Processing Trauma In a Law Enforcement Career

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Matt: Hello. Welcome and thank you for joining us today for this SAFLEO Sessions podcast. I'm Matt Garcia with the National Law Enforcement Officers Memorial Fund. I'm a former law enforcement officer, retiring after [a] 26-year career. I'm pleased to have Sergeant Renee Plum, Gunny, from the Prince George's County, Maryland, Police Department joining me for this podcast. We're going to discuss some of the wellness efforts of the Prince George's County Police Department.

Thank you for being here, Gunny. Before we start, please tell our listeners about you and your agency.

Renee: Hi, Matt. Thank you. It's great to be here. So, as you said, Sergeant Renee Plum. My nickname's Gunny. I've been on the agency for 29, almost 30 years now. I've been in patrol, training, education, K-9, Homeland Security, Internal Affairs. I've had a very blessed career. The last seven years, I have been assigned to the Psychological Services Division as the special programs' coordinator. As such, I oversee the Peer Support Program, the Chaplain Program, the Support K-9. We liaison between the embedded clinicians and the department and outside resources, and we also do training specifically to the mental health field for first responders.

Matt: Great. If you would, take us on your journey, how you came to the current position that you're in, and really—what was the drive from that first day that you entered the academy to get to where you are today?

Renee: When you start out, I don't think any of us think about the emotional toll and the trauma and all that we will go through on this occupational journey. Starting out, I just wanted to go out there and help people, and I wanted to stand up and protect people that needed to be protected. I was coming out of the Marine Corps and just wanted something bigger than [my]self to give back.

As I started getting into it, I was blessed from patrol. I was in K-9. I was in the Training Education Division. I spent some time in Homeland Security. My career was very eventful. And it wasn't until the tail end of my career that I started realizing how much I had seen and done and the impact it had on me in my personal life. So, when the head clinician asked if I was interested in coming over to the Psychological Services Division, it caught me by surprise that I was being asked, but it was an—immediately something that I thought, "Wow, what a great opportunity to be able to give back to the people who go out and do this every day and try to just make things better." My real goal is that I want everybody coming on after me to retire healthier than I did and the generations before me.

Matt: How hard has it been to make inroads within police culture? Because it's a very closed culture. It's a very trust averse culture—question everything. We don't like change. How do you find making those inroads are?

Renee: I think it's getting easier. I think that, really, what it is—is the things that we needed to talk about, suicide ideation, PTSD, anxiety. I think the PTSD is getting easier to talk about. I think that it has been kind of put out there socially in television and social media and just general conversation. I think the suicide ideation, there's still so much at risk for an officer to say, "Hey, I'm starting to have these dark thoughts, and I'm concerned. I don't trust myself. I think I need help." I think that's still a struggle. We have to show people that they can, in fact, disclose; get the help they need; and get back to work without consequence. And I think you have to earn that. I think that's grassroots.

I think the other things that we need to look forward at trying to break the stigma on is depression and anxiety. With PTSD, depression and anxiety are sitting there in that same diagnosis, if you will. So, I think that it's a lot easier to say, "I have PTSD," because there's this feeling that we do a job that gives us the right to say we have that, but we're

not as quick to say, "Hey, I think I'm dealing with clinical depression, and I need some help." So, I think the stigma part is interesting. I think it's siloed. I think that we have columns that we're okay admitting to, but I think we still have a long way to go in other areas.

Matt: And there's been a lot of recognition of the amount of trauma that officers carry from the beginning of their career to the end of their career and how that's handled and how the culture allows us to handle it. But there's been a lot of attention to the rates of suicide over the years and a recognition that, in comparison to the line-of-duty deaths, we are seeing amongst our active and our retired personnel, suicide rates much higher than the on-duty or in the line-of-duty deaths.

