Post Traumatic Stress Disorder in Public Safety

Stephen McInchak

Siena Heights University

Human Resource Management

MGT-360

Professor Stephen Ball

February 24, 2015

Post Traumatic Stress Disorder in Public Safety

What is Post-traumatic stress disorder which is also known as PTSD? The Mayo Clinic gives this definition: “Post-traumatic stress disorder (PTSD) is a mental health condition that's triggered by a terrifying event — either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event ("Definition of PTSD," n.d.). Since the events of September 11, 2001, municipalities have started to pay closer attention to the stresses that are associated with being a policeman or fireman (Mental Health Business Week, 2012). Critical incidents in both fields have affects on all the parties involved. The signs and symptoms may occur right away and sometimes they are delayed. There are officers/firemen that are barely affected by critical incidents. Some are treated and return to full duty, some are affected in such a way that they can never work in the field again (Andrews, Philpott, & Stewart, 2007).

I had an opportunity to take a different approach to this assignment. I interviewed four police officers that were involved in critical incidents. We specifically talked about how the police chiefs and city administration handled their treatment with the incidents that they were involved in. I will not refer to any of them by name or agency. All of the persons that spoke to gave me permission to relay their stories for this assignment.

**Officer 1:**

Officer 1 was involved in an officer involved shooting (OIS) that was classified as a “suicide by cop”. This is where a person wants to commit suicide and does not take the action(s) themselves to do it. They take an action(s) that puts police officers in a position where they have to use deadly force to resolve the situation. This “suicide by cop” trend is a popular way for people to take their own life at the hands of an officer. The decedent’s family then can collect on a life insurance policy in a “suicide by cop” case. There is tremendous stress and pressure on the officer that ultimately takes the person’s life in these types of incidents.

Officer 1 responded to a call for assistance in a neighboring jurisdiction. The call was dispatched as “a woman with a gun and a knife and is threatening to kill herself of any officer that tries to stop her”. There were six to seven officers on scene from that city and surrounding communities. Officer 1 was one of the five to six back up officers on scene. Officer 1 is a veteran with over 20 plus years of police experience and serves on the regional Special Weapons and Tactics (SWAT) Team. Officer 1 has been in numerous critical incidents over his career and OIS.

Officer 1 responded to the home where the woman had the gun and knife. Officer used his years of training and experience in an attempt to negotiate a peaceful resolution with the woman. The woman came out from a wooded area where she had been laying down and screaming that she just wanted to die. She walked out towards Officer 1and another officer and pointed a shotgun at them both. Officer 1 fired one round, striking the female and she fell to the ground. She later died from her wounds at the local hospital.

The chief of police at Officer 1’s department handled the situation very good. The chief did not ask the officer any questions about the incident. He knew from his own experience that Officer 1 would wait for his union representative and attorney present before making any statements. Officer 1 completed his report and was put on administrative leave immediately. The chief of police at Officer1’s department immediately called the department’s psychologist (he was also the SWAT Teams’ psychologist). Officer 1 went to see the psychologist later that day and do a Critical Incident Debrief. Police psychologists and psychiatrists suggest a debrief is done in the first 24-48 hours after the incident.

Officer 1 was off work for approximately three weeks. He went to see the psychologist one more time before returning to full duty without any issues. The police chief maintained contact with Officer 1 while he was off on leave. He interviewed Officer 1 before he came back to work to make sure there were no issues from the incident. There was very little media coverage of the incident, the local paper ran a couple of stories on the incident and the officer was never named in the paper. The prosecutor’s office cleared Officer 1 of any wrongdoing and closed the case with his actions being “justifiable”.

**Officer 2:**

 Officer 2 was dispatched to a house fire. After the fired department extinguished the fire, the police department received information the house was set on fire to cover a possible homicide. The victim was believed to be in a second story bedroom. Officer 2 was married with two younger girls at home. Officer 2 entered into the home after the fire and went to the second floor. As he walked down the hall towards the bedroom where the alleged victim was; Officer 2 passed a bedroom on the way to the victim’s bedroom. This bedroom was where the victim’s two daughters lived. The victim’s two daughters were very close in age to Officer 2’s daughters. The victim’s daughters were not a home when the fire occurred. The police located their father deceased.

