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RESEARCH ARTICLE

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Using Behavioral Skills Training to Teach Compassionate Care to Military Police: A Pilot Study

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ABSTRACT

This paper examines the use of Behavioral Skills Training (BST) to teach compassionate care to military police, aiming to increase compassionate interactions with survivors of interpersonal partner violence (IPV). Despite a high volume of IPV reports, military police receive limited training in compassionate responses, risking potential retraumatization for survivors. Using a non-concurrent multiple baseline design (NMBD), this pilot study followed three participants as they completed a six-week intervention, combining didactic learning modules, modeling, roleplay, and feedback to improve compassionate responses. Compassionate care skills were assessed during baseline, intervention, and maintenance phases. Results indicate preliminary evidence of moderate improvement in compassionate care responses suggesting BST may exert differential effects depending on contextual factors. While compassionate care skills can be taught, sustained practice requires systemic support to accommodate challenging environments. These findings underscore the potential value of expanding compassionate care training within military police contexts to promote trauma-informed responses and reduce barriers for survivors seeking justice, though further research is warranted to establish generalizability and long-term outcomes.

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Introduction and Purpose

The year 2020 was difficult on a scale that many were not prepared for, the authors of this paper included. These difficulties included an international pandemic, national economic recession, and general social unrest. The latter of these issues felt particularly impactful; stories that focused on the deaths of George Floyd, Manuel Ellis, Breonna Taylor, and Roger Fortson, along with a staggering 429 police related deaths by mid 2020 alone [1]. The subsequent reports of the murders of Army Specialist Vanessa Guillen and Specialist Asia Graham, and repeat violent offenders like Airman Devin Kelley contributed to a growing distrust of law enforcement, both military and civilian [2,3]. Yet, when watching these stories and hearing the narrative turn quickly against those on the front line, the question begged how we even got to here? How do those who are meant to serve and protect, to defend the constitution from all threats foreign and domestic seem to lack the compassion needed to connect with the most vulnerable? Objectively, the truth was not so black and white. Law enforcement are subject to their own competing contingencies and motivating operations that present constant pressure to make an ethical decision. This pressure is arguably amplified when being scrutinized by a world living through an international pandemic.

And yet… where there is a problem, lies a solution. The issue did not seem to be a unidimensional lack of regard or care, but perhaps a learning opportunity. What if law enforcement could be targeted as a special interest group to increase compassionate care in their responses? Focusing on the United States Air Force for its universality in definitions and governance, the authors decided to develop an experiment using behavioral interventions to see if compassionate care responses could be increased in military police. In addition, given their collective work with survivors of domestic violence and military sexual trauma, the authors decided to focus on these demographics as those who could potentially benefit the most from additional compassion.

The benefits of compassion cannot be understated. If military police can learn how to respond more compassionately, they may be able to offer their recipients better support. While compassion is important in all settings, this approach becomes especially important in military settings when supporting survivors of violent crime such as IPV and sexual trauma that can greatly impact the mission. The overarching purpose of this study was to determine if military police could be taught compassionate responses when interacting with those reporting violence with the long term goal of reducing the risk of retraumatization and improving the likelihood of victim participation [4]. This paper seeks to achieve this goal through two primary objectives:

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Objective 1: Evaluate the effectiveness of compassionate care training in increasing compassionate responses.
Objective 2: Assess if compassionate care training increases participant's knowledge and understanding of compassionate response principles.

Answering these objectives were the motivation in the development of this experiment which focused on not only the instruction of compassionate responses, but also the best method to measure these responses. Many professionals have sought to take a more active approach to providing compassionate care in their services, which begins with cultivating an operational definition. Lown et al. [5] proposed a definition of compassion as "the recognition, empathic understanding of and emotional resonance with the concerns, pain, distress or suffering of others coupled with motivation and relational action to ameliorate these conditions" (p. 3). Melton et al. [6] expanded this by describing compassion as the act of alleviating suffering by viewing other's experiences in relation to your own. Compassion, in this sense, differs from empathy in that there are actionable steps to alleviate the suffering, as opposed to the mere observation and relation to another's experiences.

