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Training Police Leadership to Recognize and Address Operational Stress

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A community-based agency developed training for Cleveland Police Department Lieutenants and Supervisory Sergeants. This training adapted current methods used by the U.S. Army to deal with military combat stress. Police leaders were trained to recognize signs of operational stress in their line officers and provide "Leader Actions" to minimize long-term sequelae of operational stress, such as posttraumatic stress disorder, absenteeism, resignation, and misconduct. Laminated pocket cards were provided which summarized warning signs of operational stress, self-care and partner-care actions, and leader strategies to treat early signs of operational stress. Based on focus groups with police supervisors, an incentive system was developed and implemented to reward officers seeking help or assisting other officers in managing operational stress, which could change the culture of keeping silent about problems and remove the stigma attached to help seeking. Eighty-three police supervisors have been trained, with plans to provide further training to district (precinct) commanders.

Keywords: *traumatic stress; operational stress; police training; police supervision*

Introduction

Police chiefs, precinct commanders, and all levels of police supervisors are challenged daily to support officers exposed to the traumatic stressors that are part of

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police work. Although exposure to shootings and violent apprehensions are obvious sources of traumatic exposure, other types of police activities take a toll as well. Approaching a home where domestic violence has been reported, securing a violent crime scene with homicide or suicide victims, traffic stops on vehicles with multiple warrants, and dealing with the carnage of motor vehicle accidents are examples of police activities that may not expose an officer to harm, but they can be highly stressful. Even dispatchers removed from the scene of a crime and safe from harm report stress when dealing with callers experiencing life-threatening events. The top five stressors in police work are reported to be (a) killing someone in the line of duty, (b) a fellow officer getting killed, (c) being physically attacked, (d) working with a battered child, and (e) high-speed chases (Violanti & Aron, 1994).

Supervisors know that many officers will experience reactions to traumatic exposure. Common reactions immediately after traumatic exposure include loss of sleep, emotional distancing from friends and family, hypervigilance, and numbing. In most officers, these reactions are transient and resolve with support and conversation. When the reaction is severe enough to impair occupational or social functioning, the reaction is called "acute stress disorder." If the reaction does not resolve within a matter of months, the officer may be experiencing posttraumatic stress symptoms, posttraumatic stress disorder (PTSD), or may be affected physically by the amount of traumatic exposures he or she has experienced.

Exposures to life-threatening or disturbingly graphic events are recognized as obvious sources of stress. However, research on police stressors also documents the effects of administrative and bureaucratic sources of stress, as well as the stress from conflicts between professional life and family life (Bradstreet, 1994; Toch, 2002). These stressors can sometimes have greater overall effects on police personnel, by their constant presence eroding morale and resilience, than low-frequency, high-intensity traumatic exposures. Brown and Campbell (1994) cite routine police duties, work overload, poor communication and inadequate support from management, and organizational policies as significant stressors that add to the cumulative stress levels of police officers. They also recognize additional stressors encountered by minority status within a mostly male, White workforce—specifically, women, ethnic minorities, and gay/lesbian police personnel. Other policy and administrative stressors that have been documented include shift work, incompatible partners, insufficient personnel, lack of recognition, excessive paperwork, and negative public image (Violanti & Aron, 1994). Although these stressors by themselves may not be overwhelming, they lurk as a constant presence in the background and can increase an officer's vulnerability to the cumulative effects of stress when a single intense traumatic exposure occurs. Although good health, physical fitness, adequate sleep, and a positive sense of purpose and mission build resilience to stress, the traumatic stress literature recognizes that every person, no matter how strong or resilient, has a finite ability to resist the cumulative effects of stressors (Flannery & Everly, 2000; Headquarters, Department of the Army [HQDA], 2003).

Administrative and bureaucratic sources of stress require systematic changes, such as shift to community policing or revision of bargaining agreements to change working conditions, public image, and expectations. Police leaders and administrators can do something positive and proactive to deal with the operational stresses resulting from traumatic exposure, which is the focus of the training this manuscript describes. Police leaders need tools to recognize the different levels of stress their officers are experiencing and actions they can take to support their officers and minimize long-term effects of operational stress, including absenteeism, early resignation/retirement, depression, substance abuse, and even suicide (Loo, 2003; Violanti, 1995).