 Officer 2 thought nothing of this incident when it occurred. As the days, weeks and months passed after the incident, Officer 2 began to start having flashbacks and walking past the little girls’ bedroom. Finding the deceased father in the house did not bother Officer 2. He started to be overcome by thoughts that he was actually passing by his own daughters’ rooms and something bad was now going to happen to them. Officer 2 began to have nightmares and was not able to sleep at night. Officer 2 was overcome by this anxiety and these thoughts not only at night when he tried to sleep, but during the day when he was at work.

 Officer 2 went to his sergeant and lieutenant and explained the problems he was having at home and away from work. Unfortunately the sergeant heard Officer 2’s pleas for help, but the lieutenant did not. The lieutenant would not pass the information to the deputy police chief or the police chief. Officer 2 started to have physical ailments (shakes and tremors) that prevented him from working. He was not sleeping at all during the night, so he called in to ask for duty related time off under the workman’s compensation laws. The lieutenant denied this request and told Officer 2 that he had to “toughen up” and if he couldn’t, he would have to use his own sick time if he could not come into work. This volatile situation between Officer 2 and his lieutenant became worse. The weeks turned into months and the months turned into over a year that Officer 2 was asking for help. The department and city did not officer assistance.

 After a year, Officer 2 was finally able to speak to the deputy chief and police chief and explain to them the problems that he was having. The police chief finally referred Officer 2 to someone in the Human Resources (HR) office and he was sent to a medical doctor and then a psychologist. At first, Officer 2 lost 40 pounds and then gained 40 pounds, plus another 40 pounds while he was being treated for his involvement in this critical incident. Officer 2 was eventually moved out of the uniform patrol division to the detective bureau. He started to make improvements and small steps towards his anxiety going away.

 Officer 2 was suffered through PTSD related symptoms for approximately four years. He was on numerous kinds of medication and went through many hours of therapy to help him through the lingering effects of the stress this incident caused him. Officer 2 saw two more psychologists and two different psychiatrists during his treatment. It was determined by Officer 2’s psychologist and the city’s psychologist that Officer 2 needed to be medically retired from PTSD. Officer 2 is now retired with a duty disability retirement and will never work as a police officer again.

**Officer 3:**

 Officer 3 was involved in a police officer’s worst nightmare. He and his partner responded to a domestic related call early one morning towards the end of their shift. Domestic related calls are typically family disagreements or fights between the parties. In this call, dispatch advised that the ex-boyfriend returned to the caller’s home and she wanted him to leave. Officer 3 and his partner were talking to the ex-boyfriend near the sidewalk. Officer 3 walked away a few feet towards the caller’s home and heard gunshots. He turned to see the ex-boyfriend shooting his partner and when the partner fell to the ground, the ex-boyfriend shot Officer 3’s partner execution style in the head. Officer 3 saw his partner murdered in cold blood. Officer 3 started firing at the suspect as he fled on foot. There was running gun battle that ensued between Officer 3 and the suspect. Officer 3 shot at the suspect numerous times, striking him five times. The suspect did not go down at first even though he was shot five times.

 Officer 3 radioed for backup and fire-rescue to treat his partner. Officer 3 went around by a parked vehicle and found the suspect on the ground. Officer 3’s partner was shot multiple times; he was transported to a hospital where he succumbed to his wounds. The suspect was also transported to the hospital where he was treated for multiple gunshot wounds. The suspect was later tried and found guilty the partner’s murder and he is serving a life sentence in prison.

 Officer 3 and the responding paramedics were offered assistance by the city. The assistance that the department offered was very minimal. The city contacted a group counseling center and not doctors or professionals that specifically dealt with in the line of duty deaths. Officer 3 was troubled by flashbacks, nightmares, second guessing himself and his partner’s actions of that night. He suffered from anxiety and numerous physical and emotional problems over the next months. Officer 3 told me that not only was it traumatic to lose his partner that night and see him executed, but he could not believe that he shot the suspect numerous times and at first he did not go down, then secondly once he did go down, he did not die from his wounds.

 Officer 3 and the paramedics on scene that treated his partner eventually went and sought their own professional assistance from a police psychologist that specialized in this type of incident and the psychological treatment of the survivors of similar incidents. They are all still working in their capacities.

**Officer 4:**

 Officer 4 was a twelve year veteran of his police department and had recently been promoted to Sergeant. He was a second generation police officer, a second generation SWAT officer and a second generation SWAT team sniper.