Renee: Well, I'll tell you, we spend so much time in training with officer survival and tactics and even de-escalation, and we spend so much time focusing on that, but I think that we're a little bit behind getting on board and talking about what this job does to us. One of the things I asked my troops to think about is, "First, how many dead bodies have you seen compared to your next-door neighbor? Assuming your next-door neighbor isn't a mortician or an ER doctor or something like that." And put that in perspective. And then, "Secondly, when's the last time you truly laughed at something?" To get a gauge of how they're processing emotionally.

I think that when we look at where suicide conversations started, we never talked about it—and then to be in a point now where we have that conversation. And I think it goes hand-in-hand with the trauma we're seeing. It's not normal, what we do. We normalize it, but it's not normal. The body wasn't made to see the things that most officers see for the period of time that we see it, and I think that normalizing it is very different than processing it.

Matt: How impactful, and you're spot on with that. And when I think of when you're talking about trauma and seeing more trauma—and I like that analogy, where we will see more compared to what does your neighbor actually see or experience—what is the impact of having to take that and then move on to the next call because you don't have the ability to really sit and process on a busy shift?

Renee: I think it starts numbing emotion in an unhealthy way. I think that the other thing we have to look at, over the last couple of years, there's such a shortage within law enforcement that we're actually having to go call to call to call quicker. We're seeing more because there's fewer of us. So, the compartmentalization—the analogy I give my troops is we have this work box, and every time we see something that's really

messed up and traumatic, we throw it in the work box. We put the lid on it. We go to the next call. When we see the next thing, we throw it in the box. We put the lid on it. We go to the next call.

I don't believe that we're getting the time to really even reset in between the traumas that we're seeing because we're so short. Officers are seeing more of it. There's fewer of us to spread it around. But how much stuff are we going to throw in that work box in 20, 25, 30 years before that box is full? And it's the most benign thing that we see that we kind of flip the lid open on to throw in there, and now everything just comes out, and it's a mess, and we don't know what to do. No one told me 20 years ago that, "Hey, if you don't process the trauma you see, it's going to come back and haunt you. It's going to bother you. It's going to be something that, as you get older and your mortality starts setting in, it's going to start tapping you on the shoulder."

So, I think that where it's really starting to impact officers, is that compartmentalization. We try so hard to keep it in the box, to make sure we're "normal" at home and "normal" as far as coming into work with our squad, that we end up losing a sense of ourselves, and we shut down emotion, and we start having problems being truly emotional, in appropriate levels, when we're dealing with both things outside work and sometimes things in work.

Matt: I'm so glad that you mentioned the issue of staffing. Speaking to officers from throughout the country, hearing the same thing over and over again, the difficulty of hiring, difficulty of retaining, and just the shortage of officers, but there was a department that lost four officers, died by suicide, in a 24-hour period, and the sheriff of that department mentioned the effects that minimum staffing has. Officers are responding from call to call to call, being denied days off. And because of just the need to have officers out there, and therefore, the ones that are working are not able to separate from that—from the job in a healthy way because there's such a need to fill those shifts. You're clearly seeing an effect. And I commend him on recognizing the effect that that has. What are departments these days now doing to try to counter some of that? What are they putting into place to help address some of those issues and be a resource for officers?

Renee: I think we're starting to get clinicians that want to specialize in first responder care, and they want to be culturally competent with first responders.

Matt: For any clinicians that happen to be listening to us, what do they need to focus on when working with officers? Because it is a different

environment than what a lot of clinicians are used to. What advice would you have for them—coming into this world, if you will, to be effective?

Renee: I think, "Learn the culture." Officers are willing to talk a little bit about what their days are like and what their life's like and how the job has impacted them. I think that those clinicians would do well to go to the local first responder agencies, whether it's fire or police, EMS dispatchers, and see what it's like. See how we're multitasking. We're going through high stress. We're going to boredom. We're going to high stress. We're going to boredom. There's this up-and-down flow that happens. And then to see the comradery and how, even when it may be in my personal best interest to stay at home, maybe I need to call in because I'm sick, I won't call in because I don't want to let down my squad members, and so I come to work sick. I think it would help a lot of clinicians to see how officers operate in their environment, and then they'd have a better idea when they start treating in sessions, "What is this like for this person? How is this impacting them at work?"

