

POLICE USE OF FORCE: THE ESSENTIALS OF OFFICER AFTERCARE

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Officers with prior histories of involvement in job-related traumatic situations, such as justifiable shootings, represented a second group of officers who were profiled for being at risk for excessive force, but for totally different reasons from the first group. These officers were not unsocialized, egocentric, or violent. In fact, personality factors appeared to have less to do with their vulnerability to excessive force than the emotional baggage they had accumulated from involvement in prior incidents. Because of their need to keep symptoms hidden, it was sometime before they came to anyone's attention. When they did, it was often because of an excessive force situation in which they "lost it."

Dr. Ellen Scrivner
*The Role of Police Psychology in
Controlling Excessive Force*
National Institute of Justice, 1994

Introduction

Police officers are no longer regarded as invincible and impervious to the ravages of traumatic events. This fact was never more real than in the aftermath of the terrorist attacks of September 11, 2001. The world watched in horror as the twin towers collapsed entombing thousands of innocent people along with the police and firefighters who had rushed into harm's way to rescue them. These selfless acts of bravery witnessed by a stunned nation were not a new phenomenon but in the aftermath of that horrific day, these unsung heroes captured the hearts of Americans even if for only a brief moment. Not surprisingly, the public's interest in the effects of traumatic exposure has waxed and waned throughout history. It seems to peak immediately following mass catastrophes like the attacks of September 11th and most recently with the tsunami disaster in Asia and East Africa. Nonetheless, for the thousands of law enforcement officers who risk their lives every day, traumatic exposure is a very real part of their jobs. More than ever, the increase in violence in our society echoes throughout the law enforcement community. Unlike combat veterans, who are often compared to the police, the traumatic experiences suffered by police officers are encountered day after day over a period of twenty-plus years.

Law enforcement, the media, and the public often foster the myth that police officers can handle any crisis without being affected. While the profession demands emotional stamina and resilience, shootings and other critical incidents can be traumatic even to the

most well adjusted officers. No one, no matter how healthy, well trained, or well adjusted, is immune to the normal reactions following a critical incident. Repeated, cumulative exposure to victims of violence, natural and man-made disasters, and the threat of personal assaults and death places police officers at risk for developing stress related problems that can affect them personally and professionally.

Each officer represents an investment of thousands of dollars. The effects of stress and traumatic exposure exact a high toll in lost dollars and inferior services rendered to the department and the community. The cost of worker's compensation, absenteeism, permanent disability, or replacing officers due to psychiatric retirement can be staggering. Moreover, agencies are exposed to civil liability that could exceed millions of dollars when the "use of force" by officers is adjudicated to be excessive. It is essential that police executives provide prevention and early intervention strategies to ensure that their officers have the proper tools to cope with the stress of police-involved shootings and other "use of force" encounters.

Terms & Definitions

The police officer is unique, unfortunately unique in the whole criminal justice system in that he alone really has to confront the worst manifestations of human behavior as they are actually happening and as they are actually unfolding.

Dr. George Kirkham
1974

Although the focus of this chapter is "police use of force," it would not be practical to omit the role of all critical incidents in policing because "use of force" incidents take place against the backdrop of the police experience as a whole. Moreover, it has been found that pre-incident stressors often play a part in post-incident adjustment.

Critical incident (Traumatic event): *An event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; and the person's response involved intense fear, helplessness, or horror (American Psychiatric Association, 1993).*

Examples of traumatic events or critical incidents in policing include, but are not limited to, the following:

- Police-involved shootings
- Death or injury of a fellow officer
- Serious injury or death of a child
- Gruesome homicides
- Natural, accidental, and man-made disasters
- Failed or prolonged rescues
- Viewing and handling decomposing bodies
- Police officer suicide
- Automobile accidents resulting in serious injuries or death
- Performance of duty injuries that are serious/life-threatening

Posttraumatic stress/critical incident stress: The reactions caused by exposure to an event or events that are of such intensity that a person's normal coping patterns are disrupted. Traumatic events often shatter one's assumptions about life's predictability and one's control over it. A traumatic stress response is a *normal* reaction to an abnormal event and involves the person's thoughts, and emotions. Moreover, the person's autonomic nervous system activates the brain's production of chemicals that also affect behavior (Kirschman, 1994).

