

Officer-Involved Shooting: Reaction Patterns, Response Protocols, and Psychological Intervention Strategies

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Abstract: *Psychologists who work with law enforcement agencies may be called upon to respond to an officer-involved shooting (OIS). These need not be the most traumatic critical incidents in policing, but when they are, the reasons usually involve a mix of incident characteristics, officer response styles, and departmental handling. This article describes some of the psychological reactions experienced by officers during and following an OIS and provides a model of administrative, legal, mental health, and peer support services for officers in need. Finally, the article discusses several key roles that the police psychologist can play in the process of managing an OIS. [International Journal of Emergency Mental Health, 2006, 8(4), pp. 239-254].*

Key words: *officer-involved shooting, post-shooting stress, critical incident stress, crisis intervention, police psychology*

The gun. Among all public safety and emergency service workers, the unique and ultimate symbol of the law enforcement officer is the gun. No other nonmilitary service group is mandated to carry a lethal firearm as part of their daily equipment, nor charged with the responsibility of using their own discretion and judgment in making split-second decisions to use deadly force in the line of duty. Although watching any typical TV cop show might convince the viewer that most officers regularly fire off multiple rounds without a second thought, in reality the firing of one's weapon in the line of duty is a profound event that almost always leaves a psychological trace and, in some cases, may be traumatic enough to end a career in law enforcement.

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Cop And Guns: Facts And Stats

Available data indicate that about 600 criminals are killed each year by police officers in the United States. Some of these killings are in self-defense, some are accidental, and others are to prevent harm to others. By comparison, last year, 152 officers were killed in the line of duty (Mitchell & Levenson, 2006). In most cases, taking a life occurs in the context of trying to save a life. The sources of stress attached to an *officer-involved shooting* (OIS) are multiple, and include the officer's own psychological reaction to taking a life, the responses of law enforcement peers and the officer's family, rigorous examination by departmental investigators and administrators, possible disciplinary action or change of assignment, possible criminal and civil court action, and unwanted attention - sometimes outright harassment - by the media (Baruth, 1986; Bohrer, 2005; Cloherty, 2004; Henry, 2004; Miller, 1995, 1999b, 2000, 2003b, 2005a, 2006, in press-a, in press-c; Perrou & Farrell, 2004; Regehr & Bober, 2005; Russell & Beigel, 1990).

In most jurisdictions, the legal test for justification of legitimate use of lethal force by police officers requires that any reasonable person with the training and experience of the involved officer would have perceived a threat to life in the actions taken by the suspect (Blau, 1986, 1994; Blum, 2000). Line-of-duty deadly force actions are most likely to occur in the following situations, in descending order of probability: (1) domestic or other disturbance calls; (2) robbery in progress; (3) burglary in progress; (4) traffic offense; (5) personal dispute and/or accident; and (5) stake-out and drug busts (Blau, 1994; Russell & Biegel, 1990).

Of American police officers who kill a suspect in the line of duty, 70% leave law enforcement within five years (Horn, 1991). According to McMains (1986a; 1991), by the early 1980s, an estimated 95% of police officers involved in a line-of-duty shooting had left police work within five years. By the mid-1980s, large departments had cut that rate to 3%, while smaller departments were still losing about two-thirds of officers involved in a shooting. More recent surveys have showed that less than 15% of officers sampled showed significant post-shooting distress and even fewer left law enforcement as a direct result of the incident (Honig & Roland, 1998; Honig & Sultan, 2004), and some authorities believe the psychological disability rate from OISs, and from critical incidents in general, has been overestimated (Curran, 2003). One important difference may relate to the level of administrative and mental health support provided to officers by the larger departments (either because of broader philosophies or broader budgets), giving their officers the clear message that helping them resolve their psychological trauma and maintain their mental health is a departmental priority. Accordingly, this has left a greater role for police psychologists to make a fundamental contribution to officer health and safety.

Perceptual, Cognitive, And Behavioral Disturbances

Most officers who have been involved in a deadly force shooting episode have described one or more alterations in perception, thinking, and behavior that occurred during the event (Artwohl, 2002; Honig & Roland, 1998; Honig & Sultan, 2004; Solomon & Horn, 1986; Wittrup, 1986). Most of these can be interpreted as natural adaptive defensive reactions of an organism under extreme emergency stress.

Most common are *distortions in time perception*. In the majority of these cases, officers recall the shooting event as occurring in slow motion, although a smaller percentage report experiencing the event as speeded up.

Sensory distortions are common and most commonly involve *tunnel vision*, in which the officer is sharply focused on one particular aspect of the visual field, typically, the suspect's gun or weapon, while blocking out everything in the periphery. Similarly, *tunnel hearing* may occur, in which the officer's auditory attention is focused exclusively on a particular set of sounds, most commonly the suspect's voice, while background sounds are excluded. Sounds may also seem muffled or, in a smaller number of cases, louder than normal. Officers have reported not hearing their own or other officers' gunshots. In a few cases, officers have reported hearing "the bad guy's blood drip" (James Sewell, personal communication). Overall perceptual clarity may increase or diminish.

Some form of *perceptual and/or behavioral dissociation* may occur during the critical event. In extreme cases, officers describe feeling as though they were standing outside or hovering above the scene, observing it "like it was happening to someone else." In milder cases, the officer may report that he or she "just went on automatic," performing whatever actions were necessary with a sense of robotic detachment. Some officers report intrusive distracting thoughts during the scene, often involving loved ones or other personal matters, but it is not known if these substantially affected the officers' actions during the event.

A *sense of helplessness* may occur during the shooting episode, but this may be underreported due to the potential stigma attached (Honig & Sultan, 2004). A very small proportion of officers report that they "froze" at some point during the event: either this is an uncommon response or officers are understandably reluctant to report it. In a series of interviews, Artwohl (2002) found that most of these instances of "freezing" really represented the normal *action-reaction gap* in which officers make the decision to shoot only after the suspect has engaged in clearly threatening behavior. In most cases, this brief evaluation interval is a positive precaution, to prevent the premature shooting of a harmless citizen. But in situations where the ostensibly prudent action led to a tragic outcome, this cautious hesitation may well be viewed retrospectively as a fault: "If I hadn't waited to see him draw, maybe my partner would still be alive."