I think the other thing with clinicians that are resources outside agencies is to not do knee-jerk reactions. Most officers have that dark sense of humor. Most officers will say that they don't sleep well. There are a lot of things that we say that if you're talking to a normal human being who's not a first responder or military or anything like that, you'd be like, "Oh, that's a red flag." When you start talking to officers, and we talk about not sleeping, you need to ask why they're not sleeping. You can't just take it on face value of, "Hey, why aren't you sleeping?" Shift work will really mess you up when it comes to being up at odd times, but is it that you're waking up because of dreams? Are you not able to fall asleep because of paranoia? What's causing it? So, I think ride-alongs with local agencies would be huge. And then also checking in if there are embedded clinicians in the area, checking in with them and having the conversation with them so that they can offer the best care possible to any first responder clients they have.

Matt: The embedded clinician is really a pro, I think, to any peer support team. In a perfect team—if an agency is striving to build that perfect team within an agency to address the needs of the officers, what would that team look like?

Renee: Oh man, the embedded clinician is huge. I think that the success that we've had here in Prince George's County is largely due to having embedded clinicians. We've been fortunate. We've had embedded clinicians for at least 30 years. My guess is 40, 45 years. It predates me even coming on the agency, having an embedded clinician.

Matt: What's the strength that you find with an embedded clinician over, let's say, somebody who comes in from the outside world trying to integrate into the police culture?

Renee: The first thing with the embedded clinician is the rapport is built very organically. They're just out there seeing us. They're on ride-alongs with us. We're not having to expose our soft underbellies and tell them things. We just get to know them as human beings. We're a very suspicious culture generally, so we're always reading people. So, it gives us a chance to read the clinician in a nonclinical environment. It also gives the clinician to see how officers function. So, the rapport that's built, it's interesting to me that a lot of times it's built outside the clinical session. It makes going into that clinical session a lot easier, but the embedded clinicians always being around and interacting within the ranks and being out there makes a huge difference.

I think the other advantage to the embedded clinician is we don't work with insurance. And because we don't work with insurance, we don't need to diagnose somebody to give them treatment. It's expensive sometimes when you start breaking down going to a clinician. And financially, a lot of times, people have things going on. There's a lot of times a financial issue within keeping up care. I know some insurance companies have dropped to $10, some are still 25. With some, it's so specific who you can go and see that it's difficult to get a culturally competent clinician. All this weighs into stuff, but with the embedded—the clinician, there's no co-pay. The embedded clinician is a free service, typically. You have trust and rapport, and the clinician, on the other hand, has an understanding so they don't knee-jerk react to things.

Matt: That's important because officers are very suspicious. And unfortunately, that's a hindrance to a lot for getting [the] help that they need.

Renee: So, it starts with the top command saying, "Hey, I believe in mental health, and I believe in confidentiality." That's one thing that's really important when we talk about the stigma. We have to keep the secret of confidentiality when people are working within peer support, when they're working with the clinicians. We have to make sure we respect that, and that starts at the very top.

I think the other thing that we talk about the embedded clinician, Matt—the trust that's built over time makes us more willing to be transparent and honest where I know I can say, "Hey, I've had dark moments, and I'm coming to you today, clinician, because last week, I thought about

ending my life." To have the knowledge to know I can say that safely because it's past tense and it's not current, and I can actually get those words out of my mouth to somebody and stop keeping that horrible secret inside—it's huge.