Since the Civil War, the U.S. Army has recognized that exposure to combat has stressful effects above and beyond physical injuries and disease. Whether the terms used are "melancholia" (civil war), "shell shock" (World War I), "battle fatigue" (World War II), "combat stress" (Vietnam and after), or the current term "Combat/Operational Stress," the U.S. Army recognized the traumatic effects of combat. The Army has been instrumental in developing, refining, and fielding intervention methodologies and specially trained teams that assess units and individuals, provide training for soldiers and leaders, and set up field stations to treat combat stress. These methods were battle tested during wartime in Operation Desert Storm (Campbell & Engel, 1996) and during police actions in Bosnia and Kosovo. The terrorist attacks of September 11, and studies on the psychological effects of those events, as well as the evaluation of interventions provided to victims and first-responders, have led to significant revisions in both civilian and military doctrine (National Institute of Mental Health [NIMH], 2002). An extensive review of research on the effectiveness of traumatic stress interventions was carried out by a joint working group staffed by the American Red Cross and the departments of Defense, Justice, Veterans Affairs, and Health and Human Services. As a result of this working group's review, evidence-based practice guidelines were published (NIMH, 2002). These guidelines were incorporated into the doctrine currently in use for Operations "Enduring Freedom" in Afghanistan and "Iraqi Freedom."

Although police work may not generate the same intensity of stress as military combat, the cumulative effects of numerous traumatic exposures layered on top of the routine bureaucratic and administrative stressors can have powerful effects on police officers. In our work with the Cleveland Police Department, we used the term "operational stress" to describe a similar dynamic to the "combat stress" experienced by soldiers in battle. Furthermore, with many recent military operations focusing on peacekeeping or policing missions, military doctrine has expanded the description of this type of exposure, calling the phenomenon "Combat/Operational Stress" and both the U.S. and Canadian militaries use the terms interchangeably (HQDA, 2003). Many urban police forces now use military weapons and tactics in their SWAT teams, and the similarities between police work and military experiences have begun to overlap even more closely. Williams (1987) described police work as "Peacetime Combat" and advocated early use of PTSD interventions developed for use with combat veterans.

In this project, the Partnership for a Safer Cleveland sought to incorporate principles of combat/operational stress training currently used by the U.S. Army into training for police supervisory personnel on recognizing and dealing with operational stress. This article will describe how this training was developed and implemented by experienced police trainers and members of the U.S. Army skilled in combat stress training.

Literature Review

The normal day-to-day events that police officers are forced to confront provide a potentially stress-laden environment that they must negotiate. Police officers' reactions to these events have the potential for negative emotional, psychological, and physical sequelae, if unattended. For example, Ryan and Brewster (1994) describe an Amsterdam study in which 37 police officers were engaged in a shooting incident. Of the 37, three remained symptom free, 17 reported signs of PTSD, whereas the remaining 17 were diagnosed with PTSD. Blak (1990), in a study of the effects of stress on individuals, found that although only between 4% and 10% of people exposed to a traumatic incident develop PTSD, 90% of those exposed will develop some emotional, physical, or psychological reaction to the event. These are called "sub-threshold" events, in that they do not reach the number or intensity of symptoms or result in significant impairment of occupational or social functioning necessary to reach the threshold of being diagnosed as a person with traumatic stress disorder (acute or post; Department of Veterans Affairs & Department of Defense [VA/DoD], 2004). In a study of police officers involved in a shooting, it was found that in the week following the shooting, 77% of respondents reported sleeping difficulties, 55% reported increased anxiety, 50% reported flashbacks, 35% reported nightmares, and 69% reported feeling tense. A full 3 months later, 65% reported continued flashbacks, nervousness, and tension, whereas only 35% reported no PTSD symptoms at all (Gund & Elliott, 1995).

