaluate them from their now-adult perspective. They adopt those that are appropriate for them, and live accordingly.

Life-by-design is thoughtful, mindful. To engage life-by-design, persons must accept reasonable risk, endorse the idea that they can decide many things for themselves, and use this knowledge to make a difference in their lives. Making an effort to accomplish this is the first step toward moving from a life-by-default to a life-by-design and a functional life perspective.



A functional life perspective draws from the past (mindful of consequences and lessons learned) while maintaining a view of the future (potential for actualization).

Keeping Yourself Healthy

There are many things that police officers can do to maintain a healthy lifestyle.

Few persons are perfect when it comes to making life changes. If your attempts to positively alter your lifestyle have been less than successful, do not become discouraged. Instead, try to do a little something positive each day. Even small improvements can make a difference. Make changes where you can and then work on improvement consistency.

Suggestions for positive physical health:

- Exercise regularly.
- Maintain an active lifestyle.
- Eat and drink a healthy diet.
- Maintain adequate sleep.
- Do not smoke or use tobacco products.
- Schedule recommended periodic medical examinations and tests.

Suggestions for positive psychological and emotional health:

- Make family relationships a priority. Work on developing a healthy balance between family and work demands.
- Engage in family activities that are fun for all.
- Maintain satisfying interests and hobbies. Try a hobby that is not police or law enforcement related.
- Participate in relationships outside of policing.
- Do not hesitate to ask for support during stressful times.
- Support others. We are made stronger by helping others.
- Practice what you have learned in stress inoculation and stressor management training.
- Keep in mind that no one is immune to stress.
- Utilize healthy stressor management strategies that have worked for you in the past.
- Experiment with new stressor management strategies.
- If unsatisfying, reclaim your life, family, relationships, and career.
- Utilize and implement *Some Things to Remember*.
- Keep a positive attitude.
- Do not expect perfection – from yourself or others.
- Develop a sense of humor. Learn to laugh at yourself.
- Remain mindful of your personal boundaries.
- Identify and challenge irrational thoughts.
- Apply and practice *life by design*.
- Create a plan for positive change - engage your plan.

The Concept of Stress

Stress is a multifaceted and complex phenomenon. It appears to be a factor for all living organisms. The concept of stress has its origin in ancient writings and has developed significantly over the past several decades.

Stress: Hans Selye (1907-1982), an endocrinologist and researcher, defined stress as "the nonspecific response of the body to any demand, whether it is caused by, or results in, pleasant or unpleasant conditions." A more contemporary and alternative view of stress maintains that the idea of stress "should be restricted to conditions where an environmental demand exceeds the natural regulatory capacity of an organism" (Koolhass, J., et al. 2011). Simply restated, in Selye's view the intensity of the stress response is positively correlated with the combined intensity of *all* current demands. Therefore, as the totality of demands increase, the magnitude of the stress response increases. In the latter view, stress is hypothesized to occur only when the demands exceed those of everyday living. Included in these demands are the biological processes necessary to sustain life.

The concept of stress differs from that of *stressor* and *challenge*. *Stressor* is the term used for the demands that cause stress. Therefore, stressors cause stress. *Challenges* are a particular type of stressor. Stressors that are perceived as challenges do not appear to produce the negative effects associated with stress. Instead, challenges are frequently experienced as re-energizing and motivating. Whether a stressor is perceived as a challenge or a difficulty is influenced by many factors. Among these are: type and intensity of the stressor, stressor appraisal, perceived capability to cope with the stressor, available support and resources, individual personality characteristics, and likely assessed outcomes. This is why a stressor that represents a challenge for one person may cause significant stress in another.

Stressor: a demand that initiates the stress response. Stressors can be psychological or physical, low to high intensity, short to long duration, vary in frequency, and originate in the environment or internally.

Fight or flight: a phrase coined by Walter B. Cannon (1871-1945) to emphasize the preparation-for-action and survival value of the physiological changes that occur upon being confronted with a stressor. The fight or flight response later became associated with the Alarm phase of the *General Adaptation Syndrome*.