Reactions to critical incidents can last anywhere from a few hours to several weeks after the event and may include any of the following symptoms (Bohl, 1995; Kirschman, 1994; Kates, 1999; Honig & Sultan, 2004; Gersons, 1989; Bonifacio, 1991):

Emotional Signs

- Impatience, irritability, anger, aggression
- Recurrent thoughts about the event
- Depression, anxiety, guilt
- Thoughts of suicide
- Emotional numbing
- Under-reacting or over-reacting
- Feeling hopeless and/or powerless
- Feeling vulnerable

Physical Signs

- Headaches, indigestion, tightness in the chest
- Hypervigilance, easily startled
- Dizziness, trembling, excessive sweating
- Sleep problems, nightmares, loss of appetite, diarrhea
- Fatigue, muscle aches, hypertension

Behavioral Signs

- Tearfulness, angry or violent behavior
- Avoidant behavior, withdrawing from friends and family
- Increased use of alcohol, tobacco, food, or medication
- Increase in risk-taking behavior, recklessness
- Changes in work habits
- Engaging in other self-soothing behaviors like gambling, promiscuity, credit card abuse

Cognitive Signs

- *Problems with memory, focus, and concentration*
- *Forgetfulness, trouble with decision-making*
- *Confusion and disorientation*
- *Disruptions in logical thinking*

Posttraumatic Stress Disorder (PTSD) is a diagnosable disorder brought on by exposure to severe, usually life-threatening events and causes considerable disruptions in thoughts, feelings, and behaviors and lasts for more than a month. Only a professional can make a diagnosis of posttraumatic stress disorder. Factors that can predispose a person to PTSD are: absence of a support system, the inability to talk about distressing events, past unresolved traumas, a poor sense of self, the need to feel invulnerable, and poor coping skills.

Police Use of Deadly Force

I didn't want to talk to anyone about my shooting. I refused to go to debriefing despite being ordered by the Department. I tried not to think about it. Looking back on it now, I guess I felt ashamed for having to kill this young man and angry because he gave me no choice. But, when I returned to work, I was different. I reacted more quickly. I was more paranoid and distrustful. There were certain behaviors that I would no longer tolerate. I would catch myself becoming enraged---something that never happened before my shooting. I would no longer discuss with a citizen "why" I was writing a ticket. I found myself fighting back when I was assaulted versus getting them down and in handcuffs. My fiancé and I split up after being together for three years. (Officer K after his second shooting).

Influenced primarily by contemporary media, there is a misperception by the public that police-involved shootings are a routine part of police work. In reality, however, they comprise a very small part of the police experience. Nonetheless, when an officer uses his/her weapon in the line of duty, the scrutiny devoted to the shooting is significant. In the weeks and months that follow, the criminal justice system and the department will decide if the officer's "split-second" decision to shoot was justified.

Historically, police departments have not allocated their limited funds to researching the emotional impact on officers who use deadly force. Hence, there exists a paucity of empirical data regarding the police post-shooting adjustment. However, several surveys and valuable clinical data have been collected in the past two decades by police and trauma psychologists who have worked directly with officers. The results of two large studies conducted by Honig and Roland, and Honig and Sultan of the Los Angeles County Sheriff's Department are of particular interest. The studies were conducted in 2004 with 982 subjects and 1998 with 348 subjects. (The 348 subjects in the first study were included in the 982 subjects of the second study.) Over 90% of the approximately 430 critical incidents studied were officer-involved shootings. The subjects were evaluated by the authors within three to five days of the incident and prior to participation in the Department's mandatory debriefing. The study was voluntary and confidential and yielded 100% participation. The post-shooting reactions reported by 30-50 percent of the respondents within three to five days after the incident include: increased startle response, nightmares, sleep disturbances, flashbacks, intrusive recollections, and increased feelings of anger and rage, a sense of vulnerability and/or heightened sense of danger, and fear about future situations, concentration problems, and physical distress after the shooting

(Honig and Sultan, 2004). Not surprisingly, the authors elucidated “fear and vulnerability” as key factors in post-incident adjustment. The results of their post-shooting interventions will be discussed in the section on critical incident debriefing.