Disturbances in memory are commonly reported in shooting cases. About half of these involve impaired recall for at least some of the events during the shooting scene; the other half involve impaired recall for at least part of the officer's own actions. This, in turn, may be associated with the "going-on-automatic" response. More rarely, some aspects of the scene may be recalled with unusually clarity – a *flashbulb memory*. More than a third of cases involve not so much a loss of recall as a distortion of memory, to the extent that the officer's account of what happened differs markedly from the report of other observers at the scene. In general, it is common for officers not to remember the number of rounds they fired, especially from a semiautomatic handgun.

A few cases I've interviewed could be described as "*tunnel memory*," that is, some part of the scene is recalled especially vividly, while others are fuzzy or distorted. As with research on eyewitness memory in general (Loftus, Greene, & Doyle, 1989), one's subjective vividness of recall is often uncorrelated with the accuracy of the material recalled. An administrative implication is that discrepant accounts among eyewitnesses to a shooting scene should not be automatically interpreted as one or more persons lying or consciously distorting his or her report (Artwohl, 2002), but may well represent honest differences of perception and recall.

A general neuropsychological explanation for these constrictions of sensation, perception, and memory is that the brain naturally tries to tone down the hyperarousal that occurs during a critical shooting incident, so that the individual can function through the experience using his or her "mental autopilot" responses. In a smaller number of cases, the officer experiences heightened perceptual awareness of those features of the scene that are essential for his survival. Similarly, in emergencies the processing of accurate memories for later use seems to take a neuropsychological back seat to the mechanisms necessary for getting the subject through the situation alive, right here and now (Miller, 1990). The implications for training are that a greater depth, range, and flexibility of attention and arousal control will allow officers to use such automatic responding adaptively in a wider range of extreme situations (Miller, 2006).

Reactions of Fellow Officers

The etiology of post-shooting reactions often lies in the emotional disconnect between an officer's expectations of a heroic, armed confrontation and the reality of most shooting

scenarios, which typically involve petty criminals, mentally disordered suspects, domestic hostage-barricade situations, or accidents (Geller, 1982; Miller, 2005b, in press-b; Kennedy, Homant & Hupp, 1998; Mohandie & Meloy, 2000; Perrou & Farrell, 2004; Russell & Biegel, 1990).

Post-Shooting Reaction Typologies

Although the reaction to an OIS will necessarily be influenced by the individual personality and experience of the officer (Miller, 2003a; Twersky-Glasner, 2005), certain common factors seem to underlie different types of reaction.

Several analyses (Anderson, Swenson, & Clay, 1995; Blau, 1994; Blum, 2000; Nielsen, 1991) have suggested a tripartite typology of post-shooting reactions, which parallels the three types of reaction noted to occur in the wake of traumatically stressful events in general (Bowman, 1997). These, of course, should be thought of as a continuum rather than discrete categories. In addition to individual officer characteristics, the severity of a post-shooting reaction will be determined by a host of situational factors, such as the nature of the shooting itself, the post-incident investigation, reactions of supervisors, peers, and family, and so on. Each of these reaction types also has its own therapeutic implications for helping officers in distress.

The first type of reaction involves a *transitory period of post-incident psychological distress*, which the officer is able to resolve within a few weeks, largely by self-coping efforts, such as talking with colleagues and family, praying and reflecting, and reexamining and renewing life priorities and goals. The psychological distress does not appear to substantially affect the officer's daily functioning. Peer counseling, a critical incident stress debriefing (Miller, 1999a; Mitchell & Everly, 1996), and perhaps one or two visits with a mental health professional, clergyperson, or peer support person is usually the extent of any intervention required.

The second type of reaction is a somewhat more intense, *intermediate response*, with posttraumatic symptoms persisting for several weeks or months. The officer's daily functioning may be impaired, often with a "good days/bad days" pattern. In addition to peer support and group debriefings, short-term crisis counseling with a psychologist over several weeks may be indicated to help the officer work through the traumatic elements of the shooting (Blau, 1994; Miller, 1998, 2000; Wester & Lyubelsky, 2005), as well as to provide support through any contentious administrative pro-

cesses that may follow the incident (Bohrer, 2005; Cloherty, 2004; Miller, in press-a).

The third type of reaction is characterized by *severe psychological disability*, what officers often describe as a “mental breakdown.” Here, the shooting incident has so traumatized the officer that he is unable to function. In most cases this kind of severe reaction occurs in the context of some degree of vulnerability in the premorbid personality of the officer, often exacerbated by a particularly adversarial investigation and perceived lack of support from colleagues, the department, family, and/or the community (Miller, 2003a, in press-a). Treatment will necessarily involve more long-term psychotherapy, perhaps with medication. Although some of these officers will ultimately leave police work, many of these careers may be salvaged by timely and appropriate psychological intervention.

Post-Shooting Reaction Phases

Some authorities (Nielsen, 1991; Williams, 1999) have divided the post-shooting reaction into several basic phases or stages, starting with an *immediate reaction* or *impact phase*. For officers who have just shot a suspect during a dangerous confrontation, there may be an initial reaction of relief and even exhilaration at having survived the encounter.

Later, feelings of guilt or self-recrimination may surface, especially where the decision to shoot was less than clear-cut or where the suspect’s actions essentially forced the hand of the officer into using deadly force, such as in botched robberies, domestic disputes, or suicide-by-cop (Kennedy et al, 1998; Lindsay & Dickson, 2004; Mohandie & Meloy, 2000; Perrou & Farrell, 2004; Pinizzotto, Davis, & Miller, 2005). Or the officer may simply be confronting the fact that, however justified his response, he has nevertheless taken a human life. During this *recoil* or *remorse phase*, the officer may seem detached and preoccupied, spacily going through the motions of his job duties, and operating on behavioral autopilot. He may be sensitive and prickly to even well-meaning probing and congratulations by his peers (“How close was the shooter?” or “Way to go, Bobby – you got the guy”), and especially to accusatory-like interrogation and second-guessing from official investigators or the press: “Officer Jackson, did you really believe you were in fear for your life from a confused teenager?”