General Adaptation Syndrome (GAS): (Selye, H.) the GAS is comprised of three stages: alarm, resistance, and exhaustion. *Alarm* is the body's initial response to a perceived threat and the first stage of general adaptation syndrome. During this stage, the body begins the production and release of several hormones that affect the functioning of the body and brain. During the *resistance* stage of GAS, the internal stress response continues but external symptoms of arousal disappear as the individual attempts to cope with stressful conditions. In the final stage of the GAS, *exhaustion*, the prolonged activation of the stress response depletes the body's resources, resulting in permanent physical damage or death (http://www.ehow.com/facts_6118452_general-adaptation-syndrome.html).

Homeostasis: "steady state" – an organism's coping efforts to maintain physiological, emotional, and psychological balance.

Overload stress: stress which is the result of a high intensity stressor, too many lesser intensity stressors, or a combination of both that exceeds normal coping abilities.

Deprivational stress: stress experienced due to lack of stimulation, activity, and/or interaction. An example of an environment likely to produce deprivational stress is solitary confinement. Deprivational stress is also the principle underlying the child discipline intervention know as *time out*.

Occupational stress: stress caused by job demands. Each occupation is comprised of a cluster of *unavoidable* stressors. These are demands that are inherently part of the job. For police officers, interacting with non-cooperative persons is an unavoidable stressor. If not managed appropriately, occupational stressors can result in detrimental physical, emotional, and psychological responses. *Avoidable* occupational stressors may also become problematic when present in sufficient quantity and intensity. An example of an avoidable occupational stressor is a poorly designed department policy that fails to adequately address the issue for which it was written. A poorly written policy is an avoidable stressor because it could be re-written in a way that better addresses the reason for its existence.

Stress Management – Insights into the transactional nature of stress

Epictetus: (A.D. 55 –135) (1) "Men are disturbed not by things, but by the view which they take of them." (2) "It's not what happens to you, but how you react to it that matters." Epictetus was one of the first early writers to recognize the intimate and inextricable relationship that exists between individuals and their environment.

Hans Selye: (1) "Man should not try to avoid stress any more than he would shun food, love or exercise" (2) "It's not stress that kills us, it is our reaction to it." (3) "Mental tensions, frustrations, insecurity, aimlessness are among the most damaging stressors, and psychosomatic studies have shown how often they cause migraine headache, peptic ulcers, heart attacks, hypertension, mental disease, suicide, or just hopeless unhappiness." (4) "Adopting the right attitude can convert a negative stress into a positive one." Selye is recognized by many researchers as the first person to specify the processes of biological stress. He is sometimes referred to as "father of stress research."

R.S. Lazarus (1922-2002) (1) "Stress is not a property of the person, or of the environment, but arises when there is conjunction between a particular kind of environment and a particular kind of person that leads to a threat appraisal." Lazarus maintained that the experience of stress has less to do with a person's actual situation than with how the person perceived the strength of his own resources: *the person's cognitive appraisal* and *personal assessment of coping abilities*.

Koolhaas, J., et al. "Stress revisited: A critical evaluation of the stress concept." Neuroscience and Biobehavioral Reviews 35, 1291–1301, (2011).

Signs of Excessive Stress

Impaired judgment and mental confusion
Uncharacteristic indecisiveness
Aggression – temper tantrums and "short fuse"
Continually argumentative – increased family discord
Increased irritability and anxiety
Increased apathy or denial of problems
Loss of interest in family, friends, and activities
Increased feelings of insecurity with lowered self esteem
Feelings of inadequacy

Warning Signs

1. Sudden changes in behavior, usually uncharacteristic of the person
2. Gradual change in behavior indicative of gradual deterioration
3. Erratic work habits and poor work attitude
4. Increased sick time due to minor problems and frequent colds
5. Inability to concentrate, impaired memory, or impaired reading comprehension
6. Excessive worrying and feelings of inadequacy
7. Excessive use of tobacco, alcohol, or drugs
8. Peers, family, & others begin to avoid the person because of attitude/behavior
9. Excessive complaints (negative citizen contact or family member complaints)
10. Not responsive to corrective or supportive feedback
11. Excessive accidents or injuries due to carelessness or preoccupation
12. Energy extremes: no energy or hyperactivity
13. Sexual promiscuity or sexual disinterest
14. Grandiose or paranoid behavior
15. Increased use of sick leave for "mental health days"

