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Impact on Crisis Negotiators of Suicide by a Suspect

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Abstract: *Crisis negotiators who had been involved during the last 5 years in incidents in which the suspect committed suicide completed a questionnaire and provided information about the following: (1) anxiety symptoms during the incident; (2) formal support afterwards (debriefing by a mental health professional, peer support team member, or chaplain); (3) informal support from co-workers, supervisors, administrators and investigators; (4) long-term effects of the incident in the form of post traumatic stress disorder (PTSD) symptoms and work-related problems; (5) specific coping mechanism employed to deal with the feelings aroused by the incident and (6) present feelings about the incident.*

Key words: crisis negotiators, Post Traumatic Stress Disorder, suicide investigation, law enforcement, suicide

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INTRODUCTION

Crisis negotiators work in an environment that is inherently stressful (Bohl, 1992). Stress begins even before the negotiator arrives on the scene, as he/she is called away from other duties and becomes involved in the coordination of personnel and development of a strategy. Stress continues as contact is made with the suspect and reaches a climax if the incident is not resolved with a peaceful surrender on the part of the suspect. Negotiators have a strong emotional involvement in having the incident end without death or injury to anyone; they feel completely responsible for the outcome. Consequently, if the situation concludes with the suicide of the suspect, the negotiator-who may have spent hours forging a relationship with the individual-can be expected to experience strong feelings of failure, anger, self-blame and guilt (Bohl, 1997).

Actually, however, as a search of the literature showed, the degree of distress experienced by crisis negotiators after involvement in such a situation does not appear to have been assessed. Obtaining such measures was one purpose of the present study. Participants were asked about which post traumatic stress disorder (PTSD) symptoms and work-related problems occurred after the incident, as well as the degree to which those symptoms and problems were experienced as disabling.

Crisis negotiators have various resources available to them to alleviate any negative feelings experienced after involvement in an episode that ended with the suicide of a suspect. In many departments, postincident crisis counseling is mandatory or at least available if requested. In addition, crisis negotiators typically are encouraged to avail themselves of opportunities to talk to a peer support team member or a departmental chaplain after a crisis incident. Informal support is available as well (such as from co-workers and supervisors). A second purpose of the present study was to obtain feedback from crisis negotiators about the extent to which formal sources of support were used after the incident and about the degree to which both formal and informal sources of support were found to be helpful in decreasing the level of distress.

Along with formal and informal sources of support, crisis negotiators use their own coping mechanisms to deal with the pain of having a suspect commit suicide. A third purpose of the study was to elicit information about which specific coping mechanisms are employed most frequently by crisis negotiators, as well as how negative feelings about the incident are finally resolved.

METHOD

Five hundred questionnaires were mailed to randomly selected members of the California Association of Hostage Negotiators. Participants completed the questionnaires at home and mailed them back. Fifty-five negotiators returned usable questionnaires. While this return rate is low, it

probably reflects the fact that many negotiators are never involved in incidents in which the suspect commits suicide.

Questionnaire

On the questionnaire, information was sought about the following:

1. Details about the incident. The participant was asked how long ago the incident occurred and to indicate which specific anxiety symptoms had been experienced during the incident (such as time slowed down and sounds were intensified). Six anxiety symptoms were listed and the participant checked off all that had been experienced.
2. Formal sources of support after the incident. The participant was asked whether he/she had undergone a debriefing with a mental health professional, had a talk with a peer support team member and/or talked with a departmental chaplain. For each source of formal support, the participant rated how helpful the procedure had been on a scale of 1 (*not at all helpful*) to 4 (*very helpful*).
3. Informal sources of support after the incident. The negotiator was asked to rate on a scale that ranged from 1 (*very negative*) to 5 (*very positive*) how he/she felt about the departmental procedures following the incident. The participant also rated on a scale that ranged from 1 (*no support*) to 4 (*a great deal of support*) the support received after the incident from co-workers, supervisors, administrators and investigators.
4. Long-term effects of the incident. Participants were presented with a list of 25 possible symptoms of PTSD (such as nightmares and flashbacks) and 11 possible work-related problems (such as absenteeism and lowered morale). For both sets of items, participants were asked to rate on a scale of 1 (*It had only a mild effect on my life, coping ability and functioning on the job*) to 10 (*It had a severe effect on my life, coping ability and functioning on the job*) the severity of their reactions and how long the reaction lasted (on a scale of 1 to 5, with 1 being *One month or less* and 5 being *Over one year*).
5. The individual's own coping mechanisms. Participants were presented with a list of specific coping mechanisms, 12 of which were positive (such as *Use of prior training in stress management*) and 3 of which were negative (*Increased alcohol consumption, Increased smoking* and *Trying not to think about the incident*). Participants checked off all of the coping mechanisms that had been used and space was provided for them to add others that were not on the list if they wished to do so.
6. Resolution of feelings. Participants were asked to indicate when they had first talked about the incident thoroughly. The response possibilities ranged from 1 (*Within the first day*) to 9 (*Still have not talked about it thoroughly with anyone*). In addition, participants were asked to rate how they felt about the incident now. The response