As the officer begins to come to terms with the shooting episode, a *resolution* or *acceptance phase* may ensue, wherein

he or she assimilates the fact that the use-of-force-action was necessary and justified in this particular instance of the battle for survival that often characterizes law enforcement deadly encounters. This resolution process may be complicated by continuing departmental investigations or by impending or ongoing civil litigation. In addition, even under the best of circumstances, resolution may be partial rather than total, and psychological remnants of the experience may continue to haunt the officer periodically, especially during future times of crisis. But overall, he is eventually able to return to work with a reasonable sense of confidence.

In the worst case, sufficient resolution may never occur, and the officer enters into a prolonged *posttraumatic phase*, which may effectively end his or her law enforcement career. In less severe cases, a period of temporary stress disability allows the officer to seek treatment, to eventually regain his or her emotional and professional bearings, and ultimately to return to the job. Still other officers return to work right away, but continue to perform marginally until their actions are brought to the attention of superiors (Miller, 2004).

In my experience, many officers who have been traumatized by their own deadly use of force can be effectively returned to work with the proper psychological intervention and departmental support (Miller, 2006). Indeed, this type of support – or stronger forms of encouragement – from the upper brass is typically what prompts the referral for mental health counseling in the first place.

Types of Post-Shooting Symptoms and Reactions

Again, the officer’s individual personality and experience will influence the type of post-shooting reaction he or she experiences, but certain commonalities emerge from different reports (Anderson et al, 1995; Blum, 2000; Cohen, 1980; Geller, 1982; Honig & Sultan, 2004; Russell & Beigel, 1990; Williams, 1999). Some of these will represent general post-traumatic reactions familiar to psychological trauma workers (Gilliland & James, 1993; Greenstone & Leviton, 2001; Miller, 1998; Regehr & Bober, 2005), while others will have a specific law enforcement line-of-duty shooting focus.

Physical symptoms may include headaches, stomach upset, nausea, weakness and fatigue, muscle tension and twitches, and changes in appetite and sexual functioning. Sleep is typically impaired, with frequent awakenings and often nightmares. Typical posttraumatic reactions of intrusive imagery and flashbacks may occur, along with premoni-

tions, distorted memories, and feelings of déjà vu. Some degree of anxiety and depression is common, often accompanied by panic attacks. There may be unnatural and disorienting feelings of helplessness, fearfulness, and vulnerability, along with self-second-guessing and guilt feelings. Substance abuse may be a risk.

There may be a pervasive irritability and low frustration tolerance, along with anger and resentment toward the suspect, the department, unsupportive peers and family, or civilians in general. Part of this may be a reaction to the conscious or unconscious sense of vulnerability that the officer experiences after a shooting incident. Sometimes this is projected outward as a smoldering irritability that makes the officer's every interaction a grating source of stress and conflict. All this, combined with an increased hypervigilance and hypersensitivity to threats of all kinds, may result in overaggressive policing, leading to abuse-of-force complaints (Miller, 2004, 2006).

Ultimately, this may spiral into a vicious cycle of angry and fearful isolation and withdrawal by the officer, spurring further alienation from potential sources of help and support. At the same time, some officers become overly protective of their families, generating an alternating *control-alienation syndrome* (McMains, 1986b, 1991), which is disturbing and disorienting to the family. All this, combined with emotional lability ("I just get mad or cry at the drop of a hat") and cognitive symptoms of impaired concentration and memory, may lead the officer to fear that he or she is going crazy.

Incident-Specific Factors Influencing the Post-Shooting Reaction

Apart from the universal reactions and individual personality and history of the officer, certain features of the line-of-duty shooting incident itself can affect the severity, persistence, and impact of post-shooting symptoms and reactions (Allen, 2004; Anderson et al, 1995; Blau, 1986; Bohrer, 2005; Honig & Sultan, 2004; McMains, 1986b).

One obvious factor is the degree of threat to the officer's life. This can operate in two ways. First, the officer who feels that he or she was literally about to die may be traumatized by the extreme fear involved, but may feel quite justified and relatively guilt-free in using deadly force on a clearly murderous suspect. But where the danger was more equivocal, there will be less of the fear factor and more second-guessing about what degree of force was actually necessary. Police

officers pride themselves in their ability to manage a tense situation and perform under pressure, so they may feel overwhelmed by doubt and self-recrimination where the situation abruptly got out of control and turned deadly.

Related factors include the amount of preparation and warning that existed prior to the shooting and the length of time the dangerous incident persisted, which also may have varying effects. On the one hand, officers caught off guard are unlikely to have even a brief interval to think through their decision to shoot and may later perceive themselves, or be perceived by others, as having reacted out of fear, no matter how justified the shooting is later judged to be. On the other hand, where the shooting follows a prolonged stand-off, with a lot of back-and-forth negotiating and maneuvering, as in hostage-barricade or suicide-by-cop scenarios, the extended period of time the officer spent agonizing over the decision to use deadly force may later take a deleterious psychological toll.

All of the above factors relate to two important dimensions: the amount of *control* the officer feels he or she had over the situation and degree of *conflict* that exists over the necessity to take a human life. Generally, the less control and the more conflict the officer has experienced during the event, the more severe will be the psychological reaction (Miller, 1998, 2006).

The officer's reaction to the shooting may also be related to the characteristics of the suspect. At one extreme is the armed bank robber who, having been duly warned and ordered to surrender, brazenly draws down on the officer or puts a gun to a hostage. In such a case, there is likely to be universal agreement that the officer had no choice – indeed, was duty-bound – to fire on the perpetrator in order to save innocent lives. At the other extreme is the obnoxiously inebriated high school punk who is pulled over for a traffic violation, exchanges a few sharp words with the officer, and is shot for refusing to drop an object in his hand that turns out to be a cell phone. A similar example is the schizophrenic homeless person who has heretofore been known only as a noisy neighborhood pest, but now is psychotically waving around a hammer or a kitchen knife and is shot while lunging at the officer.

