

Law Enforcement Traumatic Stress: Clinical Syndromes and Intervention Strategies

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INTRODUCTION

Every time we dial 911, we expect that our emergency will be taken seriously and handled competently. The police will race to our burgled office, the firefighters will speedily douse our burning home, the ambulance crew will stabilize our injured loved one and whisk him or her to the nearest hospital. We take these expectations for granted because of the skill and dedication of the workers who serve the needs of law enforcement, emergency services, and public safety.

These "tough guys" (Miller, 1995) - the term includes both men and women - are routinely exposed to special kinds of traumatic events and daily pressures that require a certain adaptively defensive toughness of attitude, temperament, and training. Without this resolve, they couldn't do their jobs effectively. Sometimes, however, the stress is just too much, and the very toughness that facilitates smooth functioning in their daily duties now becomes an impediment to these helpers seeking help for themselves.

This article first describes the types of critical incidents and other stresses experienced by law enforcement personnel. Many of these challenges affect all personnel who work in public safety and the helping professions, including police officers, firefighters, paramedics, dispatchers, trauma doctors, emergency room nurses, and psychotherapists (Miller, 1995, 1997, 1998a, 1998b, 1999, in press); however, the focus here will be on the stressors most relevant to police officers, criminal investigators, and other law enforcement personnel. Secondly, this article will describe the critical interventions and psychotherapeutic strategies that have been found most practical and useful for helping cops in distress.

The target audience for this article is a dual one. This article is for law enforcement supervisors and administrators who want to understand how to provide the best possible psychological services to the men and women under their command. It is also for mental health clinicians who may be considering law enforcement consultation and therefore want some insight into the unique challenges and rewards of working with these personnel.

STRESS AND COPING IN LAW ENFORCEMENT

Police officers can be an insular group, and are often more reluctant to talk to outsiders or to show "weakness" in front of their own peers than are other emergency service and public safety workers. Officers typically work alone or with a single partner, as opposed to firefighters or paramedics, who are trained to have more of a team mentality (Blau, 1994; Cummings, 1996; Kirschman, 1997; Reese, 1987; Solomon, 1995). This presents some special challenges for clinicians attempting to identify and help those officers in distress.

The Patrol Cop

Even those civilians who have no great love for cops have to admit that theirs is a difficult, dangerous, and often thankless job. Police officers regularly deal with the most violent, impulsive, and predatory members of society, put their lives on the line, and confront cruelties and horrors that the rest of us view from the sanitized distance of our newspapers and TV screens. In addition to the daily grind, officers are frequently the target of criticism and complaints by citizens, the media, the judicial system, adversarial attorneys, social service personnel, and their own administrators and law enforcement agencies (Blau, 1994).

Police officers generally carry out their sworn duties and responsibilities with dedication and valor, but some stresses are too much to take, and every officer has his or her breaking point. For some, it may come in the form of a particular traumatic experience, such as a gruesome accident or homicide, a vicious crime against a child, a close personal brush with death, the death or serious injury of a partner, the shooting of a perpetrator or innocent civilian, or an especially grisly or large-scale crime; in some cases, the traumatic critical incident can precipitate the development of a full-scale posttraumatic stress disorder, or PTSD (Miller, 1994, 1998c). Symptoms may include numbed responsiveness, impaired memory alternating with intrusive, disturbing images of the incident, irritability, hypervigilance, impaired concentration, sleep disturbance, anxiety, depression, phobic avoidance, social withdrawal, and substance abuse.

For other officers, there may be no singular trauma, but the mental breakdown caps the cumulative weight of a number of more mundane stresses over the course of the officer's career. Most police officers deal with both the routine and exceptional stresses by using a variety of situationally adaptive coping and defense mechanisms, such as repression, displacement, isolation of feelings, humor—often seemingly callous or crass humor—and generally toughing it out. Officers develop a closed society, an insular "cop culture," centering around what many refer to as The Job. For a few, The Job becomes their life, and crowds out other activities and relationships (Blau, 1994).