Reviewing the literature for practical application of compassionate care suggests that many different professions and populations recognize the benefits of applying compassionate care to military police, themselves [7]. There has also been significant research demonstrating the benefits of compassionate care for survivors of sexual trauma and domestic violence [8]. Within these applied settings, compassionate care is the foundation for trauma-informed and survivor-centered approaches because it emphasizes validation of individual experiences, professional rapport, and actions that reduce retraumatization.

The application of compassionate care to survivors is well researched, but teaching compassionate care has been focused on providers [9], parents [10,11] and educational institutions [12]. While each of these is important, this paper seeks to bridge the gap between our understanding of the benefits of compassionate care and recognizing that this is a learned skill. This study will further compassionate teaching application to a demographic that has not yet been targeted for compassionate care skills training: military police.

Literature Review of Interpersonal Violence in Military Populations

IPV and MST are a significant and underrecognized reality for many military affiliates [13,14]. The Family Advocacy Program (FAP), an organization that focuses on prevention and intervention of familial abuse [15] notes that abuse is categorized into four typologies: physical abuse, emotional abuse, sexual abuse, and neglect [16]. It is typically considered a pattern rather than a one-off incident [17]. Reviewing data provided by FAP from 2015-2019, the United States Government Accountability Office reports that there were over 40,000 reports of IPV that "met criteria" across the Navy, the Army, the Marine Corps, and the Air Force; met criteria refers to a report that has been accepted as a legitimate claim of IPV as per the Department of Defense [18].
Given the prevalence of IPV, the likelihood of a survivor speaking with a member of military police is high; yet military police are rarely trained on how to connect with victims. Compassionate care is a learned skill [19]. Without knowing how to compassionately interview a survivor of IPV, the interviewer not only risks impeding additional disclosures, but also retraumatizing the interviewee. Retraumatization occurs when a person who has experienced a traumatic event has a lower threshold of vulnerability and may develop symptoms of that trauma a second time upon exposure to similar antecedent or environmental conditions [20].

Following an abusive incident in the military community, the first stop for the survivor is often to make a formal statement to military police. Depending on how the interview is conducted and whether the survivor feels heard, blamed, respected, or ignored, there is an increased risk for retraumatization [21]. With the potential cycle of retraumatization and risk of not being believed, survivors may be hesitant to report their experiences to the police. For survivors who make the initial report, approximately 65% prematurely cease an active role in the investigation (Wunsch et al., 2021).

Methods

This pilot study utilized a non-concurrent multiple baseline design (NMBD) across three active duty participants. Each of these participants completed up to eleven synchronous sessions over the course of four weeks with two additional weeks for a maintenance probe and a social validity survey; this timeline is demonstrated in Table 1. These six weeks were broken into six phases: initial interview, baseline data collection, didactic learning modules, post didactic probe, intervention, and a maintenance probe. An optional social validity survey was sent following the completion of the maintenance probe.

Table 1: General Timeline of Participation.

Week	Phase
Week 1	Initial interview and screening
Week 2	Baseline data collection followed by invitation to complete online didactic intervention learning modules
Week 3	Post didactic probe
Week 4	Intervention phase: feedback and roleplay
Week 5	Intervention phase
Week 6	Maintenance phase

One element of the intervention phase that made this experiment particularly unique was the inclusion of a role-play scenario to assess the participant's compassionate responses in real time. One of the researchers served as the actor for these role-plays, bringing a unique perspective from their extensive practical and research- based expertise in the field of IPV. The actor enacted multiple roles and scenarios, adhering to a loosely structured script that maintained consistency in the details relevant to the character being portrayed. These scenarios spanned all four categories of IPV as defined by the Family Advocacy Program [16].

Participants and Settings

Participants for this pilot study were all active-duty military

police currently employed in the United States Air Force (USAF). All individuals took part voluntarily and received no compensation. Each participant had an oral interview to gauge if they had had any type of compassionate care training in the past, personally or professionally. In order to protect their anonymity, participants will be referred to by pseudonyms: Victor, Amanda, and Leon. Victor was a 28-year-old Caucasian male with nine and a half years of experience in the field. Amanda was a 24-year-old Caucasian female with less than three years of experience. Leon was a 36-year-old Caucasian male with eighteen years of experience. All three participants were regularly expected to interview survivors of IPV as part of their duties, yet none had had formal training on compassionate care.