A common reaction is anger at the suspect himself for forcing the officer to take a life, even if it is the suspect's own life. Inasmuch as anger and guilt are often intertwined, greater anger may be shown toward a relatively more "innocent"

suspect whose stupid behavior resulted in a totally unnecessary shooting – e.g., the psychotic street person or the kid with the big mouth – than at a suspect who more clearly “deserves” to get shot – e.g., the armed robber fleeing a bank who fires at the officer first. Much of this anger may smolder below the surface and emerge as general irritability, problems with authority, and family conflicts (Miller, 2004, in press-c).

Degree of control and conflict extend into the post-shooting phase as well. The amount and kind of attention the officer receives from his administration, peers, the community, and the media will influence his own reaction to the event (Blau, 1994; Bohrer, 2005; Henry, 2004; Klein, 1991; Russell & Biegel, 1990; Rynearson, 1988, 1994; Rynearson & McCreery, 1993; Sewell, 1986; Sprang & McNeil, 1995). Supervisors and administrators are understandably concerned about the public relations aspect of a shooting and, although most are generally supportive of their personnel, their effort to appear objective and unbiased to the public may at times make it seem that they’re coming down too hard on the officer.

The reactions of the officer’s peers may help or harm his attempts to cope with the situation. As noted above, at first he may receive accolades from his fellow officers for “finishing the job.” Because of the powerful identification factor, peers may want to hear all about the event, because someday they may be there too and they want to believe that, in the breach, they will do the right thing. Many of these peers also hope that the officer’s guts to pull the trigger will rub off on them should they encounter a similar situation. However, if the officer fails to regale them with an uplifting narrative of struggle and triumph, and instead reveals the conflict, doubt, and pain he is going through, the contagion effect may cause his fellow officers to avoid him.

The implied psychological contract of such post-crisis mutual congratulatory rituals seems to involve a kind of blanket immunity against what Solomon and Horn (1986) call the *mark of Cain* and Henry (2004) describes as the *death taint*: “You have made real for us the life-and-death situation we all fear. So you’d better show us how nobly and heroically you’re dealing with this, throw us a positive spin, or all you’ve done is shove our mortality in our faces, which freaks us out, and then to protect ourselves, we’ll will shun you or degrade you.” This probably accounts for the creepily uncomfortable backslapping attaboys that are so commonly inflicted on the officer by his colleagues after a shooting. Unfortunately, these reactions may only serve to heighten the officer’s

anxiety about what he would really do “next time.”

Even if they won’t admit it to their brother officers, many officers feel genuinely sad at having had to take a human life, even if they objectively recognize that they had no choice in the situation and that the perpetrator clearly asked for it. Human nature being what it is, police officers and others, such as soldiers, who are trained to kill when necessary, cannot just shed their familial, religious, and cultural upbringing when they don the uniform. An officer may thus become irritated at his colleagues who want him to play the happy warrior, while they have no clue as to the turmoil he is going through. But the officer is hurting and still needs all the support he can get so, fearing rejection, he may not want to burst his colleagues’ bubble. He thus feels compelled to put up a brave facade so as not to alienate this well-meaning, if lunkheaded, source of support from his peers. Painful as putting up this false front may be, it’s still better than total isolation (Miller, 2006).

On-Scene Response

All of the factors noted above have important implications for productive departmental management and helpful clinical intervention of OISs at every stage of the event, from incident response to follow-up resolution. By far, the most common complaint voiced by these officers concerns their treatment by their own departments, from the first post-incident moments onward. Even in uncontestedly “righteous” shootings, officers often feel demeaned and treated like guilty suspects, setting up a vicious cycle of suspicion and recrimination.

The corollary prescription is that every officer who has risked his life should be treated with basic courtesy and respect. Even if there is suspicion of misconduct, there is nothing to be gained from an adversarial attitude – indeed, an officer who is treated decently will be more inclined to cooperate with investigators (Miller, 2004). Thus, the proper handling of involved officers begins at the shooting scene itself.

On-Scene Law Enforcement Response

In many departments, an OIS results in the call-out of many departmental personnel, including other officers, the involved officer’s supervisors, the chief of police in some smaller jurisdictions, paramedics, and typically the depart-

ment psychologist, if there is one. I present here a composite model protocol for on-scene response to officer-involved shootings culled and amalgamated from a variety of sources (Baruth, 1986; Blau, 1994; IACP, 2004; McMains, 1986a, 1986b, 1991; Williams, 1991). This model can be adapted and modified to the needs of the individual police agency. How this protocol is carried out in practice can make a tremendous difference in the later psychological adjustment of the involved officers and in department-wide morale.

In the policy-and-procedure planning stages, it should be decided which personnel respond to what types of critical incidents, including shootings. As noted above, responders may include back-up officers, administrative officials, departmental investigators, peer support staff, mental health professionals, departmental attorney, media spokesperson, police chief or division captain, and others. At the time of the shooting, all designated personnel should respond to the scene.

Reassurance to the involved officer should be provided by departmental authorities. Reassurance, in this context, doesn't have to (and at this early stage, probably shouldn't) entail any positive or negative judgment about the officer's actions, but should simply communicate an understanding and appreciation of what the officer has just been through, and the assurance that the department will support him or her as much as possible throughout the process. As noted above, one of the biggest complaints officers have about the post-shooting departmental response is the feeling that "I'm being treated like a criminal by my own people." Especially at this psychologically sensitive stage, the officer should be given the benefit of the doubt and treated with respect by departmental authorities.

The officer should be provided on-scene access to legal counsel and to a mental health professional. In many jurisdictions officers may refrain from making any statement to authorities at the scene until an attorney is present and/or until they have been assessed by a qualified mental health professional as mentally fit to make a statement. This protects the officer's rights and at the same time makes it difficult to later challenge any on-scene statements on the basis of their having been made under mental duress.

The officer's weapon will almost always be impounded. This is a fairly standard on-scene policy, but the way it is carried out will make a big difference in how the officer adjusts to the post-shooting aftermath. In the worst case, the officer is unceremoniously stripped of his sidearm in full view

of his colleagues, and in some cases in front of jeering bystanders, and is forced to parade around with an empty holster – the epitome of emasculatory humiliation. In the best case, the weapon is turned over in private, and in many instances a replacement weapon is provided or the empty holster removed while the on-scene investigation proceeds.