The results of another important study funded by the Department of Justice (Award 97-IJ-CX-0029) and reported in 2001 bears mention. Conducted by sociologist and former police officer, David Klinger, this study examined the reactions of officers both during and after shooting incidents. (Klinger had been involved in a fatal shooting just four months after graduating from the Los Angeles Police Academy in July, 1981. He left law enforcement in 1984.) The eighty (80) study participants hailed from nineteen (19) different municipal and county agencies in four states. Each participant completed a seventeen page questionnaire and sat for an audio-taped interview with Klinger. Entitled, *Police Responses to Officer-Involved Shootings*, the entire work is a “must read” for police executives. While this author questions some of the “psychological” interpretations that Klinger makes as a non-clinical professional, the study elucidates some of the most salient issues regarding various police departments’ policies and procedures for handling police-involved shootings. One very important factor that Klinger discusses officers’ perceptual distortions during the shooting and memory deficits in the aftermath (e.g. how many shots were fired). He highlights the need for police investigators to be trained to work this knowledge into their investigations. Moreover, investigators should realize that officer’s recall may be inaccurate or they may have memory deficits. This does not translate into officer dishonesty. He cautions that investigators need to take the officer’s account *as a point of departure for the rest of the inquiry and work back and forth between them and other evidence to develop the most accurate possible picture of what occurred* (Klinger, 2002).

The Metropolitan Police Employee Assistance Program (MPEAP) in Washington, D.C. has provided debriefing to over 800 officers involved in shooting incidents in the past twenty years. General Order 201.28 requires that officers attend a total of six mandatory debriefing sessions conducted by therapists who staff the Program. In 1998 we composed *The Police Post-Shooting Impact Scale* to identify those factors that influence the impact of deadly force encounters on police officers. Using the criteria in the scale helps to predict, with considerable accuracy, how officers will respond after they have been involved in a shooting. They are listed below:

Magnitude of the Event

- Was the officer(s) injured? If so, how seriously?
- Was the officer’s partner injured or killed?
- Was the suspect injured or killed?
- Who was the suspect? (i.e. a child, mentally ill person)
- What were the precipitants of the shooting? (i.e. “Suicide by Cop?”)
- Grotesqueness of the shooting.
- Physical proximity of the officer to the suspect.
- Disruptions of the officer’s expectations (i.e. A young woman asks an officer for directions, then shoots at him at “point blank” range).
- Were citizens’ lives in danger?

- Were officers' lives in danger?
- Potential for liability.
- Degree of warning.

Officer Demographics

- History of prior shootings or critical incidents.
- Officer's reaction immediately after the shooting. (Did he/she feel vulnerable?)
- Officer's coping style (i.e. withdraws, uses alcohol).
- Officer's prior learning or mastery (Previous training/debriefing).
- Amount of stress, change, or losses in the officer's life at the time of the shooting.
- Nature and degree of family support.
- Officer's financial status (i.e. Credit card debt that is a source of stress).
- Assessment of alcohol use.
- Ability of officer to accept help from a support system.

External Factors

- The police department's response.
- Was the officer debriefed? How soon after the shooting?
- Were peers supportive?
- What was the media's response? (Were the facts distorted?)
- What was the community's response?