possibilities ranged from 1 (*I have accepted it and resolved my feelings about it*) to 4 (*It bothers me tremendously and is causing much difficulty in my life*).

7. Demographic information. Participants provided information about age, sex, rank, years as a crisis negotiator and how many times he/she had been involved in an incident in which a suspect committed suicide.

PROCEDURE

To evaluate the effects of the two formal sources of support (debriefing by a professional and meeting with a member of a peer support team), participants were divided into two groups: individuals who had received either of the 2 forms of formal support (N ' 33) and individuals who had received neither form of formal support (N ' 22). Comparisons between the groups were made with t-tests for independent groups or chi square analyses. Only those group comparisons that were significant are reported.

RESULTS

Demographic Information

The groups did not differ significantly in age, sexual composition, or rank. The mean age was 41.6 years (SD ' 6.92). The majority of participants (74.5%) were male. Police officers constituted the most frequent rank (41.5%); the rest were sergeants (24.5%), detectives (24.5%), lieutenants (5.6%), or agents (3.7%). The groups also did not differ significantly in number of years as a negotiator or the number of prior incidents in which the participant had been involved. Years as a negotiator spanned a wide range, from less than 1 year to 23 years (M ' 8.1, SD ' 5.27). Number of prior incidents ranged from 1 to 13 (M ' 2.5, SD ' 2.68).

Details About the Incident

The groups did not differ with respect to the time since the incident occurred; the range was from 1 month to 60 months (M ' 23.7, SD ' 18.74). As for the number of anxiety symptoms that participants experienced during the incident, 36% of the sample were unable to recall any symptoms at all. Those participants who reported one or more symptoms tended to be in the group that had received formal support. Consequently, the difference between the formal-support group (M ' 2.2, SD ' 1.27) and the group that had not received formal support (M ' .59, SD ' 1.09) in number of anxiety symptoms reported was significant (t [53] ' 4.96, p $<$ .001). Among those individuals who reported one or more anxiety symptoms, the order, from most frequently reported to least frequently reported, was as follows: time slowed down (63%), sounds intensified (54%), tunnel vision (48%), heightened visual detail (34%), sounds diminished (26%) and time sped up (23%).

Formal Sources of Support After the Incident

Fifty-one percent of the sample had experienced a debriefing with a mental health professional after the incident. The great majority of these individuals regarded the experience positively; 61% rated it "very helpful," and 29% rated it "somewhat helpful." A minority were neutral (7%) or negative (3%) about the experience. Thirty-five percent of the sample had met with a peer support team member. All of these individuals regarded the experience positively; 58% rated the experience as "very helpful" and 42% rated the experience as "somewhat helpful." No one was neutral or negative about the experience. The single individual who had talked with a departmental chaplain was neutral about the experience.

The groups did not differ significantly with respect to how they viewed departmental procedures, coworker support and support from supervisors after the incident. Although only a minority (26%) rated departmental procedures after the incident as "somewhat negative" or "very negative," ratings of departmental procedures were not strongly positive. Only 45% rated departmental procedures as "somewhat positive" or "very positive," and another 28% were neutral. In contrast, support received from co-workers and supervisors was rated positively; 85% of the participants reported that co-workers provided "some support" or a "great deal of support," and 78% reported that supervisors provided "some support" or a "great deal of support."

On ratings of the support received from administrators ($\chi 2$ [3, N ' 53] ' 8.15, $p < .05$) and investigators ($\chi 2$ [3, N ' 50] ' 8.39, $p < .04$), the two groups differed significantly. The differences arose because participants in the formal-support group tended to make positive ratings of the support received from administrators and investigators whereas participants in the group that had not received formal support tended to make negative ratings of the support received from the same sources.

Long-Term Effects of the Incident

The distributions of scores for the total number of PTSD symptoms, the severity of the symptoms and the duration of symptoms all were markedly skewed. The same was true for the distributions of scores for the total number of work-related problems, the severity of the problems and the duration of the problems. Consequently, the medians (the middlemost scores rather than the means) are reported here.