At some shooting scenes, personnel remain at the site for hours. This may be necessary for purposes of the investigation and to deal with community members and the media, but no one should hang around the scene longer than necessary and everything possible should be done to discourage the development of a carnival atmosphere. In particular, it is recommended that the officer be removed from the scene as quickly as possible. Again, this should be done in a private and respectful way, perhaps the officer being driven home or back to the station by a supervisor or a pair of colleagues, to await further action. They should accompany him to his door and leave only when he has assured them he is okay.

Of course, when necessary, the officer should be provided with medical care, either at the scene or at a local hospital. The officer's family should be notified of the shooting in person as soon as possible, even if everybody is still on-scene: the last thing you want is for the family to hear about the shooting on the radio or TV, or get a call from neighbor who's seen or heard the story. If the family is out of town, every effort should be made to contact them, preferably through direct contact by a law enforcement agency in that location.

If media arrive at the scene, the officer should be shielded from them and any statements should be made through a departmental spokesperson. Most medium-to-large departments have a Public Information Officer who is part of the critical incident response team; in smaller agencies, the Sheriff or Chief may have to be the front person. In general, any statement that could affect the internal investigation or other legal action should be avoided. Agencies should consult with their departmental attorneys about local and state regulations as part of the process of developing their own OIS policies.

On-Scene Psychological Intervention

Encouragingly, at least one study has found that 100% of large departments and 69% of small departments provide professional support for traumatized officers (McMains, 1986a; 1986b). As part of the on-scene response team, the

police psychologist has a specific but important role to play (McMains, 1991; McMains & Mullins, 1996).

First, the nature of the incident must be determined. When the call-out psychologist gets the call, he or she should try to find out as much as possible about the incident and the current scene as possible. This may vary, depending on the timing of the call. Sometimes, the call may come within minutes of the shooting incident, in which case there is not much information to be had, other than the location of the scene. Other times, the psychologist may be called almost as an afterthought, hours after the rest of the responders have arrived, only because someone has suggested that the psychologist be contacted due to unforeseen complications at the scene. This kind of snafu usually reflects a problem with the call-out policy at the planning stages or it may occur in a very dangerous or complex scene where other services, such as medical or biotox decontamination, may take precedence. As a rule, however, if there is a call-out psychologist, he or she should be summoned to the scene as soon as possible.

When the psychologist arrives at the scene, the involved officer should be identified and his mental status determined. This may range from extremes of panic, confusion, and disorientation – rare, in my experience – to unnatural calmness and stoic denial (“I’m okay; no problem”) – a far more common response. Frequently, emotions will swing at the scene, the officer blank and icy one moment, then nervous and shaky the next. As discussed below, validating these reactions as normal stress responses is an important part of on-scene intervention.

A comfortable place should be found to conduct the interview with the officer. “On-scene” doesn’t necessarily mean standing over a body or pacing back and forth in front of the news cameras. I’ve conducted on-scene interviews behind bushes, under trees, behind a throng of officers or a row of vehicles, in the back seat of patrol cars, and in a SWAT wagon. As long as the officer stays inside the established perimeter and can be found by authorities when needed, he or she is still technically on-scene.

For the visibly upset officer, calming and distraction techniques may be utilized to bring his mental state into a more rational and receptive mode. For the defensive, sealed-over officer, what I often find helpful is a one-on-one version of the critical incident stress management procedure known as *defusing*, which follows a basic tripartite structure (Miller, 1999a; Mitchell & Everly, 1996):

First, the officer should be asked what happened. This will typically elicit a stiff, dry, detail-laden rendition of events, as if the officer were testifying before a review board or in court:

Officer: I saw the guy coming out the dark breezeway, carrying a box or something bulky like that, hugging the wall like he was trying to hide. I identified myself as a police officer and told him to stop, put the box down slowly, and face the wall. He dropped the box and put his hand in his pocket. I drew my weapon and ordered him to freeze. He pulled out something metal, which I took to be a blade or a firearm. He was standing under one of the breezeway lights and I remember seeing a yellow glint off the object. I drew down on him in a modified Weaver stance and ordered him to drop the object. He raised it higher and started coming towards me. In fear for my life, I fired, I think, three or four times. He fell and was quiet, and the object skidded several feet away into the grass. I radioed for backup and attempted to administer aid, but I think he was already dead. I located the object and found that it was a small, silvery semiauto with a taped grip.

Listening to the story will give a good sense of the sequence of events. Next, the officer should be asked to describe “what was going on in your mind while it was happening.” This often elicits clues to the officer’s cognitive and emotional state:

Officer: The guy and me kind of surprised each other. I guess neither of us expected the other one to be on the campus that time of night, so we both sort of jumped when we saw each other. I could feel the adrenalin jack up my body. I don’t think I really had time to be nervous, I just kind of went on automatic and the whole thing had a kind of unreal aspect to it, you know what I mean? – like it was me doing it, but it wasn’t me. After I found the gun and called on the radio, that’s when it hit me I could’ve been killed. Then, shit, suddenly I’m shaking like a little girl; it was embarrassing. But I pulled it together before the other guys got there.

Finally, the officer should be provided with information and support regarding any disturbing reactions that he may be having at the scene. It should be remembered that the goal of on-scene psychological intervention is not to conduct psychotherapy: that may or may not come later. Rather, the immediate goal is to allow the officer to loosen up just enough to be able to assess his mental status, but be able to use temporary mental strengthening techniques (Miller, 2006)

to help him “keep it together” until the immediate crisis is resolved:

Psychologist: Hey, man, you’re just following the textbook. Any time somebody’s in an emergency or crisis mode, nature puts the nervous system on autopilot so we can concentrate on what we need to do to get the job done and live through the experience. It’s like the adrenaline acts like mental Novocain to numb you out just enough to survive and let your survival instinct and training kick in. Then, after this “Novocain” wears off, you feel all the emotions as a delayed reaction. So, from what you’ve told me, there’s nothing unusual about your response. It’s not my ultimate judgment call to make, but from how you described it, it sounds like you did what you had to do.