Excessive stress can be expressed in physical or psychological symptoms, including:

Muscle tightness/migraine or tension headache
Clenching jaws/grinding teeth or related dental problems
Chronic fatigue/feeling down or experiencing depression
Rapid heartbeat/hypertension
Indigestion/nausea/ulcers/constipation or diarrhea
Unintended weight loss or gain - changes in appetite
Abnormally cold or sweaty palms
Nervousness and increased feelings of being jittery
Insomnia or sleeping excessively – strange dreams or nightmares
In extreme cases – psychotic reactions/mental disorder

Examples –

1. From cheerful and optimistic to gloomy and pessimistic.
2. Gradually becoming slow and lethargic, increasing depression.
3. Coming to work late, leaving early, sick time abuse.
4. Rambling conversation, difficulty in sticking to a specific subject.
5. Lack of participation in normally enjoyed activities.

Stressor Related Disorders – DSM

There are several stressor-related disorders identified in the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Most police officers are familiar with *posttraumatic stress disorder* but are unaware that there are several other psychological diagnoses associated with stressors.

Do not self-diagnose. Police officers should contact an experienced licensed clinician with any questions or concerns about stressors and stressor related disorders.

Adjustment Disorder

- with depressed mood
- with anxiety
- with mixed anxiety and depressed mood
- with disturbance of conduct
- with mixed disturbance of emotions and conduct
- unspecified

Acute Stress Disorder

- symptoms present for at least 3 days but no longer than 1 month

Posttraumatic Stress Disorder

- duration of symptoms for more than 1 month
- with dissociative symptoms
- with delayed expression – symptoms appear 6+ months following the incident

Posttraumatic Stress Disorder for Children 6 years and younger

Other Specified Trauma-and Stressor-Related Disorder

- Persistent complex berevement disorder

Unspecified Trauma-and Stressor-Related Disorder

Conversion Disorder (Functional Neurological Symptom Disorder)

- psychological stress is "converted" into a physical symptom
- the symptom or deficit is not better explained by another recognized medical or DSM disorder (various subtypes)

Brief Psychotic Disorder

- duration of symptoms of at least 1 day but less than 1 month
- with or without marked stressor(s)
- with postpartum onset –onset within 4 weeks postpartum
- with catatonia

Associated Mood Disorders

- mood disorders that may co-exist with stressor related disorders

Additional DSM information can be found online at: www.psychiatry.org

Some Things to Remember

When confronting change and managing stress there are some things that you can do that can help. Most of the following suggestions are self explanatory, some are not. This is because some of them are specialized and are most often used within the parameters of a specific counseling program.

Some Things to Remember

- Watch how you talk to yourself (relationship with self)
- Relaxation breathing-*breath through stress*-inhale nose/exhale mouth
- Maintain a high level of self-care, make time for *you*
- Keep yourself physically active, not too much too soon
- Utilize positive and appropriate coping statements
- Enhance your internal (self) awareness and external awareness
- Remember the limits of your personal boundary
- Practice stimulus control and response disruption
- Monitor deprivational stress and overload stress
- Use "pocket responses" when needed/consider oblique follow-up
- Apply thought stopping/blocking to negative thoughts
- Identify and confront internal and external *false messages*
- Confront negative thinking with positive counter-thoughts
- Break stressors into manageable units; deal with one at a time
- Relax, then engage in a graded confrontation of what you fear
- A managed experience will lessen the intensity of what you fear
- Only experience changes experience, look for the positive
- Reclaim your marriage; reclaim your career; *reclaim your life*
- Stressor strategies: confrontation, withdrawal, compromise (combination)
- Match coping strategy with stressor – the strategy must address the stressor
- Remember: transactions and choice points = different outcomes
- *Work*: do not forget why you do what you do (Occupational Imperative)
- Utilize your physical and psychological buffers
- Healing involves changes in intensity, frequency, and duration
- Use your shield when appropriate (psychological shield against negativity)
- Things do not have to be perfect to be ok
- Create positive micro-environments within stressful macro-environments
- Think of strong emotion as an *ocean wave*- let it in, let it fade
- Trigger anxiety— *I know what this is; I know what to do about it*
- Goal to become *stronger and smarter* (with the above = the 2 and 2)
- *Walk* off and *talk* out your anxiety, fears, and problems (walk and talk)
- Being vulnerable does not equal being helpless
- Enhance resiliency – develop and focus your innate coping abilities
- Develop and practice relapse prevention strategies
- Develop and utilize a sense of humor, learn how to smile
- Time perspective: part, present, future (positive – negative)
- Things are never so bad that they can't get worse
- Do not forget that life often involves selecting from imperfect options
- Access your power: the power of confidence, coping, and management
- Stay grounded in what you know to be true
- Keep things in perspective: keep little things little, manage the big things