So, I think that when we look at the work we have to do, the embedded clinician is going to be able to do that work a lot quicker because a lot of times—already have rapport. They're culturally competent. They know what's at risk for officers when they come forward and say, "Hey, I'm in a dark place." I think the command staff has to be really present and really give 100 percent to the confidentiality component and protect their people. And I don't mean that in a codependency way. I mean that in—if the secret doesn't need to be told to somebody, don't tell it. You tell the people that need to know to make sure the person's taken care of, liability, the agency and all that, but you don't use it as just fodder for conversation.

Matt: You're so correct in that, and you mentioned the importance of having buy-in from the command level. The goal is [that] we don't want to see another officer die by suicide, but we also want to see officers retire and enjoy a fulfilling chapter two, if you will—a life after retirement. And we don't want anything from the job carrying over in an unhealthy way. The buy-in from the command staff is so important.

I'm glad you touched upon that because, as these peer support teams grow and as officers who are part of peer support become supervisors and then from supervisors become commanders, there's a greater appreciation—the benefits of everything that you've talked about and the importance of having these systems in place to really keep officers safe.

What I want to ask you as we wrap up here, for any officer that is struggling to come forward—with your experience in this field, with everything that you have done within the Psychological Services Unit, what would you say to that officer who is struggling to come forward out of either fear of repercussion or really not sure what's going to happen after?

Renee: I think the first thing is know that there are other resources outside your own agency. There's COPLINE. There's Blue H.E.L.P. There's so many resources now in place that if you don't trust your own internal resources, know that there's more out there.

I think the other thing that officers need to realize is this job is not worth your life. If you were hitting that point where you're afraid of losing this

job, and so you're keeping the secret of suicide ideation, this job isn't worth your life. Your family needs you, your parents, your siblings—whoever it is, you've got to start looking bigger and go, "Okay, sooner or later, this job ends for all of us. We retire. We leave. We move on."

If you're a police officer and you don't trust your agency, contact your fire department peer support. Learn to call the resources outside if you want to test the water. If you don't address it, it's going to come out anyways because you can't have an injury—no matter if it's an invisible injury, initially. You can't have an injury for a long period of time before it starts impacting you at work. Typically, it impacts us at home first and then it starts coming out at work, but if you don't address it, sooner or later, it's going to come due.

Matt: Thank you. Thank you. And being someone who has retired, I can appreciate everything that you're saying and how important it is for your quality of life to deal with it on the job so that you can have fun when you move beyond the job because you still have a whole other world out there. And it is so important, what you've shared, and how important it is to make sure, along the way [that] you're doing what you need to do, and you're utilizing those resources, and you're reaching out for help.

Thank you so much for everything that you've shared with us today, Gunny. Any final words before we end today?

Renee: Just—for those of you just starting out in this occupation, just get a clinician and go in and see them once every six months or once a quarter, and just empty that work box out. Make it just part of your overall wellness system, just like working out and watching what you eat or drinking water. Get to the point that you just do preventative maintenance check-ins with a clinician and talk about any calls for service that are sticking with you or that bothered you and continue that going forward. And for those of you that have been on for a long time, and you've never done that, now's the time to do it. I don't care if you're a month away from retirement. We all deserve to have a good, happy, healthy retirement. Go in, start emptying that box out. If you're retired, it's not too late either. Go take care of yourself. You gave so much. Get something back now.

Matt: Man, I wish I had you around 30 years ago. Thank you so much.

And for our listeners, thank you for listening to the SAFLEO Sessions podcast. I encourage you to visit the SAFLEO website for more information on this topic and other resources that are focused on officer

wellness and suicide prevention. In SAFLEO, we passionately believe that a healthy officer is a better and safer officer. Until next time, be well, stay safe, and be courageous. Thank you.

Speaker 1: The SAFLEO Program is dedicated to providing training, technical assistance, and resources to law enforcement agencies, staff, and families to raise awareness, smash the stigma, and reduce and prevent law enforcement suicide. For additional information regarding the SAFLEO Program, please visit safleo.org. That's S-A-F-L-E-O.org. Follow us on Instagram, Facebook, and Twitter.

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