As noted above, one reason for an accurate assessment of the officer’s mental status at the scene is for the determination of mental fitness to make a statement to authorities, which may be very important for subsequent legal aspects of the case. Although in my experience this is rare, some officers may be sufficiently confused, disoriented, emotionally vulnerable, and cognitively suggestible to be legally incompetent to understand their legal rights and/or to make a statement to authorities at the scene – a kind of “temporary insanity” caused by extreme traumatic stress. In such cases, the psychologist may recommend that investigators wait until the officer has had a chance to recover some measure of psychological equilibrium, which may require only a few minutes to calm down or some basic reassuring intervention at the scene, or, in the extreme case, may necessitate removal to a safe facility for further evaluation and treatment.

Psychologists who make the recommendation to postpone the on-scene investigation can expect flak from investigators who want to get on with the process, as well as sometimes from the on-scene departmental attorney, although the latter will typically support any recommendation that will prevent unnecessary self-incrimination of the officer. A related issue is confidentiality. Technically, anything said in confidence to a licensed mental health clinician is protected by doctor-patient confidentiality. But this is not as strong as attorney-client privilege, and, in extremely politically sensitive cases, psychologists’ records and/or testimony may be subpoenaed if one side or the other is being particularly aggressive in pressing their case. In such circumstances, it is important to remember that, from a psychological point of view, the exact details of what happened in the incident are less important than the officer’s psychological reaction, and

that psychologist’s job as an on-scene mental health professional is not necessarily to record all the minutiae of the officer’s recollection or judge the merits of his actions, but to assess how the incident is affecting his mental status at the scene.

Following my on-scene evaluation and while still at the site, I will usually make a recommendation for at least one follow-up evaluation at my office, scheduled several days post-incident. This gives the officer a few days to calm down and loosen up, and allows me to get a better perspective on how he or she is coping psychologically after the initial shock of the incident has worn off. This also serves as an informal fitness-for-duty (FFD) evaluation in a nonconfrontational setting; additionally, such an FFD evaluation may be formally mandated by some departments as a precondition to the officer returning to work (Rostow & Davis, 2004). At follow-up, if the officer is assessed to be experiencing no unusual signs or symptoms (some degree of residual distress is normal for a few days or weeks), release to full duty is usually recommended. Otherwise, a range of recommendations may be made, such as additional time off with or without subsequent follow-up psychotherapy. Again, police psychologists should always consult with their departments regarding protocols for such incidents – ideally, they should be involved in developing those protocols.

Psychological Management of Officer-Involved Shootings

Following the original shooting incident and the follow-up session, some officers may request additional sessions with the psychologist “to get my head straight about this.” In other cases, a supervisor may recommend this or may order it. In still other cases, there may not have been any on-scene intervention at all, and the follow-up consultation is the first contact between the officer and the psychologist. As with any critical incident, it is important that each department have in place a system for smooth and nonstigmatized referral of officers for mental health counseling when they need it (Miller, 2006).

Principles and Guidelines of Post-Shooting Intervention

A number of authors (Horn, 1991; McMains, 1986a, 1991; Wittrup, 1986; Zeling, 1986) have developed a set of recommendations for implementing psychological services follow-

ing an OIS. These have been summarized and adapted here. The reader will note that most of these are, in fact, specialized and individualized applications of the general principles of law enforcement critical incident intervention (Miller, 1998, 1999a, 2000, 2006).

The intervention should begin as soon after the shooting incident as possible, indeed, as noted above, on-scene. In some cases, an officer's obvious distress at the scene or shortly thereafter creates the need for an immediate intervention. In other cases, distress may be suppressed or concealed for hours, days, or weeks, so intervention must await the time that problems in coping become apparent. In such cases, intervention should not be rushed, but should be started as quickly as possible when the need surfaces. In any event, a departmental policy should be developed that gives priority to these referrals so that, at a minimum, an officer can be seen within 24 hours of a request.

McMains (1986a, 1991) believes that the intervention should occur as close to the time of the shooting as possible in order to minimize the sensitization to any possible trauma. This, of course, is the essence of on-scene intervention. However, I believe that clinical judgment should prevail on a case-by-case basis, and that in some cases, as just noted above, the best thing that can be done is to remove the officer from the scene to prevent heightened sensitization and continual retraumatization. This is especially true where the officer's on-scene distress clearly continues to grow with each passing minute spent at the site.

Nevertheless, to provide for the most efficient and effective use of time and resources, subsequent intervention should be undertaken at a location that the officer finds safe and nonthreatening, usually an office away from the department. Depending on the officer's shift schedule, a regular time should be established for the sessions.

Intervention should be short-term and focused on supporting officers through the crisis, as well as returning them to active duty as soon as possible. The range of issues to be covered will be determined on a case-by-case basis, depending on how the incident has affected the officer, his family, colleagues, and others. But the general guideline is that post-shooting psychological intervention should be focused on resolving the critical incident in question.

Clinically, the psychologist should remember that his or her role in these treatment settings is as therapist and supportive advocate, not investigator or judge. What the psy-

chologist is advocating for is the officer's mental health and stability, not any particular side of the case. Accordingly, a realistically positive atmosphere should prevail during the course of the intervention. Absent clear evidence to the contrary, the assumption should be that the officer acted properly, can successfully manage the current crisis with a little help, and will soon return to active status. Indeed, during particularly contentious investigations, the psychologist's office may be the only place the officer does not feel like a hounded criminal.

Administratively, confidentiality should be respected and protected by the department, and the only information from psychological counseling available to outside authorities should be the psychologist's written summaries of case status, fitness-for-duty, and other administratively-relevant data. Indeed, to have any credible program of psychological services, officers must feel secure that, except insofar as they relate to a specific departmental referral question, personally sensitive information, thoughts, and feelings do not leave the psychologist's office (Miller, 1995, 1999b, 2000, 2003b, 2006).