Warning Signs of Alcoholism – Information

1. Do you ever drink after telling yourself you won't?
2. Does your drinking worry your family?
3. Have you ever been told that you drink too much?
4. Do you drink alone when you feel angry or sad?
5. Have you ever felt you should cut down on your drinking?
6. Do you get headaches or have hangovers after drinking?
7. Does your drinking ever make you late for work?
8. Have you ever been arrested because of your drinking?
9. Have people annoyed you by criticizing your drinking?
10. Have you ever felt bad or guilty about your drinking?
11. Have you ever substituted drinking for a meal?
12. Have you tried to stop drinking or to drink less and failed?
13. Have you ever felt embarrassed or remorseful about your behavior due to drinking?
14. Do you drink secretly to avoid the concerns of others?
15. Do you ever forget what you did while you were drinking?
16. For women - Have you continued drinking while pregnant? (even small amounts)
17. For women - Have you continued drinking while breastfeeding? (even if only between feedings or in small amounts)
18. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
19. Have you ever had to take a drink while at work to feel better?
20. Do you feel shaky, unsettled, or sick if you do not have a drink for a few days?
21. Have you ever stockpiled alcohol to avoid anxiety about not having it available?
22. Do you hide alcohol to avoid the concerns of family or friends?
23. Do you plan activities to insure that alcohol is available?
24. Do you look for happy or sad occasions to justify drinking alcohol?
25. Has the availability and consumption of alcohol become an overriding concern?

<u>Some Information About Alcohol</u>

The earlier an individual begins drinking, the greater his or her risk of developing alcohol-related problems in the future.

Any alcohol use by underage youth is considered to be alcohol abuse.

A drink can be one 12-ounce beer, one 5-ounce glass of wine, or 1.5 ounces of 80-proof distilled liquor.

The liver is the primary site of alcohol metabolism, yet a number of the byproducts of this metabolism are toxic to the liver and may cause long term liver damage.

The short-term behavioral effects of alcohol follow the typical dose-response relationship characteristic of a drug; that is, the greater the dose, the greater the effect.

Drinkers expect to feel and behave in certain ways when drinking. Expectations about drinking can begin at an early age, even before drinking begins.

Most people who use alcohol do so without problems. However, about 17 percent of alcohol users either abuse it or are dependent on it.

Any successful physiological treatment for alcoholism must also include a psychological component.

Children of alcoholics are more likely than children of nonalcoholic parents to:

- suffer child abuse
- exhibit symptoms of depression and anxiety
- experience physical and mental health problems
- have difficulties in school
- display behavior problems
- experience higher healthcare costs

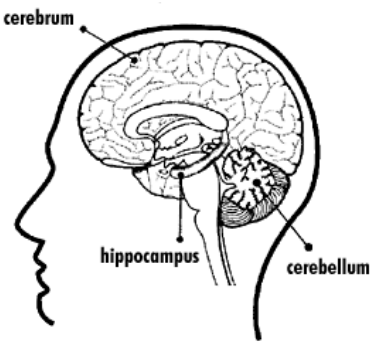
Biological (genetic) and psychosocial factors combine with environmental factors, such as the availability of alcohol, to increase the risk for developing drinking problems.

The perception of risk, risk taking, acting on impulse, and sensation-seeking behaviors are all affected by alcohol use.

Individuals who are intoxicated may misread social cues, overreact to situations, and not be able to accurately anticipate the consequences of their actions.