Baseline Data Collection

The first three to five interactions focused on collecting baseline data to determine the initial rate of compassionate responses. During these sessions, participants met via Zoom™ with an actor who presented as an individual wishing to report a domestic violence incident. These sessions were recorded and later coded to determine the baseline rate of compassionate care responses. No feedback or modeling was given during these initial sessions.

Didactic Learning Modules

Following the baseline, participants were invited to work through a series of modules designed to teach compassionate care skills using an online learning platform, Canvas™. These skills were accompanied by videos of two novel actors modeling compassionate interactions and were based on the criteria outlined in the 12-Item Schwartz Compassionate Care Scale [22]. Each module concluded with a 5 question quiz that required 100% to pass to the next module. Following the third quiz, participants were required to complete a 10 question final exam and earn 80% to continue on to the next phase. These probes were designed to measure the user's fluency in conceptual knowledge of compassionate care based on their didactic training.

Post Didactic Probe

Once participants completed the asynchronous, didactic instruction and modeling phase, they were invited to complete another synchronous, scenario based interview with the actor. The goal of this role-play scenario was to provide a comparison to the baseline data after the participant had completed the didactic learning modules.

Intervention

Following the post didactic probe, participants were offered feedback on their responses. This feedback was based on an initial review of the presence or absence of compassion based on the skills described above and provided an opportunity for guided rehearsal along with addressing specific performance deficits. In addition to the feedback, researchers regularly assessed each participant for any signs of personal distress, offering a gentle reminder that the actor is not actually in danger and that nothing that they said impacted the actor's current safety.

Maintenance Probe

The final synchronous session occurred two weeks after the last intervention scenario and did not include any feedback. The actor guided the participant through additional scenarios; as before, these described an IPV situation that the victim (actor) wanted to report. Sessions were recorded and reviewed for presence or absence of accurate compassionate responses.

Inter-rater Reliability

Inter-rater reliability data was collected on 37% of the videos taken across all participants in each of the four phases, and analyzed using Cohen's Kappa (K). Each researcher separately reviewed the recorded videos and determined the number of responses per interval that were categorized as a hit or a miss, an adaptation of signal detection theory (SDT) [23]. Results were then compared; all intervals that were mutually agreed upon as no opportunity were removed. The remaining categories were analyzed using K, which is a robust measure that accounts for agreement by chance. The K scale classifies agreement levels as follows: values below 0 indicate poor agreement, 0.00–0.20 slight, 0.21–0.40 fair, 0.41–0.60 moderate, 0.61–0.80 substantial, and 0.81–1.00 almost perfect agreement. Inter-rater reliability indicated substantial agreement across both coding tasks (hit and miss), with K values of .77 (Victor and Leon) and for .80 (Amanda), respectively. The latter approached the threshold for almost perfect agreement.

Social Validity

One of the most positive products of this study was the results of the social validity survey. Participants were sent an optional survey at the conclusion of the study and assured that the researcher would not review the results until all three had returned the survey or a month following the last session of the final participant, as to preserve the anonymity of the participants. The survey asked a variety of questions regarding the compassionate care learning experience and offered a Likert scale for responses with 5 being "strongly agree" and 1 being "strongly disagree". The results indicated that participants had an overall positive experience with the compassionate care learning modules; results can be found in table 2 of the end of this document.

Table 2: Survey Questions and Participant Responses.

Survey Question	Participant Response
The Compassionate Care learning experience improved how I empathize with victims at work	100% responded "strongly agree"
The Compassionate Care learning experience helped with improving my rapport/relationship with the victims I work with.	100% responded "strongly agree"
The Compassionate Care learning experience was easy to use/understand.	100% responded "strongly agree"
The Compassionate Care learning experience helped me grow my interpersonal skills.	100% responded "strongly agree"
The Compassionate Care learning experience made me feel more comfortable when interacting with victims	66.6% responded "strongly agree"
I enjoyed this training	100% responded "strongly agree"

Results

Victor, Amanda, and Leon all exhibited strengths and weaknesses at various stages of their compassionate training. A graph demonstrating these data points can be found in Figure 1 at the end of this document.