Even if the department strives to scrupulously respect doctor-patient confidentiality, others may not be so accommodating. For example, relatives of shooting victims who bring civil rights violation charges against the officer or file lawsuits against the department or municipality may try to subpoena psychological records or testimony to use in their case. Accordingly, Wittrup (1986) recommends that police psychologists receive from the jurisdiction a formal, written *statement of referral*, along with a *save from prosecution and/or civil litigation* document, so that they are relatively insulated from such assaults on confidentiality. Again, psychologists should be aware of the laws, rules, and regulations of their respective localities.

Post-Shooting Psychotherapeutic Strategies

On initial contact with the officer, the psychologist's role may replicate the basic intervention stages of a critical incident stress debriefing model (Bohl, 1995; Miller, 1999a, 2000; Mitchell & Everly, 1996), applied, in this case, on an individual level.

First, the facts of the case should be reviewed with the officer. Similar to the fact phase of a debriefing, this allows for a relatively nonemotional narrative of the traumatic event. But in the case of an OIS, it serves a further function. Pre-

cisely because of the cognitive and perceptual distortions that commonly occur in these kinds of incidents, what may be particularly disturbing to the officer is the lack of clarity in his own mind as to the actual nature and sequence of events. Just being able to review what is known about the facts of the case in a relatively safe and nonadversarial environment may provide a needed dose of mental clarity and sanity to the situation. In fact, Solomon (1991, 1995) describes one such format for this process as going over the incident “frame by frame,” allowing the officer to verbalize the moment-to-moment thoughts, perceptions, sensory details, feelings, and actions that occurred during the critical incident. This format helps the officer become aware of, sort out, and understand what happened.

Next, the officer’s thoughts and feelings about the shooting incident should be reviewed. This resembles the thought and reaction phases of a debriefing, but may not be as cut-and-dried as with a typical group debriefing. It should be remembered that an OIS represents a special kind of critical incident and it may take more than one attempt for the officer to productively untangle and reveal what’s going on in his mind. He should be given extra time or extra sessions to express his thoughts and feelings, and his reaction should be monitored so as not to encourage unproductive spewing or loss of control. One of the most important things the psychologist can do at this stage is to help modulate emotional expression so that it comes as a relief, not as an added burden.

The officer should be provided with authoritative and factual information about psychological reactions to a shooting incident. The kinds of cognitive and perceptual distortions that take place during an OIS, the posttraumatic symptoms and disturbances, and the sometimes offputting and distressing reactions of colleagues and family members, are likely to be quite alien to the officer’s ordinary experience, and might be interpreted by him or her as signs of going soft or crazy. The clinician should attempt to normalize these responses for the officer, taking a somewhat more personal and individualistic approach than might be found in the typical group debriefing’s information-education phase. Often, just this kind of authoritative reassurance from a credible mental health professional can mitigate the officer’s anxiety considerably.

Finally, follow-up services, which may include additional individual sessions, family therapy, referral to support services, possible medication referral, and so on, should be pro-

vided for the officer. As with most cases of critical incident psychological intervention, follow-up psychotherapy for OISs tends to be short-term, although additional services may be sought later for other problems partially related or unrelated to the incident. Indeed, any kind critical incident may often be the stimulus to explore other troublesome aspects of an officer’s life and the success in resolving the incident with the psychologist may give the officer confidence to pursue these other issues in an atmosphere of trust (Blau, 1994; Miller, 1998, 2006).

Peer Support Programs

To augment or supplement professional mental health services, an increasing number of police departments have instituted *peer support programs* for the psychological aftermath of OISs and other critical incidents.

Rationale of Peer Support

Some general assumptions underlie the use of peers as counselors (Klein, 1991; Levenson & Dwyer, 2003; McMains, 1991). First, it is assumed that fellow police officers will have more credibility than mental health professionals because the former have “been there” and “know the job.” There may well be legitimate situations where an officer may feel more comfortable with a fellow officer; however, in my experience (Miller, 2006), this has not been an issue, and I have not yet had an officer refuse to see me (that I know of), or hold back on self-disclosure (as far as I can discern), because I’m not a sworn officer. In fact, the opposite seems to be true. Many officers have commented that they are relieved to talk to someone outside the departmental fishbowl and outside of law enforcement generally. They already know, or think they know, the predictable response they’re going to get from their brass and colleagues, and they’re looking for a fresh perspective. Additionally, talking to a nonofficer removes the “competition factor” – that is, no matter how sympathetic a fellow officer may be, the officer in crisis may still fear appearing weak or ineffectual before one of his own by revealing too much about his reactions to the critical incident.

I’ve gotten some feedback from colleagues who are both licensed mental health professionals and sworn active or retired officers, and even they have experienced a reluctance of officers to open up because the officer-therapist “is still a cop at heart.” Other officers have commented that officer-therapists sometimes take a presumptive attitude that “be-

cause I am/was an officer, I know what you're going through," even before letting the officer in crisis fully express himself. Remember, an officer after an OIS is often in a prickly hypersensitive state of "no-you-*don't*-friggin-know-what-I'm-going-through," and may resent even well-meaning expressions of commiseration by peers. In such cases, a civilian psychologist may actually be a more sympathetic and receptive audience because he or she doesn't pretend to know it all and humbly understands that there is something to learn from the officer's experience.

On the other hand, some officers may simply be too creeped-out by the thought of seeing a "real shrink" to avail themselves of formal psychological services. Or they may have had unpleasant experiences with mental health professionals in the past, either within or outside the context of their law enforcement careers (Max, 2000). Many officers just feel more comfortable talking with fellow cops. In particular, some of the old-timers, who began their careers before the modern therapy-culture era, may be more used to the command structure model of discussing problems with a senior officer. And, just because I personally have experienced little difficulty with officers' willingness to see me, I'll never know how many officers silently declined to make the call because they felt that I just wouldn't understand where they're coming from, or were just too put off by the prospect of seeing a mental health practitioner of any kind. Still another consideration concerns the demographics of the law enforcement community I serve, which may be somewhat more receptive to mental health services than police departments in other parts of the country.