It has long been observed that there is an association between alcohol use and aggressive or violent behavior. Clearly, violence occurs in the absence of alcohol, and drinking alcohol alone is not sufficient to cause violence. However, numerous studies have found that alcohol is involved with about half of perpetrators of violence and their victims. This relationship holds across cultures and for various types of violence. In the United States, alcohol use is a significant factor in:

68 percent of manslaughter cases
62 percent of assault offenders
54 percent of murders
48 percent of robberies
44 percent of burglaries



Regions of the brain affected by alcohol

From: http://science.education.nih.gov/supplements/nih3/alcohol/guide/info-alcohol.htm

Police Officer Suicide Risk Factors

The first step in preventing police officer suicide is to identify risk factors. A risk factor is anything that increases the likelihood that an officer will consider suicide.

Police officer suicide risk factors:

Diagnosis of depression, anxiety, or other mood disorder.
Veiled or outright threats of suicide. Development of a suicidal plan.
Marital, money, and/or family problems.
Recent discipline or pending discipline, including possible termination.
Over-developed sense of responsibility. Responsibility absorption.
Frustration or embarrassment by some work-related event.
Internal or criminal investigations; allegations of wrongdoing; criminal charges.
Assaults on an officer's integrity, reputation, or professionalism.
Recent loss, such as divorce, relationship breakup, financial, and so on.
Little or no social support system.
Uncharacteristic dramatic mood changes. Being angry much of the time.
Increased aggression toward the public. Citizen complaints.
Feeling "down" or depressed; feeling trapped with no way out.
Feelings of hopelessness and helplessness.
Feeling anxious, unable to sleep or sleeping most of the time.
History of problems with work or family stress.
Making permanent alternative arrangements for pets or livestock.
Increased alcohol use or other substance abuse/addiction.
Family history of suicide and/or childhood maltreatment.
Uncharacteristic acting out; increased impulsive tendencies.
Diagnosis of physical illness or long-term effects of physical illness.
Recent injury which causes chronic pain; overuse of medications.
Disability that forces retirement or leaving the job.
Self-isolation: withdrawing from family, friends, and social events.
Giving away treasured items. Saying "goodbye" in unusual manner.
Easy access to firearms or other lethal means (a constant for police officers).
Unwillingness to seek help because of perceived stigma.
Sudden sense of calm while circumstances have not changed.

Police officers are encouraged to talk to a trusted person, a member of the peer support team, or a mental health professional if experiencing thoughts or feelings of suicide. Confidential help and support are available. Remember, asking for help does not necessarily mean that you are unfit for duty or that your job will be jeopardized.

Spouses and family members - If you observe officer-behaviors associated with suicide risk, *do not hesitate to bring the subject of suicide into the open*. Discuss your observations. If warranted, make a plan for appropriate intervention. If you feel that the officer is *imminently suicidal*, do not leave him or her alone. Remove access to firearms. Contact emergency services. Do this even if the officer objects. You may save a life.

National Suicide Hotline: 1-800-273-8255

Action Plan Worksheet

Step 1

The Action Plan Worksheet is designed to structure efforts for change.

What are the issues? What am I **WORRIED** about? Have I clearly identified the problem(s)?	→	IDENTIFY THE ISSUES, WORRIES, AND PROBLEMS TO BE ADDRESSED.

Steps 2-4

How am I thinking about the problem? Are my thoughts rational or irrational? Do I need help to understand the difference? Is there a better way to think about or conceptualize the problem? What are my **OPTIONS**?	→	IDENTIFY OPTIONS. RECONSIDER IRRATIONAL CONCEPTUALIZATIONS. CONSIDER: *choices*, *decisions*, AND *likely consequences*. Think of options as *opportunities* to move forward.

Step 5

What do I want to **CHANGE**?	→	DO I NEED TO CHANGE MYSELF OR MY ENVIRONMENT? MAYBE SOME OF MYSELF AND SOME OF MY ENVIRONMENT. CONSIDER: *development of coping skills*.

Step 6

SPECIFY and **PRIORITIZE** desired changes and goals.	→	MAY INVOLVE CHANGING THOUGHTS, FEELINGS, BEHAVIORS, AND ELEMENTS OF THE ENVIRONMENT.

Step 7

What are the **ROADBLOCKS**? What obstacles are in the way of change? → ANTICIPATE THE DIFFICULTIES OF POSITIVE CHANGE.