Although there are many definitions of stress in the literature (Kolbell, 1995; Kureczka, 1996; Patterson, 1992), police stress has been defined as an imbalance between what is required of an officer and what the officer is capable of giving, under conditions where failure may have dire consequences (Patterson, 1992). A stressor can be both positive and/or negative, and a person's reaction to a stressor is highly individualized and dependent on the meaning that he or she attributes to an incident (Alexander, 1994a). How an officer constructs his or her interpretation of the incident will determine how severe his or her reaction will be (Everly, 1994).

Research on stress and coping has shown that individuals develop patterned ways of coping with stress in their daily lives (McCubbin, Thompson, & McCubbin, 1996). The same ways of coping may at times be adaptive or at other times maladaptive. For example, denial as a coping method may be adaptive at some times but not at others. Rather than viewing coping as a fixed or rigid "style" or personality trait, the

appraisal and coping process is seen as a continuing feedback loop. Specifically, factors that mediate one's appraisal of a stressful event may be unique to each individual (Folkman & Lazarus, 1980). Fuller (1990) divided police stressors into four categories:

1. Stressors because of the nature of police work.
2. Stressors resulting from departmental policies.
3. Stressors dealing with the criminal justice system and societal expectations about police conduct.
4. Stressors resulting from psychological issues unique to each officer.

As might be expected, officers use a variety of coping methods, some positive and some less adaptive, to deal with police stresses (Hart, Wearing, & Heady, 1994). Positive examples include talking with coworkers, obtaining counseling, and exercising (Reese, 1987). Less adaptive behaviors include alcohol abuse, withdrawing from friends and family, and suicide (Beijen, 1995; Dietrich & Smith, 1986; Richmond, Wodak, Kehoe, & Heather, 1998; Seligmann, 1994; Violanti, Marshall, & Howe, 1985). Officers who feel they can control their situation and environment are better able to handle stress (McCafferty, McCafferty, & McCafferty, 1992). However, the nature of critical incidents often makes it unlikely for an officer to have that control (Mitchell & Everly, 1996). Repeated exposure to direct trauma or vicarious trauma puts an officer at risk for developing PTSD (Fullerton, McCarroll, Ursano, & Wright, 1992). Furthermore, officers' perceptions that the police department supervisory chain or policies are not supportive can add greater stress in an environment that has the capacity to be supportive and therapeutic (Violanti & Aron, 1994; Zhao, He, & Lovrich, 2002). In a similar context, a police officer's family can either be a source of comfort, resilience, and healing after a traumatic event or an additional source of stress if there are marital or family problems (Alexander, 1994b).

Although it is not clearly understood why some people develop PTSD and others do not (Braverman, 1992), PTSD has been recognized as a unique disorder in the *Diagnostic and Statistical Manuals of Mental Disorders* since 1980 (American Psychiatric Association, 1980, 1987, 1994). Officers are at risk for PTSD not only through direct experience of a critical incident but also as first-responders to victims of critical incidents through vicarious exposure to trauma (e.g., motor vehicle accident scene) (Wollman, 1993). Recent research on traumatic exposure in both combat (Hoge et al., 2004) and natural disasters (U.S. Department of Health and Human Services, 2005) documents progressive reactions to traumatic events: from combat (or operational) stress that occurs during the event to acute stress disorder that occurs 2 to 4 days after exposure to acute PTSD that occurs between 1 and 3 months after the event to chronic PTSD that is identified 3 months or longer after the event.

Interventions at the time of trauma exposure are more likely to be performed by nonclinical peers or supervisory personnel who are first-responders (National Child

Traumatic Stress Network & National Center for PTSD, 2005), and the recommended actions during the immediacy of the event are quite different from the actions for chronic PTSD identified later (VA/DoD, 2004). An important concept is that the progression through these trauma reactions is not inevitable (Figley, 1986). Early interventions in the form of "Psychological First Aid" (National Child Traumatic Stress Network & National Center for PTSD, 2005) have been shown to limit the effects of traumatic exposure and prevent progression to later and more debilitating traumatic stress disorders (U.S. Department of Health and Human Services, 2005).

Past studies on police officers have shown that the longer the help delayed, the more extreme the reaction. For example, Fuller (1990) reported that those officers receiving prompt intervention for exposure to trauma returned to duty on average 2 weeks after the trauma, compared to an average of 46 weeks for those whose postevent stress intervention was delayed.