In the United States, two-thirds of officers involved in shootings suffer moderate or severe problems and about 70 percent leave the force within seven years of the incident. Police are admitted to hospitals at significantly higher rates than the general population and rank third among occupations in premature death rates (Sewell et al, 1988). Interestingly, however, despite the popular notion of rampantly disturbed police marriages, there is no evidence for a disproportionately high divorce rate among officers (Borum & Philpot, 1993).

Perhaps the most tragic form of police casualty is suicide (Cummings, 1996; Hays, 1994; McCafferty et al, 1992; Seligman et al, 1994). Twice as many officers, about 300 annually, die by their own hand as are killed in the line of duty. In New York City, the suicide rate for police officers is more than double the rate for the general population. In fact, these totals may actually be even higher, since such deaths are sometimes underreported by fellow cops to avoid stigmatizing the deceased officers and to allow families to collect benefits. Most suicide victims are young patrol officers with no record of misconduct, and most shoot themselves off-duty. Often, problems involving alcohol or romantic crises are the catalyst, and easy access to a lethal weapon provides the ready means. Cops under stress are caught in the dilemma of risking confiscation of their guns or other career setbacks if they report distress or request help.

Special Assignments and Units

Aside from the daily stresses and hassles of patrol cops, special pressures are experienced by higher-ranking officers, such as homicide detectives, who are involved in the investigation of particularly brutal crimes, such as multiple murders or serial killings (Sewell, 1993). The protective social role of the police officer becomes even more pronounced, at the same time as their responsibilities as public servants who safeguard individual rights become compounded with the pressure to solve the case.

Moreover, the sheer magnitude and shock effect of many murder scenes, and the violence, mutilation, and sadistic brutality associated with many serial killings, especially if they involve children, often overwhelm the defense mechanisms and coping abilities of even the most seasoned officers. Revulsion may be tinged with rage, all the more so when fellow officers have been killed or injured. Finally, the cumulative effect of fatigue results in case errors, impaired work quality, and deterioration of home and workplace relationships. Fatigue also further wears down defenses, rendering the officer even more vulnerable to stress and impaired decision-making.

Dispatchers and Support Personnel

In addition to line-of-duty officers, a vital role in law enforcement is played by the workers who operate "behind the scenes," namely the dispatchers, complaint clerks, clerical staff, crime scene technicians, and other support personnel (Holt, 1989; Sewell & Crew, 1984). Although rarely exposed to direct danger (except where on-scene and behind-scene personnel alternate shifts), several high-stress features characterize the job descriptions of these workers. These include: (1) dealing with multiple, sometimes simultaneous, calls; (2) having to make time-pressured life-and-death decisions, (3) having little information about, and low control over, the emergency situation; (4) intense, confusing, and frequently hostile contact with frantic or outraged citizens; and (5) exclusion from the status and camaraderie typically shared by on-scene personnel who "get the credit."

After particularly difficult calls, dispatchers may show many of the classic posttraumatic reactions and symptoms, but they are often overlooked by police supervisors and consulting mental health clinicians alike. As with other tough jobs, these individuals deserve the proper treatment and support.

INTERVENTION SERVICES AND STRATEGIES

To avoid overly "shrinky" connotations, mental health intervention services with law enforcement personnel are often conceptualized in such terms as "stress management" or "critical incident debriefing" (Anderson et al, 1995; Belles & Norvell, 1990; Mitchell & Bray, 1990; Mitchell & Everly, 1996). In general, one-time, incident-specific interventions will be most appropriate for handling the effects of overwhelming trauma on otherwise normal, well-functioning personnel. Where posttraumatic sequelae persist, or where the psychological problems relate to a longer-term pattern of maladaptive functioning, more extensive individual psychotherapeutic approaches are called for. To have the greatest impact, intervention services should be part of an integrated program within the department, and have full administrative commitment and support (Blau, 1994; Sewell, 1986).