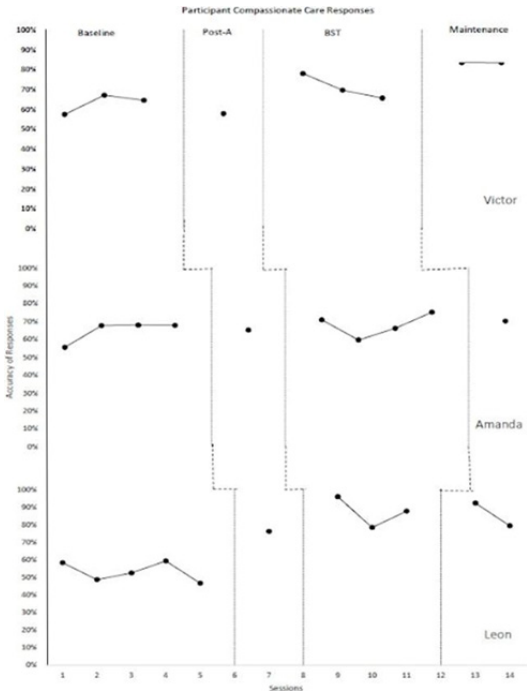

Figure 1: Compassionate Responses Across Participants.

Victor

Victor's performance is consistent with the anticipated results of this intervention. His stable baseline (57–64%) reflects moderate sensitivity to stimuli, albeit with consistent difficulty appropriately addressing the victim. The slight decline following asynchronous coursework (54%) suggests that didactic instruction alone is insufficient for practical application. In contrast, the introduction of the next stage of intervention (rehearsal and feedback) produced clear gains (70–78%), indicating increased accurate compassionate responses. This growth was further strengthened during maintenance (83%), suggesting durable and potential generalized improvement in clinical judgment. However, Victor continued to show persistent deficits in appropriately addressing the victim, indicating that additional trauma-informed response skills may require more targeted intervention in these areas.

Amanda

Amanda's response pattern reflects more variability and limited overall growth. Her baseline range (56–68%) indicates moderate but inconsistent sensitivity to stimuli, with deficits in appropriately addressing the victim; while many military members are encouraged to address others formally as sir or ma'am, this did not align with what was requested by the survivor in the interview. Similar to Victor, her limited improvement following asynchronous coursework (65%) indicates that didactic instruction alone did not respond to execution.

During the rehearsal and feedback phase, Amanda demonstrated variable performance (60–75%), with some improvement (highest score of 75%) but inconsistent growth overall. This suggests partial and unstable increases in sensitivity, rather than a clear recalibration of detection and response processes. Her continued strengths in attending and avoiding jargon, coupled with her consistent difficulty with appropriately addressing the victim and trigger warnings indicates that lower-level skills were acquired, but higher-order trauma-informed responses remained underdeveloped. The maintenance score (70%) further supports this interpretation, showing less retention of compassionate skills compared to her peers. Overall, this pattern suggests that while some intervention components produced improvement, Amanda probably requires additional practice to achieve stable changes.

Leon

Leon's performance shows evident improvement from low baseline levels to substantially higher levels following intervention. His baseline range (47–59%) reflects limited compassionate responses, with deficits in trigger warnings and appropriately addressing the victim. Unlike Amanda and Victor, Leon demonstrated a notable increase following asynchronous coursework (76%), suggesting that remediation plus instruction may enhance early cue recognition, though continued deficits in compassionate responses indicate persistent limitations. The most pronounced change occurred during the rehearsal and feedback phase (78–96%), where Leon's performance reached high levels of accuracy. This pattern reflects an increase in appropriate responses (hits), consistent with the intervention's mechanism of targeting real-time discrimination and response execution. The emergence of greater accuracy in skills such as maintaining focus and involving the victim in decision-making further suggests improved trauma-informed clinical judgment. However, the continued pattern of lower accuracy in trigger warnings and appropriately addressing the victim indicates that some trauma-informed responses remained less consistently executed. Overall, Leon's trajectory provides strong support for the intervention model, demonstrating that active rehearsal and feedback are critical for producing robust growth in compassionate responding.