The San Jose Police Department has demonstrated the effectiveness of their Critical Incident Stress Debriefing (CISD) Team. Between 1972 and 1987, a period when they did not have a CISD team, 52 officers were involved in shootings, and 17 of those officers subsequently left the department. Since the inception of their CISD team, 122 officers have been involved in shootings, and none of these officers has left the department (Benner, 1994). Their contention was that the presence of the CISD team was a causal factor in retaining the officers involved in shootings, although not clearly proven because of the inability to control for all other possible influences, such as community attitudes, training, or changes in postshooting procedures.

Another study compared the outcome of two aircraft disasters: the 1978 San Diego and the 1986 Cerritos airplane crashes. These disasters were similar in having the same numbers of victims, homes destroyed, and civilians killed on the ground. In San Diego, mental health professionals provided individual counseling, whereas in Cerritos, 12 critical incident stress debriefings were conducted with follow-up care. In San Diego, five officers, seven firefighters, and 15 paramedics resigned within one year of the accident. There was also a 31% increase in mental health services utilization by employees. In contrast, Cerritos did not lose firefighters or police officers but one paramedic, and the employees experienced only a 1% increase in the use of mental health services (Everly & Mitchell, 1997). As with the aforementioned study in San Jose, this study established association but not causality, although one of the authors (Mitchell) has a well-established training program teaching his model of traumatic stress intervention. Unfortunately, some elements of the Mitchell model have been shown to be harmful when applied in a mandatory debriefing format (NIMH, 2002).

Studies with U.S. Forces engaged in peacekeeping missions in the Balkans have shown that critical incident stress management (CISM) techniques have been effective in limiting the incidence of PTSD in soldiers witnessing the results of ethnic cleansing (Castro, Bienvenu, Hufmann, & Adler, 2000). This type of military mission

has many parallels with police work, such as highly restrictive rules of engagement for weapons use (defensive only), creation of a visible presence to deter hostilities (which makes an exposed soldier or police officer more vulnerable), and interventions after hostile acts that expose both military and civilian personnel to gruesome sights. All military units deployed on wartime or peacekeeping missions have organic combat (or peacekeeping) stress control units. The stress control teams organic to the military unit are supplemented by combat stress control teams provided by higher level units within a theater of operations. The military doctrine that describes the organization, training, and activities of these combat stress control units is set forth in Field Manual 8-51 "Combat and Operational Stress Control: Tactics, Techniques, and Procedures" (HQDA, 2003).

The most recent military research pertaining to mental health impact of combat operations in Iraq (Hoge et al., 2004) shows that 17.1% of Army soldiers returned from duty with measurable psychiatric symptoms, including depression, anxiety, and PTSD. Of greater concern is that less than half seek help for these symptoms, and those who reported the highest level of symptoms are twice as likely to perceive stigma in receiving mental health services and to distrust mental health providers. These findings dovetail closely with the results of our focus groups within the Cleveland Police Department: perceived stigma in utilizing the employee assistance unit, lack of trust in the providers, and a belief that accessing any type of mental health care shows them to be weak or crazy and a threat to their remaining on duty as police officers.

The findings in these studies accentuate the importance of the supervisor's role in monitoring the levels of stress within a combat or police unit and being aware of emerging stress reactions that accelerate beyond "normal" responses to stress. Furthermore, there are simple, basic stress-management techniques that Army stress control units regularly teach commanders and supervisory sergeants (HQDA, 2003; National Child Traumatic Stress Network & National Center for PTSD, 2005). These "Leader Actions" are used for assessing soldiers' levels of stress and providing early nonclinical interventions that may help contain operational stress reactions at the work site, allow officers to recover quickly from a critical incident, facilitate early return to duty, avoid the perceived stigma of mental health utilization, and build a command climate, wherein help seeking within the chain of command is perceived as helpful and not career threatening. These tried-and-proven leader interventions are what our team focused on training within the Cleveland Police Department.