Critical Incident Stress Debriefing (CISD)

Although components of this approach comprise an important element of all therapeutic work with traumatized patients, critical incident stress debriefing, or CISD, has been organizationally formalized for law enforcement and emergency services by Jeff Mitchell and his colleagues (Mitchell, 1983, 1988, 1991; Mitchell & Bray, 1990; Mitchell & Everly, 1996), and the "Mitchell model" of CISD is now implemented in public safety departments throughout the United States, Britain, and other parts of the world (Davis, 1998/99; Dyregrov, 1989). CISD is a structured intervention designed to promote the emotional processing of traumatic events through the ventilation and normalization of reactions, as well as preparation for possible future experiences. CISD is an essential

technique associated with efficient and effective Critical Incident Stress Management (CISM).

According to the Mitchell model, following a critical incident, there are a number of criteria on which peer support and command staff might decide to provide a debriefing to personnel. These include: (1) many individuals within a group appear to be distressed after a call; (2) the signs of stress appear to be quite severe; (3) personnel demonstrate significant behavioral changes; (4) personnel make significant errors on calls occurring after the critical incident; (5) personnel request help; (6) the event is unusual or extraordinary.

The structure of a CISD usually consists of the presence of one or more mental health professionals and one or more peer debriefers, i.e. fellow police officers or emergency service workers who have been trained in the CISD process and who may have been through critical incidents and debriefings themselves. A typical debriefing takes place within 24-72 hours after the critical incident, and consists of a single group meeting that lasts approximately 2-3 hours, although shorter or longer meetings are determined by circumstances.

The formal CISD process consists of seven standard phases:

Introduction: The introduction phase of a debriefing is when the team leader introduces the CISD process and approach, encourages participation by the group, and sets the ground rules by which the debriefing will operate. Generally, these guidelines involve issues of confidentiality, attendance for the full duration of the group, however with nonforced participation in discussions (no "hot seat"), and the establishment of a supportive, noncritical atmosphere.

Fact Phase: During this phase, the group is asked to describe briefly their job or role during the incident and, from their own perspective, some facts regarding what happened. The basic question is: "What did you do?"

Thought Phase: The CISD leader asks the group members to discuss their first thoughts during the critical incident: "What went through your mind?"

Reaction Phase: This phase is designed to move the group participants from the predominantly cognitive level of intellectual processing into the emotional level of processing: "What was the worst part of the incident for you?"

Symptom Phase: This begins the movement back from the predominantly emotional processing level toward the cognitive processing level. Participants are asked to describe their physical, cognitive, emotional, and behavioral signs and symptoms of distress which appeared (1) at the scene or within 24 hours of the incident, (2) a few days after the incident, and (3) are still being experienced at the time of the debriefing: "What have you been experiencing since the incident?"

Education Phase: Information is exchanged about the nature of the stress response and the expected physiological and psychological reactions to critical incidents. This serves to normalize the stress and coping response, and provides a basis for questions and answers: "What can we learn from this experience?"

Re-entry Phase: This is a wrap-up, in which any additional questions or statements are addressed, referral for individual follow-ups are made, and general group solidarity and bonding are reinforced: "How can we help one another the next time something like this occurs?" "Was there anything that we left out?"

For a successful debriefing, timing and clinical appropriateness are important. The consensus from the literature and my own clinical experience support scheduling the debriefing toward the earlier end of the recommended 24-72 hour window (Bordow & Porritt, 1979; Solomon & Benbenishty, 1988). To keep the focus on the event itself and to reduce the potential for singling-out of individuals, some authorities recommend that there be a policy of mandatory referral of all involved personnel to a debriefing or other appropriate mental health intervention (Horn, 1991; McMains, 1991; Mitchell, 1991; Reese, 1991; Solomon, 1988, 1990, 1995). However, in other cases, mandatory or enforced CISD may lead to passive participation and resentment among the conscripted personnel (Bisson & Deahl, 1994; Flannery et al, 1991), and the CISD process may quickly become a boring routine if used indiscriminately after every incident, thereby diluting its effectiveness in those situations where it really could have helped. Departmental supervisor and mental health consultants must use their common sense and knowledge of their own personnel to make these kinds of judgement calls.