 Officer 4 responded to a SWAT operation where an active shooter had shot at a handyman in a trailer park complex. The responding officers had the shooter contained to his trailer, but he was still actively shooting inside the trailer and outside at other occupants of the park. The SWAT team was deployed in the trailer park. Officer 4 was in position across the street from where the shooter was barricaded in the trailer. The SWAT team attempted to bring a Crisis Negotiator close to the home in an armored vehicle. The negotiator tried to make contact with the shooter via the public address system on the armored vehicle. The shooter was standing in a window in his trailer and fired a shot at the SWAT armored vehicle. The suspect then pointed his gun across the street where a uniformed officer and Officer 4 were inside a trailer. Fearing for his own life, the life of fellow officers and the citizens still in surrounding trailers, Officer 4 fired a single round striking the shooter. The shooter died from the round Officer 4 fired. The investigation into the incident revealed that Officer 4 used reasonable force and was justified in the actions he took.

 Officer 4 was taken from the scene and met with his attorney and completed his police report. The SWAT team had made arrangements for Officer 4 to see their team psychologist because he specialized in these types of incidents. Unfortunately for Officer 4, his own department had a different plan of action for him. A lieutenant from Officer 4’s department made Officer 4 go to a different police psychologist that was not from the area. Officer 4 took a self admitted “tough guy” approach to his recovery after the incident. He did not think that the incident affected him and came back to work after approximately six weeks off. Officer 4 told everyone “I’m okay, I’m ready to come back to work”. He really was not ready to come back to work. The incident was weighing on his mind, he had family related issues with his teenage son going on at home and there was a change in administration at his department.

 Officer 4 attempted to come back to work and could not focus on anything. He told the administrators from his police department that he was not comfortable with the psychologist that the lieutenant had sent him to see. Officer 4 was curious as to why the department knew the SWAT team psychologist was available to see him, but his own department chose to send him to a different psychologist that was unfamiliar with the area and the tactical team the officer was on. Officer 4 started to second guess his decision and was wondering what he had done wrong. His department was not supporting him or getting him the help he needed. Officer 4 started to have nightmares, anxiety attacks, cold sweats and had a hard time concentrating on the simple tasks in life. Officer 4 informed me that he was not the normal person that he knew himself to be before the incident. Two months after the incident, he went to the ATM to withdraw money, he withdrew the money and took his card. He walked away from the ATM machine without taking his money.

 Officer 4 recently was retired from the police department on a duty disability retirement. This took approximately ten months to complete. The officer’s doctor/psychologist, the city’s doctor and the pension board all agreed that he would not be able to come back to work in a full capacity.

**Evaluation:**

 In Officer 1’s case, he was supported by his department and administration. Officer 1 had no immediate issues from the critical incident that he was involved in. The administration, starting with the chief of police, took the right steps in getting Officer 1 the proper assistance after the traumatic incident that he was involved in.

 In Officer 2’s case, he was unsure personally exactly what he was dealing with. When he realized that his health and psychological issues were a result of the critical incident that he was involved with; he asked for help. Unfortunately, he was told by his immediate supervisors that he was fine and to return to duty. The department’s line supervisors did not handle this situation appropriately. They should have contacted city hall and the city administration and got him help sooner. Officer 2’s career may have been able to be saved and he could still be working today. Officer 2 was retired on a duty disability pension and will never work as a police officer again.

 Officer 3 is still working on his department. He continues to deal with the incident and aftermath of losing his partner that night. Officer 3 believes the department could have prepared for and reacted to this incident better by getting him one on one psychological help from a doctor that dealt specifically with critical incidents like losing a partner.

 Officer 4 is now medically retired from his department. The administration of his police department wanted to show that they knew what psychologist he should see and what type of help he needed. The administration never asked the officer what doctor he was comfortable talking to. The administration was very inexperienced in these types of incidents. They did not listen to the SWAT team’s suggestions to see the team’s psychologist. They made no effort to contact surrounding agencies and see how more experienced administrations have dealt with similar situations. Officer 4 never really got a chance to get the immediate help he needed right after the critical incident.

 How do administrators and city managers deal with the aftermath of critical incidents and getting their employees the right help? First and foremost, we all have to understand that the brain and body’s reaction to a critical incident is like having a concussion. There are no two persons’ bodies and brains that are the same. We all react to critical incidents and concussions differently. Some people will have immediate reactions from the incident(s) and some of us will have delayed reactions from the incident(s). The bottom line is that we have to help our employees in finding the right assistance (Sweeney, 2013). No longer can we take the approach that police officers are strong and have no weaknesses. Police officers are human beings and have feelings too. We need to make our officers realize that there is help out there and they don’t need to be afraid to ask for it.