Step 8

PLAN to address or overcome the obstacles. → IT IS EASY TO THINK ABOUT OBSTACLES AS OVERWHELMING. DEVELOP A CREATIVE ACTION PLAN THAT INCLUDES OVERCOMING OBSTACLES.

Step 9

IDENTIFY how and when you will **IMPLEMENT** your action plan. → IMPLEMENT THE ACTION PLAN.

Step 10

How will I **EVALUATE** the outcome and **EXPLORE** more options after I have implemented my action plan? → EVALUATE THE OUTCOME OF THE ACTION PLAN. REVISE AS NEEDED. SPECIFY RELAPSE PREVENTION STRATEGIES.

Joanne Rupert, M.A. NCC (LCSO PST) & Jack A. Digliani

Comprehensive Model for Police Advanced Strategic Support (COMPASS)

Positive and supportive agency administrators - Positive organizational environment

Pre-hire psychological assessment independent of police staff psychologist

Agency commitment to *staff psychologist* and *peer support team* concepts

Early involvement of staff psychologist
(1) Establishes psychologist/officer relationship
(2) Breaks down "shrink" stereotype
(3) Stigma reduction for seeking help

In-service recruit academy: staff psychologist presentations -stress inoculation, critical incident protocol, preparation for FTO program, PATROL, function of peer support team, role and responsibilities staff psychologist, and other relevant topics

Psychologist and Training/Recruit Officer Liaison **(PATROL)** program:
Trainee officer meets with psychologist at least once per Field Training Officer (FTO) training phase. PATROL is independent of FTO training but coordinated with FTO program. Spouse invited. Spouse program. Training, work, and non-work issues. Confidential setting. PATROL is a preemptive psychological support program for officers-in-training and their families

Enhances psychologist/officer relationship
Continues stigma reduction for seeking help

Police staff psychologist: provides (1) psychological services for employees and their families - couples counseling (2) training and clinical supervision of the Peer Support Team (3) support for peer support team members (4) critical incident protocol development, (5) coordination with other support resources, (6) liaison with other agencies, (7) Make it Safe Initiative, (8) other services as appropriate - *Employee Assistance Programs (EAP) and insurance plan community counseling services can be beneficial but appear insufficient to provide the range of support services optimal for police officers. The staff psychologist is in a unique position to overcome the reluctance of many officers to seek professional support when needed*

Preemptive programs – programs designed to assist officers prior to the development of difficulties – includes the PATROL program, the computer crimes child pornography investigators quarterly contact support program, Proactive Annual Check-In (PAC), and the TIP program.
In-service presentations (presented periodically) – stress inoculation, health and wellness, critical incident protocol and trauma intervention program, police marriage and family issues, interacting with special populations, officer suicide prevention, interacting with suicidal persons, and other relevant topics

Retirement preparation program – (1) Practical issues (financial, etc), (2) Psychological and emotional issues (3) Departing the police role, (4) Family and other social issues

Peer Support Team (PST): comprised of officers and others trained in peer support and functioning within written policy and operational guidelines:

(1) Structured with Coordinator, Clinical Advisor, or Clinical Supervisor
(2) Clinical supervision and "ladder of escalation" (referral, advisement, and immediate supervision when needed)
(3) Monthly in-service training and group supervision
(4) Integral part of staff psychologist pre-emptive and intervention programs
(5) *Major concepts* – interest, commitment, credibility, supervision, confidentiality, limitations of peer support, remaining within the boundaries of PST training, referral, special programs, and reach out

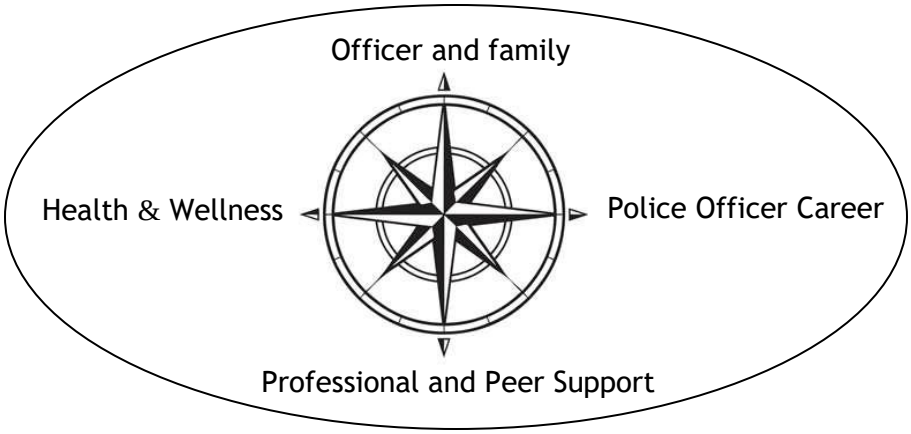
Spouse and family programs**:** specialized programs involving the PST and staff psychologist designed to support the spouse and family members of police officers