Special Applications of CISD for Law Enforcement

To encourage participation and reduce fear of stigmatization, the administrative policy should strongly and affirmatively state that debriefings and other postincident mental health and peer-support interventions are confidential. The only exceptions to confidentiality are a clear and present danger to self or others, or disclosure of a serious crime by the officer. Where only one officer is involved, as in a shooting, or as a follow-up or supplement to a formal group debriefing, individual debriefings may be conducted by a mental health clinician or trained peer (Solomon, 1995).

In an officer-involved shooting, when there is an ongoing or impending investigation, Solomon (1988, 1995) recommends that the group debriefing be postponed until the initial investigation has been completed and formal statements have been taken by investigators. Otherwise, debriefing participants may be regarded as witnesses who are subject to subpoena for questioning about what was said. For particularly sensitive or controversial situations or complicated internal affairs investigations, it may be advisable to postpone the group debriefing until the investigation has been officially resolved. Individual interventions can be provided for the primarily involved officer(s) in the meantime, and/or a group debriefing may proceed with other, nonprimarily involved

personnel who may have been affected by the incident, especially where the response team was multidisciplinary and multidepartmental (police, firefighters, paramedics, etc.).

Finally, as a follow-up measure, Solomon (1995) recommends holding a critical incident peer support seminar, in which the involved officers come together for two or three days in a retreat-like setting, several months postincident, to revisit and reflect upon their experience. The seminar is facilitated by mental health professionals and peer support officers.

Sewell (1993, 1994) has adapted a CISD-like stress management model to the particular needs of detectives who investigate multiple murders and other violent crimes. The major objectives of this process are: (1) ventilation of intense emotions; (2) exploration of symbolic meanings; (3) group support under catastrophic conditions; (4) initiation of the grief process within a supportive environment; (5) dismantling of the "fallacy of uniqueness;" (6) reassurance that intense emotions under catastrophic conditions are normal; (7) preparation for the continuation of the grief and stress process over the ensuing weeks and months; (8) preparing for the possible development of physical, cognitive, and emotional symptoms in the aftermath of a serious crisis; (9) education regarding normal and abnormal stress response syndromes; and (10) encouragement of continued group support and/or professional help.

Perhaps the most comprehensive adaptation of the CISD process comes from the work of Bohl (1995) who explicitly compares and contrasts the phases in her own program with the phases of the Mitchell model.

In Bohl's program, the debriefing takes place as soon after the critical incident as possible. A debriefing may involve a single officer within the first 24 hours, later followed by a second, with a group debriefing taking place within one week to encourage group cohesion and bonding. This addresses the occupationally lower team orientation of most police officers who may not express feelings easily, even or especially in a group of their fellow cops.

The Bohl model makes no real distinction between the cognitive and emotional phases of a debriefing. If an officer begins to express emotion during the fact or cognitive phase, there is little point in telling him or her to stifle it until later. To be fair, the Mitchell model certainly does allow for flexibility and common sense in structuring debriefings, and both formats recognize the importance of responding empathically to the specific needs expressed by the participants, rather than following a rigid set of rules.

In the emotion phase itself, what is important in the Bohl model is not the mere act of venting, but rather the opportunity to validate feelings. Bohl does not ask what the "worst thing" was, since she finds the typical response to be that "everything about it was the worst thing." However, it often comes as a revelation to these law enforcement "tough" guys that their peers have had similar feelings.