The total number of PTSD symptoms reported by participants covered the full range of possibilities; but most of the scores clustered towards the high end and the median score was 24 (out of a possible 25). Ratings of the severity and duration of PTSD symptoms also covered a wide range (from 1 to 7.8 for severity and from 1 month or less to over 1 year for duration), but most of the scores clustered towards the low end of their respective distributions. The median score for severity was 1.2 and the median score for duration was 1 month or less. Thus, although most of the participants admitted to having experienced the full range of PTSD symptoms, they claimed that

those symptoms had lasted only briefly and had exerted only a mild effect on their lives, coping abilities and functioning on the job. The most frequently reported symptoms were as follows: a sense of loss of control over things (85%); depression (78%); flashbacks (76%); a heightened sense of danger (75%); vulnerability (75%) and irritability (75%).

The total number of work-related problems reported by participants covered the full range of possibilities, but most of the scores were clustered towards the high end. In fact, the median score was 11, which was at the very top of the possible range of scores. Ratings of the severity and duration of work-related problems also covered a wide range (from 1 to 5.5 for severity and from less than one month to over one year for duration), but most of the scores clustered towards the low end of their respective distributions. The median score for severity was 1 and the median score for duration was one month or less. Thus, as was the case with PTSD symptoms, although most of the participants admitted to having experienced the full range of work-related problems, they claimed that those problems had lasted only briefly and had exerted only a mild effect on their jobs. The most frequently-reported problems were distrust of the department (71%), lowered self-confidence (67%), distrust of peers (64%) and fears for the future (64%).

Comparisons between the groups that had and had not received formal support showed that the groups did not differ significantly with respect to the total number of PTSD symptoms, the overall severity of those symptoms, or the overall duration of symptoms. When separate comparisons were made between the groups on a symptom-by-symptom basis, no significant group differences were found. The groups also did not differ significantly with respect to the total number of work-related problems, the overall severity of those problems, or the overall duration of problems. However, when the groups were compared on a problem-by-problem basis, three significant differences were found. The duration of a decline in work performance (t [29] ' 1.97, p < .05), duration of a tendency to overreact on the job (t [25] ' 2.03, p < .05) and duration of disciplinary problems at work (t [26] ' 3.12, p < .004) all were significantly less for the group that had received formal support than for the group that had not received formal support.

To determine whether PTSD and work-related problems were related to the number of prior incidents in which the individual had been involved, a series of correlation coefficients was computed. There were no significant correlations between number of prior incidents and the following: number of PTSD symptoms, number of work-related problems, overall severity of PTSD symptoms, overall severity of work-related problems, overall duration of PTSD symptoms and overall duration of work-related problems.

Individual Coping Mechanisms

The group that had received formal support (M ' 4.4, SD ' 2.25) reported the use of a significantly greater number of coping mechanisms (t [53] ' 3.87, p < .001) than the group that had not received formal support (M ' 2.3, SD ' 1.49). For the group that had received formal support, the

coping mechanism reported most frequently was debriefing. Other comparisons between the two groups with respect to their frequency of use of each specific coping mechanism showed that the group that had received formal support made significantly greater use of support from co-workers ($\chi2$ [1, N ' 55] ' 3.94, $p < .05$) and friends ($\chi2$ [1, N ' 55] ' 4.34, $p < .04$) than the group that had not received formal support.

The 4 coping mechanisms that were reported most frequently by the entire group of participants were all positive. They were as follows: critical incident debriefing (82% and for the formal-support group only), support from co-workers (53%); support from family (42%) and use of prior training in stress management (40%). Some positive coping mechanisms were added to the list by participants. One such mechanism (used by 7% of the sample) was cognitive appraisal. Participants made a rational assessment of the incident and concluded that, even though they had behaved appropriately, they could not have altered events. For example, one participant reported that he had been relatively unmoved by the suicide, because it was known that the suspect had sexually abused his daughter and had planned to commit suicide before the negotiator arrived on the scene. Other positive coping mechanisms added to the list by participants were prayer (4%), increased time with the family (2%), increased emotional expressiveness (2%) and a temporary change of assignment (2%).

Negative coping mechanisms seem to have been used infrequently. Trying not to think about feelings occurred in a substantial minority (20%), but increased alcohol consumption (9%) and increased smoking (7%) both had a relatively low rate of occurrence. Two of the possible coping mechanisms listed that were not used by anyone were support from the department chaplain and use of medication prescribed by a doctor.