 When physical injuries occur on the job, we have the officers evaluated by and a physician and they are prescribed physical therapy or rehabilitation. When Officers are found to suffer from stress that is related from their duties, what do we do? There are times when nothing is done for the officers that are involved in these critical incidents. They sometimes go months or years without any type of treatment. The officers are suffering inside and we cannot see it. We need to get them help (Andrews, Philpott, & Stewart, 2007). We need to have policies and procedures in place and the administrations cannot turn their backs on these officers.

In June 2012 in Phoenix, AZ, Officer Craig Tiger shot and killed a man with a baseball bat. One year after the incident, Officer Tiger was still suffering with nightmares, depression, and flashbacks. He wanted to drive to a remote cabin and take his own life. He was drinking heavily and on his way to his cabin, he was arrested for drunk driving. After the arrest, officer Tiger was ordered to attend a 30-day inpatient treatment program. While in there he was diagnosed with PTSD. Phoenix Police Chief Daniel Garcia subsequently fired Officer Tiger. Chief Garcia told Officer Tiger “You’re no longer worthy to wear the badge. I no longer believe in you or trust you. You’re not worth saving. Whether or not you have been diagnosed with PTSD is not my problem”. In November 2014, Officer Tiger took his own life (Brown, 2015)

https://apbweb.com/urgent-request-fellow-officers/

Police unions across the US are pushing for officers to be able to collect workers’ compensation benefits if the suffer from post-traumatic stress disorder, whether they got it from the general stress of police work or from responding to a deadly shooting rampage (Gurman, 2014). These benefits vary by state to state. Officers is Columbine, CO (April 20, 1999), Aurora, CO (July 20, 2012) and Newtown, CT (Dec 14, 2012) responded to incidents that they were involved in as first emergency responders. None of the officers took any deadly force actions when they arrived on scene and observed scenes and scores of deceased bodies that they would prefer not to describe or relive. These officers and first responders suffered from the stressors of their jobs and responding to these incidents. A “stressor” is some activity, event or other stimulus that cause either a positive or negative reaction in the body (Dias, 2011, p. 435).

Each city, city manager’s office, human resource department, and/or police department and state worker’s compensation laws need to look at these incidents and there aftermaths. We need to realize that we need to help the people that are helping us by putting their lives on the line every day. The officers and first responders need to know that it is ok to ask for help and when they do, we have to be able to be ready to provide the correct help.

References

Andrews, B., Philpott, C. R., & Stewart, L. (2007). Delayed-onset posttraumatic stress disorder: A systematic review of the evidence. *American Journal of Psychiarty*, *164 (9*), 1319-26. Retrieved from http://search.proquest.com/docview/220468915?accountid=28644

Brown, C. (2015, January, January). Agencies need to do more for cops in serious trouble: Officer Tiger’s death is a wake up call. *American Police Beat*, *22(1*), 22.

Dias, L. (2011). *Human resource management*. [Adobe ]. Saylor.org/books. ISBN 13: 978-1-4533194-3-7. Downloaded Jan. 9, 2014 from https://open.umn.edu/opentextbooks/BookDetail.aspx?bookId=71

Glenn, S. (2011, July 21). Former lakewood officer says PTSD caused cruise crash. *McClatchy-Tribune Business News*. Retrieved from http://search.proquest.com/docview/878411425?accountid=28644

Gurman, S. (2014, May 16). Police unions push for medical coverage of PTSD. *Spartanburg Herald-Journal*. Retrieved from http://search.proquest.com/docview/1525795888?accountid=28644

Hayward, M. (2013, October 20). PTSDsidelines first-responderto shooting of Manchester police officer. *McClatchy-Tribune News*. Retrieved from http://search.proquest.com/docview/1443173459?accountid=28644

Post-traumatic stress disorder-PTSD. (n.d.). Retrieved from http://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/basics/definition/con-20022540

Sweeney, A. (2013, September 20). Chicago police officer with PTSD struggles to find treatment. *McClatchy-Trubune Business News*. Retrieved from http://search.proquest.com/docview/1433945460?accountid=28644

Post-traumatic stress disorders; burden of full & subsyndromal PTSD in police who responded to the world trade center disaster. (2012). *Mental Health Business Week,* , 5. Retrieved from http://search.proquest.com/docview/1020319408?accountid=28644

Post-traumatic stress disorders; stress response predictor in police officers may indicate those at high risk for PTSD. (2011). *Psychology & Psychiatry Journal,* , 212. Retrieved from http://search.proquest.com/docview/909432425?accountid=28644