Still, some emotions may be difficult to validate. For example, guilt or remorse over actions or inactions may actually be appropriate, as when an officer's momentary hesitation or impulsive action resulted in someone getting hurt or killed. In the Bohl model, the question then becomes: "Okay, you feel guilty what are you going to do with that guilt?" That is, "What can be learned from the experience to prevent something like this from happening again?"

The Bohl model inserts an additional phase, termed the "unfinished business" phase, which has no formal counterpart in the Mitchell model. Participants are asked, "What in the present situation reminds you of past experiences? Do you want to talk about those other situations?" This phase grew out of Bohl's observation that the incident that prompted the current debriefing often acts as a catalyst for recalling past events. The questions give participants a chance to talk about incidents that may arouse strong, unresolved feelings. Bohl finds that such multilevel debriefings result in a greater sense of relief and closure than might occur by sticking solely to the present incident. In many cases, it has also been my own experience that feelings and reactions to past critical incidents will sometimes spontaneously come up during a debriefing about a more recent incident, and this must be dealt with and worked through as it arises, although team leaders must be careful not to lose too much of the structure and focus of the current debriefing.

The education phase in the Bohl model resembles its Mitchell model counterpart, in that participants are schooled about normal and pathological stress reactions, how to deal with coworkers and family members, and what to anticipate in the days and weeks ahead. Unlike the Mitchell model, the Bohl model does not ask whether anything positive, hopeful, or growth-promoting has arisen from the incident. Officers who have had to deal with senseless brutality might be forgiven for failing to perceive anything positive about the incident, and expecting them to extract some kind of "growth experience" from such an event may seem like a sick joke.

A final non-Mitchell phase of the debriefing in the Bohl model is the "round robin" in which each officer is invited to say whatever he or she wants. The statement can be addressed to anyone, but others cannot respond directly; this is supposed to give participants a feeling of safety. My own concern is that this may provide an opportunity for last-minute gratuitous sniping, which can quickly erode the supportive atmosphere that has been carefully crafted during the debriefing. Additionally, in practice, there doesn't seem to be anything particularly unique about this round robin phase to distinguish it from the standard re-entry phase of the Mitchell model. Finally, adding more and more "phases" to the debriefing process may serve to decrease the forthrightness and spontaneity of its implementation. Again, clinical judgement and common sense should guide the process.

LAW ENFORCEMENT PSYCHOTHERAPY

As noted above, police officers have a reputation for shunning mental health services, often perceiving its practitioners as "softies" and "bleeding hearts" who help criminals go free with over complicated psychobabble excuses. Other cops may fear being "shrunk," having a notion of the psychotherapy process as akin to brainwashing, a humiliating and emasculating experience in which they lie on a couch and sob about their dysfunctional childhoods. More commonly, the idea of needing "mental help" implies weakness, cowardice, and lack of ability to do the job. In the environment of many departments, some officers realistically fear censure, stigmatization, ridicule, thwarted career advancement, and alienation from colleagues if they are perceived as the type who "folds under pressure." Still others in the department who may have something to hide may fear a colleague "spilling his guts" to the shrink and thereby blowing the malfeasant's cover (Miller, 1995, 1998c).

Administrative Issues

There is some debate about whether psychological services, especially therapy-type services, should be provided by a psychologist within the department, even a clinician who is also an active or retired sworn officer, or whether such matters are best handled by outside therapists who are less involved in departmental politics and gossip (Blau, 1994; Silva, 1991).

On the one hand, the departmental clinician is likely to have more knowledge of, and experience with, the direct pressures faced by the personnel he or she serves; this is especially true if the psychologist is also an officer or has had formal law enforcement training or ride-along experience. On the other hand, in addition to providing psychotherapy services, the departmental psychologist is likely to also be involved in performing work status and fitness-for-duty evaluations, as well as other assessments or legal roles which may conflict with that of an objective helper. An outside clinician may have less direct experience with departmental policy and pressures, but may enjoy more therapeutic freedom of movement.