Description of Training

This training was conducted within the context of a 10-year mutually beneficial relationship between the Cleveland Police Department (CPD) and the Partnership for a Safer Cleveland (PSC). The PSC has sponsored previous training sessions for police officers on youth-focused policing, countering gang membership with young

ladies' and gentlemen's clubs, and public awareness campaigns to reduce gun-related crimes, drug-related commerce, and gang-related graffiti. The training development team consisted of the following: the PSC executive director (Walker), a faculty member at Case Western Reserve University who had done extensive training with the CPD (Singer); an active duty U.S. Army social work officer with extensive research and clinical experience in combat-related PTSD (Chapin); and one retired Army social work officer with extensive operational experience in providing combat stress interventions and training (Brannen). Both military members had been mental health responders to the September 11 terrorist attacks, one in New York City and the other at the Pentagon.

The development team conducted focus groups with the chief of police and senior commanders, personnel and training directors, and supervisory sergeants and lieutenants to assess current issues and needs within the department. Accordingly, the training was structured to be one on-duty voluntary session of no more than 30 supervisors, offered as an elective in completing required hours of annual human relations training. We implemented the training as a 3-hr seminar held off-site at a local university. Trainers included the two U.S. Army social work officers. The active Army trainer participated in his official capacity with his department's permission, because the development team believed that one trainer in military uniform would help establish credibility and reinforce the military relevance of the training materials.

Topics included an overview of the physical, emotional, and social effects of stress and basic stress management strategies. This was followed by a description of operational stress and its similarity to military combat stress. Next came a discussion on how police supervisors could recognize operational stress experienced by the officers in their unit, including the importance of frontline efforts with officers caring for their patrol partners, which in the military is called "buddy care." Finally, the trainers shared tools for assessing operational stress signs in their line officers and "Leader Actions" to provide early intervention to officers experiencing high levels of operational stress. The training team developed two pocket tri-fold cards that summarized the assessment and leader action tools provided. One card summarized the self-care/partner-care actions for stress management and the second card focused on leader actions for operational stress. The cards were laminated and sized so that they would fit into the standard CPD uniform chest pocket. Excerpts from these cards are reproduced in Tables 1 and 2.

Finally, the trainers provided a specific tool for rewarding officers who take positive action to reduce or manage their own stress, help a coworker or partner during a difficult time, or challenge the social climate wherein help seeking is stigmatized. One topic that received much attention in the focus group discussions was the department-wide climate that discouraged help seeking, assigning stigma to those who sought help from in-house employee assistance programs (EAPs). Officers experiencing symptoms of operational stress would postpone help seeking until job-related problems forced a supervisory referral or forced disciplinary action in addition to therapeutic referral. Related to this issue was further discussion in focus

Table 1
Operational Stress and Fatigue: Self-Care/Partner-Care

What to Do About Operational Fatigue for Yourself and Your Partner

- Make yourself look calm and in control
- Focus on the immediate operation
- Expect to continue duties; focus on a well-learned task or drill, follow standard operating procedures
- Think of yourself succeeding; talk about it
- Take a deep breath, shrug shoulders to reduce tension
- Remember that operational fatigue is normal and others have it too—helps to joke about it
- Stay in touch with your partner and the rest of your unit/platoon
- Get the facts: Do not jump to conclusions or believe rumors
- If operational stress fatigue signs do not begin to get better with good rest, tell someone you trust

Protect Yourself and Your Partner(s) From Operational Fatigue

- Welcome new members onto your team or shift and get to know them quickly. If you are new, be active making friends.
- Be physically fit: Maintain endurance, strength, and agility
- Know and practice life-saving first aid, CPR, and EMT skills
- Practice rapid relaxation skills:
  - Three deep slow breaths over one min
  - Tighten fist and forearms for 15 s, release
- Help each other out when things are tough at home or in the district
- Be informed: Ask your leaders questions, ignore rumors
- Work together to give everyone enough food, water, shelter, and hygiene and sanitation
- Get 6 to 9 hr sleep per day