For these reasons, I do encourage the development of law enforcement peer support programs, not because professional psychologists are necessarily less effective at helping cops, but because there will be times when another cop is the best resource, or at least the best initial point of contact, for an officer in distress. In fact, a fair number of referrals to my office have come from officers who know me and have encouraged other, more skittish cops to "at least give the guy a shot." One further advantage of using officer peers as counselors relates to basic bullshit-detection. In a few cases, some officers, especially if they are under investigation for a suspicious shooting, may actually prefer talking to a civilian psychologist precisely because they feel they can do a snow job on the unsuspecting softie. This kind of dissimulation may be less successful with a fellow officer peer-counselor who knows the ropes.

Another assumption of peer counseling is that police officers don't usually require extensive mental health services because they are a select sample of professionals, at least somewhat more mentally stable than the general population by virtue of their initial screening and training (Klein, 1991; McMains, 1991; Miller, 2003a, 2004). Critical incident stress responses, including those resulting from officer-involved shootings, are seen as normal reactions to an abnormal situation by relatively normal people, and the goal of peer counseling is to restore officers' original psychological equilibrium, not make fundamental changes in their personalities. This, of course, is consistent with the whole philosophy of critical incident intervention (Blau, 1994; Bohl, 1995; Miller, 1998, 1999a, 2000, Mitchell & Everly, 1996).

Structure of Peer Support Programs

Peer counseling teams almost always consist of volunteers who have a good performance history with the department, and who have gone through some form of formal training and certification program, which includes a basic understanding of psychological stress syndromes; basic crisis intervention and counseling skills; understanding special problems encountered with officer-involved shootings and other critical incidents; and knowing when and how to refer for professional mental health services when necessary. In this regard, departments that institute peer counseling programs should be sure to make professional psychological backup help available if further treatment is indicated.

Always important is the issue of confidentiality. Officers may fear unwarranted disclosure, especially with counselors who are peers and not licensed professionals. This issue cannot be overemphasized because the success of a peer support program will stand or fall based on the confidence officers have in the peer counselors' discretion and competence. Again, this fear of the fishbowl and rumor mill is one of the reasons officers may actually prefer to talk to an outside clinician. More practically, what happens if the peer-counseled officer admits that he was intoxicated during the shooting, or expresses a clear racist bias that may have contributed to his decision to use deadly force? What does the peer counselor do then? These issues must be carefully worked out in advance for a peer counselor system to work.

The basic elements of peer counseling are not very different from professional clinical intervention in relatively noncomplex cases, and include active listening skills; allowing the officer to ventilate and tell his story in a supportive,

nonjudgmental atmosphere; provision of reassurance and accurate information about stress syndromes; recommendation of strategies for handling symptoms and dealing with other people during the investigation and recovery process; and referral for professional mental health services, if necessary (Blau, 1994; Klein, 1991).

Model Post-Shooting Intervention Programs

Elsewhere (Miller, 2006), I have reviewed in detail several post-shooting intervention programs from around the country (Antonovsky & Bernstein, 1986; Milgram & Hobfoll, 1986; Solomon & Mastin, 1999; Somodevilla, 1986) that illustrate the basic elements of peer support and professional intervention for OISs. Here I will summarize the key elements that such successful programs share in common. This model can be used as a template by police psychologists and the law enforcement agencies they serve to design, modify, or adapt their own post-shooting programs and protocols to the needs of their individual agencies.

Reasonable respect and compassion: “We hear what you’re going through”.

Departmental reassurance and validation: “We may not have all the facts yet, but the leadership is behind you.”

Information flow: “Within the limits of departmental policies and procedures, we’ll do everything we can to keep you in the loop.”

Removal from the scene: “Let’s go sit in my patrol unit and go over what happened.”

Replacement firearm: “Here’s a temporary issue till the investigation is complete.”

Access to an attorney: “The departmental attorney is on her way to the scene. For later on, here’s how to contact your PBA rep.

Family welfare: “We’re going to call your family and let them know you’re all right, and that you may have to stay past your shift till we’re finished here.”

Shooting folder: “This is a private file, separate from your regular jacket, kept by the Captain, so we can accurately collate the facts relevant to this case and communicate only with those on a need-to-know basis.”

Handling media: “Our departmental spokesperson will be running interference for you during this process and we appreciate your cooperation in honoring our policy of not

making any unauthorized statements to the media.”

Administrative leave: “Please understand that this is not a disciplinary suspension, but that this kind of administrative leave is part of our departmental policy, both for your own welfare and to give us time to complete our investigation.”

Psychological services: “Please feel free to access our departmental psychologist or any other qualified mental health professional you choose. This is not a requirement or a fitness-for-duty exam, but is for your own well-being and is confidential.”

Peer support: “Would you like to talk to Tony? He’s a fellow officer who’s been through some critical incidents himself; he knows the drill.”

Support from the wider law enforcement community and concerned citizens: “Hey, we’re getting calls from the deputies over in the next county asking how you’re doing. And some of the church members on the block where you took down that crack house have written a nice letter of commendation to the Chief.

Reinforcement of professional competence: “We’re not pulling you totally out of service, officer. If you’re up to it we still need your help, so for now you’re reassigned to communications.”

Opportunity to learn and grow: “We’re gonna make some good out of this by learning how to keep our officers safer.”

Overall, successful post-shooting programs share the important common elements of: (1) flexible access to peer counselors and/or mental health professionals; (2) maintenance of an attitude of respect for involved officers, backed up by appropriate actions; and (3) unequivocal support and encouragement of the peer support program from top levels of the department or agency.

CONCLUSIONS

Officer-involved shootings (OISs) need not be the most traumatic critical incidents in policing, but when they are, the reasons are usually due to a mix of incident characteristics, officer response styles, and departmental handling. By providing immediate administrative, legal, psychological, and peer support services to officers in need, investigators typically find their jobs easier. Even in the unfortunate case of a “rogue cop” being found to have negligently or deliberately

used excessive force, how a department deals with its worst will be watched very carefully by officers who want to infer what will happen to the rest among them if they ever have to fire their weapon in order to discharge their duty to protect. In the entire process of managing an OIS, police psychologists have a vital and indispensable role to play.

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