My own experience has been that officers who sincerely come for help are usually less interested in the therapist's extensive technical knowledge of The Job, and more concerned that he or she demonstrate a basic trust and a willingness to understand the officer's situation the cops will be more than happy to provide the grim details. These officers expect mental health professionals to "give 100 percent" in the psychotherapy process, just as the officers do in their own jobs; they really don't want us to be another cop, they want us to be a skilled therapist that's why they're talking to us in the first place.

Many cops are actually glad to find a secure haven away from the "fishbowl" atmosphere of the department and relieved that the therapeutic sessions provide a respite from shop talk. This is especially true where the referral problem has less to do with direct job-

related issues and more with outside pressures, such as family or alcohol problems, that may impinge on job performance. In any case, the therapist, the patient, and the department should be clear at the outset about the issues relating to confidentiality and chain of command, and any changes in ground rules should be clarified as needed.

Trust and the Therapeutic Relationship

Difficulty with trust appears to be an occupational hazard for workers in law enforcement and public safety who typically maintain a strong sense of self-sufficiency and insistence on solving their own problems. Therapists may therefore frequently find themselves "tested," especially at the beginning of the treatment process. As the therapeutic alliance begins to solidify, the officer will begin to feel more at ease with the therapist and may actually find comfort and sense of stability from the psychotherapy sessions. Silva (1991) has outlined the following requirements for establishing therapeutic mutual trust:

Accurate Empathy: The therapist conveys his or her understanding of the officer's background and experience (but beware of premature false familiarity and phony "bonding").

Genuineness: The therapist is as spontaneous, tactful, flexible, and nondefensive as possible.

Availability: The therapist is accessible and available (within reason) when needed, and avoids making promises and commitments he or she can't realistically keep.

Respect: This is both gracious and firm, and acknowledges the officer's sense of autonomy, control, and responsibility within the therapeutic relationship. Respect is manifested by the therapist's general attitude, as well as by certain specific actions, such as signifying regard for rank or job role by initially using formal departmental titles, such as "officer," "detective," "lieutenant," until trust and mutual respect allow an easing of formality. Here it is important for clinicians to avoid the dual traps of overfamiliarity, patronizing, and talking down to the officer on the one hand, and trying to "play cop" or force bogus camaraderie by assuming the role of a colleague or commander.

Concreteness: Therapy should, at least initially be goal-oriented and have a problem-solving focus. Police officers are into action and results, and to the extent that it is clinically realistic, the therapeutic approach should emphasize active, problem-solving approaches before tackling more sensitive and complex psychological issues.

Therapeutic Strategies and Techniques

Since most law enforcement and emergency services personnel come under psychotherapeutic care in the context of some form of posttraumatic stress reaction, both clinical experience and literature (Blau, 1994; Cummings, 1996; Fullerton et al, 1992; Kirschman, 1997) reflect this emphasis. In general, the effectiveness of any intervention technique will be determined by the timeliness, tone, style, and intent of the intervention. Effective interventions share in common the elements of briefness, focus on specific symptomatology or conflict issues, and direct operational efforts to resolve the conflict or to reach a satisfactory conclusion.

In working with police officers, Blau (1994) recommends that the first meeting between the therapist and the officer establish a safe and comfortable working atmosphere by the therapist's articulating : (1) a positive endorsement of the officer's decision to seek help; (2) a clear description of the therapist's responsibilities and limitations with respect to confidentiality and privilege; and (3) an invitation to state the officer's concerns.

A straightforward, goal-directed, problem-solving therapeutic intervention approach includes the following elements: (1) creating a sanctuary; (2) focusing on critical areas of concern; (3) specifying desired outcomes; (4) reviewing assets; (5) developing a general plan; (6) identifying practical initial implementations; (7) reviewing self-efficacy; and (8) setting appointments for review, reassurance, and further implementation (Blau, 1994).