Resolution of Feelings

The majority of participants indicated that they had talked about the incident on the day it occurred (58%) or within the first 3 days (16%); only a minority (7%) reported that they had never talked about the incident. In response to the question about how they felt about the incident now, the majority of participants (80%) reported that they had accepted it and had resolved their feelings about it. There were no differences between the groups that had and had not received formal support on either of these variables.

DISCUSSION

The great majority of participants reported they had experienced virtually all of the 25 PTSD symptoms listed, as well as all of the 11 work-related problems. Both findings suggest the suicide of a suspect is highly traumatic for the negotiator. However, participants also reported many PTSD symptoms and work-related problems were mild. They were of such short duration they did not interfere with their lives. This suggests involvement in incidents in which a suspect commits suicide

is only minimally disturbing to crisis negotiators. Although more research would be necessary, it is likely that the discrepant findings are attributable to the lingering effects of the macho police ethic, whereby emotional distress is denied. Negotiators were willing to admit that they had indeed experienced a long list of PTSD symptoms and work-related problems, but they nevertheless felt obliged to minimize the seriousness of those symptoms and problems.

A similar interpretation applies to the data on coping. Although many individuals used only a small number of coping mechanisms (in some cases only one), the majority of participants nevertheless reported that any distress experienced after the incident was resolved quickly and the coping techniques they reported having used were largely positive. Few negotiators admitted to having increased their smoking and drinking. Crisis negotiators are chosen for their psychological stability (Bohl, 1997) and so it is credible that they might have concentrated on the use of such positive coping mechanisms as insights obtained during critical incident debriefing, support from family and friends and prior training in stress management. However, there is a possibility that at least some of the participants reported what they thought they should have done, rather than what they actually did.

A large minority (40%) of the participants were not debriefed by a professional or a member of a peer support team, but whether that was due to lack of opportunity is not clear. Those individuals who received some form of formal support rated it highly. As for informal sources of support, only co-workers and supervisors received high ratings from all participants regardless of group. That their own departments, administrators and investigators received mixed evaluations is cause for concern and suggests that officials need to be more sensitive to the distress experienced by negotiators after the suicide of a suspect.

A number of differences were found between the formal-support and no-support groups. The fact that the formal-support group remembered having experienced more anxiety symptoms during the incident than the no-support group probably is attributable to experiences after and not during the incident. In the course of debriefing, the individual is encouraged to describe the incident and attendant anxiety feelings in detail. Thus the likelihood of subsequent recall of those same symptoms many months after the incident was increased in the formal-support group.

The fact that the formal-support group rated the help received from administrators and investigators positively whereas the no-support group did not suggests a possible benefit of the debriefing experience. The opportunity during debriefing to vent some negative feelings about the incident probably increases the individual's level of comfort about what happened and, therefore makes it less likely that the negotiator who has been debriefed will respond defensively when questioned about the incident later. The same explanation probably applies to another finding: the fact that the formal-support group made more use of support from co-workers and friends than the no-support group.

There were indications, as well, of other benefits received from debriefing. 1) As already noted, participants in the formal-support group rated the debriefing experience positively. 2) For the formal support group, the most frequently selected of the 15 coping mechanisms listed on the questionnaire was help received from critical incident debriefing. 3) The formal-support group reported the use of a greater number of coping mechanisms than the group that had not received support. 4) The formal-support group made a faster recovery than the no-support group from 3 work-related problems that developed after the incident: a decline in work performance; a tendency to overreact on the job and disciplinary problems at work.

Because formal support was found to have a number of benefits, it was surprising to find that it did not decrease the total number of PTSD symptoms or work-related problems. There are limitations, however, to what can be accomplished in a single postincident debriefing and it may be that several such sessions spread over a period of several weeks would be necessary to produce any lasting effects on PTSD symptoms and work-related problems. As for the apparent lack of effect of formal support on the overall severity and duration of PTSD symptoms and work-related problems, the explanation lies in the tendency, already discussed, for negotiators to minimize the degree to which they were affected by episodes that ended with the suicide of a suspect.

CONCLUSION

As shown by the prevalence of PTSD symptoms and work-related problems, crisis negotiators experience psychological distress after the suicide of a suspect, but they minimize the seriousness and duration of those symptoms and problems, report the use of positive coping methods to deal with their distress and claim that their feelings about the incident are readily resolved. Informal support from co-workers and supervisors is reportedly helpful. Formal support in the form of debriefing by a professional or a member of a peer support team is appreciated by negotiators and has some demonstrable benefits, such as speeding recovery from work-related problems and increasing the number of coping mechanisms used to deal with psychological distress.