Discussion

The goal of this study was to determine if compassionate care responses can be taught to military police. Two of the three participants showed considerable improvement in compassionate care responses, providing preliminary evidence for future applications. In alignment with single subject research design, each subject served as their own control. Interestingly, Victor's scores dropped from baseline following the didactic learning modules, but increased following the intervention. In comparison, Leon's compassionate care response rate increased from baseline to intervention phase and was maintained two weeks later. Amanda's scores decreased from baseline to post asynchronous role play. Her intervention scores were mostly higher than her baseline scores, although there was still one data point that decreased to baseline levels.

Findings and Limitations

The data from Victor, Amanda, and Leon, while a smaller sample size, have direct implications for training standards and

behavioral health protocols in military settings by demonstrating the impact of teaching compassionate care in producing meaningful changes in applied clinical performance.

First, the results from asynchronous, didactic instruction alone indicated that there was little to no improvement in compassionate responses. This suggests that policy should not rely on knowledge-based training alone. Second, the substantial improvements during rehearsal and feedback phases support establishing rehearsal with structured feedback as a core training standard. Finally, the limitations across participants in some compassionate care skills highlight the need for minimum competency thresholds within training protocols. Rather than treating compassionate care as a global skill, these protocols can specify observable behaviors that must reach proficiency. Adaptive training pathways should also be incorporated in which individuals who do not demonstrate improvement receive additional practice, remediation, or feedback.

Despite the rigor of the design for this study, the small sample size still serves as an important limitation. An increased number of participants would help address some of the outstanding issues seen in the participant data, namely the ceiling effects, regression to the mean, and potential Hawthorne (reactivity) effects. A larger population would allow for greater analysis of screening and training efficacy, although the authors maintain that the data from this experiment is sufficient for a pilot study.

Recommendations

The question begs, can compassionate care be taught? Based on the data, the researchers conclude *yes* - although with varying degrees of success. As with any other facet of life, there are competing contingencies that must be taken into consideration when teaching a new skill. Individuals who serve as military police often work long hours with significant variability in their daily duties. While only three members participated in this study to completion, the author both formally and informally interviewed many more. Throughout these discussions, each of these potential participants indicated that they simply did not have the time nor the energy to prioritize compassion in their day to day lives. It seems as though if we want kinder, more compassionate military police, there need to be systemic changes before this training can be maintained.

Conclusion

The importance of compassion cannot be overstated, especially when working with survivors of trauma. A lack of compassion can result in premature termination of participation in the investigation and amplify the risk for retraumatization. This study provides hope for the future training of compassionate care responses to military police. If compassionate care is considered to be behavior, then it can be taught. If an individual is in an environment where compassion is not reinforced, then training will not be maintained; this is irrespective of the level of compassion from the participants or the efforts of the trainer. Ultimately, what this study concluded is that while compassionate care can be taught, the environment must be structured to support maintenance.

This endeavor was undertaken not only to further our understanding of the teachability of compassionate care, but as a symbol of intention to continue serving survivors of IPV, MST, and other traumas. To have experienced such injustice is egregious enough; yet, to then have to relive that experience through the reporting process with someone who lacks compassionate responding can be re-traumatizing. Nothing will eliminate the trauma that these survivors have experienced, but anything that can be done to reduce the pain and offer support is a step in the right direction. Retraumatization can and should be mitigated at all costs and that starts with just a bit of compassion.

Data Availability and AI Usage

The authors confirm that the data supporting the findings of this study are available within the article [and/or] its supplementary materials. During the preparation of this work the authors used AI resources in order to improve language and readability. After using this tool, the authors reviewed and edited the content as needed and take full responsibility for the content of the publication.

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