Blau (1994) delineates a number of effective individual intervention strategies for police officers, including the following:

Attentive Listening: This includes good eye contact, appropriate body language, and genuine interest, without inappropriate comment or interruption. Clinicians will recognize this intervention as "active listening."

Being There With Empathy: This therapeutic attitude conveys availability, concern, and awareness of the turbulent emotions being experienced by the traumatized officer. It is also helpful to let the officer know what he or she is likely to experience in the days and weeks ahead.

Reassurance: In acute stress situations, this should take the form of realistically reassuring the officer that routine matters will be taken care of, deferred responsibilities will be handled by others, and that the officer has administrative and command support.

Supportive Counseling: This includes effective listening, restatement of content, clarification of feelings, and reassurance, as well as community referral and networking with liaison agencies, when necessary.

Interpretive Counseling: This type of intervention should be used when the officer's emotional reaction is significantly greater than the circumstances that the critical incident seem to warrant. In appropriate cases, this therapeutic strategy can stimulate the officer to

explore underlying emotional stresses that intensify a naturally stressful traumatic event. In a few cases, this may lead to ongoing psychotherapy.

Not to be neglected is the use of humor, which has its place in many forms of psychotherapy, but may be especially useful in working with law enforcement and emergency services personnel. In general, if the therapist and patient can share a laugh, this may lead to the sharing of more intimate feelings. Humor serves to bring a sense of balance, perspective, and clarity to a world that seems to have been warped and polluted by malevolence and horror. Humor—even sarcastic, gross, or callous humor, if handled appropriately and used constructively—may allow the venting of anger, frustration, resentment, or sadness, and thereby lead to productive, reintegrative therapeutic work (Fullerton et al, 1992; Miller, 1994; Silva, 1991).

Departmental Support

Even in the absence of formal psychotherapeutic intervention, following a department-wide critical incident, such as a line-of-duty death or a particularly stressful rescue or arrest, the mental health professional can advise and guide law enforcement departments in encouraging and implementing several organizational response measures, based on the available literature on individual and group coping strategies for public safety personnel (Alexander, 1993; Alexander & Walker, 1994; Alexander & Wells, 1991; DeAngelis, 1995; Fullerton et al, 1992; Palmer, 1983). Many of these measures are applicable proactively as part of training before a critical incident occurs. Some specific measures include the following:

- (1) Encourage mutual support among peers and supervisors. The former typically happens anyway; the latter may need some explicit reinforcement. Police officers frequently work as partners and understand that shared decision-making and mutual reassurance can enhance effective job performance.
- (2) Utilize humor as a coping mechanism to facilitate emotional insulation and group bonding. The first forestalls excessive identification with victims, the second encourages mutual group support via a shared language. Of course, the mental health clinician needs to monitor the line between adaptive humor and unproductive gratuitous nastiness that only serves to entrench cynicism and despair.
- (3) Make use of appropriate rituals to give meaning and dignity to an otherwise existentially disorienting experience. This includes not only religious rites related to mourning, but such respectful protocols as a military-style honor guard to attend bodies before disposition, and the formal acknowledgment of actions above and beyond the call of duty. Important here is the role of "grief leadership," in which the commanding officer demonstrates by example that it's okay to express grief and mourn the death of fallen comrades or civilians and that the dignified expression of one's feelings about the incident will be supported, not denigrated.

CONCLUSION

Psychotherapy with law enforcement and emergency services personnel entails its share of frustration as well as satisfaction. A certain flexibility is called for in adapting traditional psychotherapeutic models and techniques for use with this group and clinical work frequently requires both firm professional grounding and "seat-of-the-pants" maneuverability. Incomplete closures and partial successes are to be expected, but in a few instances, the impact of successful intervention can have profound effects on morale and job effectiveness that may be felt department-wide. Working with these "tough guys" takes skill, dedication, and sometimes a strong stomach, but for mental health clinicians who are not afraid to tough it out themselves, this can be a fascinating and rewarding area of clinical practice.

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