groups about the lack of positive incentives or reward authority at the first-line supervisory level, which was also an item rated as significantly stressful (48 on a scale of 0-100 by police officers in Violanti's & Aron's 1994 study). The development team discussed the Army's use of "Commander's Coins" to provide immediate positive reinforcement for a job well done, especially for smaller actions that would not justify an award citation, requiring a lengthy approval process through command channels. We then developed the concept of a "dog-tag," which would be given as a symbol of a supervisor's recognition to an officer who obtained help for a stress issue, or to a police partner who helped an officer deal with a stressful situation. These dog-tags are heavy gauge bronze, with the CPD shield and "Proud to Serve" motto on one side. On the other side is "CPD," spelled out in chain-link letters. Above is engraved, "One For All" and below, "Strengthening the Chain." These mottos reinforce training points from the class: that all police officers are placed in harm's way and that the social support network within the department can be strengthened when each officer manages his or her own stress and helps out a partner or coworker who is experiencing overwhelming levels of operational stress. The chain attached to the dog-tag is a 4-pound breakaway chain to minimize chances of injury during an operation. A photo of both sides of the dog-tag is included in Figure 1.

Table 2
Leader Actions for Operational Stress:
For Common and Warning Operational Fatigue

- Set example of being in control while feeling normal fear
- Remind everyone that operational fatigue is normal—others (even you!) have it, too
- Know your job well; keep unit/platoon focused on mission: Get everyone to think and talk about succeeding
- Stay in touch with unit/platoon members, supervisor, and other unit/platoon leaders
- Keep everyone informed:
  - Explain situation and objectives
  - Do not hide unpleasant possibilities but put them in perspective of how the officer will handle them
  - Tell the officers what is expected but prepare them also for the unexpected
  - Explain reversals and delays positively
  - Control rumors; get the true facts from your own supervisor
  - Allow officers to vent fears and feelings
- Rotate officers' jobs when you can (may need to cross-train)
- Assign easy tasks to officers showing signs of operational fatigue
- Assure best possible medical aid and rapid evacuation of injured and wounded officers
- Show appropriate respect and honor for officers who have died
- Arrange for adequate sleep: 6 to 10 hr ideal, but at least 4 hr
- Debrief unit/platoon after difficult operation to
  - Have everyone tell what they saw and did
  - Reconstruct and agree on what really happened
  - Resolve any misunderstandings and mistrust
  - Let feelings be expressed and accepted as normal
  - Focus positively on lessons learned
- Get officers with off-duty problems to talk them out; watch reactions after phone calls, and give emotional support

Each participant in the training was personally awarded one dog-tag for his or her commitment to being a caring supervisor (by electing to participate in the training). Then each participant was given five more dog-tags to award at their discretion to officers they wish to recognize for going out of their way to help someone or to seek early assistance in dealing with a problem or stress issue. Furthermore, the PSC has set aside funds to purchase more dog-tags for supervisors to distribute when initial supplies are fully utilized.

A significant limitation of this project and its documentation was that no formal quantitative evaluation instruments were used to measure the effectiveness of training or outcomes. The project was originally designed to be presented once as a pilot for acceptability among first-line supervisors. Qualitative after-action feedback to the chief of police has been unanimously favorable, and a number of the dog-tags have been awarded by participating supervisors to their officers. The team was invited back to train the EMS/police/fire dispatch supervisors and another group of

Figure 1
Dog-tags

police supervisory sergeants and lieutenants. Plans are progressing to train all 10 district (precinct) commanders. The training team continues to integrate evolving combat stress doctrine growing from Operations Enduring Freedom and Iraqi Freedom, "Battle-Mind Training," emerging effectiveness research on psychological first aid to prevent PTSD, and mind–body medicine techniques for stress management (Gordon, Staples, Blyta, & Bytyqi, 2004). There are further plans to include formal quantitative evaluation tools, develop additional training materials, and widen the scope of training to include other police departments.

Conclusion

This training was conducted in an effort to provide police supervisors the same tools that the U.S. Army uses to recognize signs of operational stress in its personnel and to act decisively to minimize the impact of traumatic exposures and ongoing operational stresses. The training was implemented at a time of department-wide stress over municipal budget crises, reduction in the police department's budget, layoffs, and reassignment of many officers to accommodate the service gaps in the aftermath of layoffs. Other police chiefs and supervisors can implement this type of training even in smaller- and medium-sized police departments.

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