Peer Support Team Brochure
Peer Support Team Newsletter
PST shift briefing programs
PST debriefings - interventions
PST poster information

Police staff psychologist and peer support team members: the staff psychologist and uninvolved members of the peer support team are made available to officers involved in *supervisory inquiries* and *internal investigations* – this information is specified within the officer-advisement investigative documents

Transitional adjustment support: when officers retire, resign, or are terminated they are eligible for three visits with the staff psychologist beyond their employment

Retiree programs: programs for officers that retire from the department in good standing that offer volunteer opportunities, occasional or periodic social activities, and other meaningful continued involvement with the agency - recognition for years of service to the department and community



COMPASS: *Helping police officers to find their way.*

Officer Notes

About the Author

Jack A. Digliani, PhD, EdD is a licensed psychologist and a former deputy sheriff, police officer, and detective. He served as a law enforcement officer for the Laramie County, Wyoming Sheriff's Office, the Cheyenne, Wyoming Police Department, and the Fort Collins, Colorado Police Services (FCPS). He was the FCPS Director of Human Services and police psychologist for the last 11 years of his FCPS police career. While in this position he provided psychological services to employees and their family, and clinically supervised the FCPS Peer Support Team. He has received several commendations from various law enforcement agencies for his work in police psychology.

Dr. Digliani also served as the police psychologist for the Loveland Police Department and Larimer County Sheriff's Office (Colorado). During his service he provided psychological counseling services to department members and their families. He was also the clinical supervisor of the agencies' Peer Support Teams. He has worked with numerous municipal, county, state, and federal law enforcement agencies. He specializes in police and trauma psychology, group interventions, and the development of police, fire, and other first-responder peer support teams.

Dr. Digliani is the author of *Contemporary Issues in Police Psychology*, *Reflections of a Police Psychologist*, *Law Enforcement Peer Support Team Manual*, *Firefighter Peer Support Team Manual*, *Law Enforcement Critical Incident Handbook,* and *Law Enforcement Marriage and Relationship Guidebook*. He is a contributor-writer of Colorado Revised Statute (CRS) 13-90-107(m) *Who may not testify without consent*, the statute and paragraph which grants law enforcement, firefighter, and medical/rescue peer support team members specified confidentiality protection during peer support interactions. He is also the principal author of the peer support section of the *Critical Incident Protocol* of the Eighth Judicial District of Colorado. Portions of his Trauma Intervention Program have been incorporated into CRS 16-2.5-403, *Peace officer-involved shooting or fatal use of force policy* (2019).

In 1990, he created the *Psychologist And Training/Recruit Officer Liaison* (PATROL) program, a program designed to support police officer recruits and their families during academy and field training.

Dr. Digliani developed the Freezeframe method of critical incident debriefing. He also advanced the conceptualizations of Option funnel versus Threat funnel, Level I and Level II peer support, Life-by-Design, the 2-and-2, and the *Comprehensive Model for Police Advanced Strategic Support* (COMPASS). COMPASS is a career-long psychological health and wellness strategy for police officers.

In 2013, Dr. Digliani developed the conceptions of primary and secondary danger. He then created the Make it Safe Police Officer Initiative, a 12-element strategy designed to reduce the secondary danger of policing. In 2015, Dr. Digliani crafted the *Peer Support Team Code of Ethical Conduct*. He created the *Peer Support Team Utilization and Outcome Survey* in 2017, a survey specifically designed to assess the use and efficacy of agency peer support.

Law Enforcement

Critical Incident Handbook