The stress of a shooting can be compounded by the actions taken by the police department in the aftermath. The following suggestions for departmental post-shooting procedures were made by officers attending the MPEAP debriefing groups over a fifteen year period:

- Officers should be given time off to recover from the negative reactions of a shooting without being made to feel guilty or that they are "getting over."
- Police departments should not release the name(s) of officers involved in shootings. The practice of releasing this information to the press is detrimental and perhaps even dangerous to officers and their families.
- Police officials should receive training regarding the dynamics of shooting incidents.
- Police officials should discourage rumors within the department by providing accurate information to fellow officers regarding the circumstances of the shooting.
- Police officials should call the officer who is out on administrative leave after a shooting to provide information and to communicate concern and interest for the officer's well-being.
- Some officers are not comfortable working on a limited duty assignment in the station immediately after their shooting, especially if they are assigned to work the desk taking citizens complaints.
- Some officers feel vulnerable when the department takes their weapons in the aftermath of a shooting. Arrangements for a "loaner" weapon should be made as soon as possible after the shooting. The process for obtaining a "loaner weapon" should not be lengthy or time-consuming. Officers are sometimes

easily frustrated when they are forced to deal with complicated or confusing bureaucracy.

Critical Incident Stress Debriefing: The Standard for Officer Aftercare

The term *Critical Incident Stress Debriefing* (CISD; Mitchell, 1983) is most widely associated with the work of Jeffrey Mitchell, Ph.D. who designed a system of brief group meetings based on the principles of crisis intervention practice and theory. Commonly known as CISD, the meetings take place in the aftermath of a critical incident such as a police shooting. While there are several variations of brief psychological care following traumatic events such as mass disasters, Mitchell was the first to introduce a structured model based on his work with emergency services personnel in the early 1980's. The desired outcome for all models is the mitigation of symptoms that may occur in the aftermath of exposure to traumatic events.

In recent years the CISD model has been the target of criticism due to some claims that CISD could prevent PTSD. Sufficient empirical data does not exist at this time to prove its efficacy in preventing posttraumatic stress disorder; however, that does not mean that CISD isn't a necessary and valuable tool. Even detractors of the critical incident debriefing model advise some form of clinical screening and intervention for individuals who are at risk for developing PTSD (e.g. history of prior trauma, low social support, hyperarousal, Bonano, p.22). Critical incident debriefing is most effective when it takes place as soon as possible after the incident (ideally within the first 24 to 48 hours post-incident) before officers isolate and suppress the thoughts, emotions, and reactions that occur naturally after a critical incident.

The goals of critical incident debriefing are:

1. To mitigate the painful effects of the incident. (Debriefing allows officers the opportunity to vent their feelings in an atmosphere of support and understanding.)
2. To provide valuable education about critical incident stress and how to inoculate against cumulative stress.
3. To normalize the many reactions that officers experience after a critical incident.
4. To offer a safe, confidential environment where officers can share their experiences with other officers who have experienced a critical incident.
5. To communicate to officers that they are the most valuable resource the department has and that the police family takes care of its own.
6. To restore the officer to a fully functioning level so that he can return to work.

Countless surveys of debriefing participants have yielded consistently high marks as to its beneficial effects. Findings in Honig and Roland and Honig and Sultan studies were *consistent for resiliency, the type and frequency of reactions experienced, the tendency to not seek services voluntarily, and the extremely high rate of subjects who found these interventions valuable* (Honig and Sultan, 2004). Following the initial study in 1998, the authors noted that *virtually all subjects reported finding the intervention valuable. In addition, an evaluation of both worker's compensation claims and stress disability retirements among this group lend further support to this type of intervention* (Honig and

Sultan). Although all of the study participants reported that the debriefing was valuable, sixty percent of the officers stated that they would not have attended the debriefings if they weren't ordered by the Department. The high degree of reactivity (3-5 days post-shooting) reported by 30-50 percent of the respondents and the measurable results regarding overall adjustment support the efficacy of critical incident care.

Klinger found that the efficacy of post-shooting interventions depended upon the context within which the counseling sessions took place. Many of the officers in his study did not view the sessions as helpful because they felt that the department's only interest was in covering itself from a liability standpoint. Consequently, these officers reported that they either withheld information from the mental health professional hired by the department or "flat-out lied" because they did not wish to offer up any information to a "stranger" who was affiliated with their department (Klinger, 2001).

Debriefings should be a part of a comprehensive, integrated program that provides pre-incident preparation through ongoing stress education beginning in the police academy and continuing throughout an officer's career as part of retraining; mandatory debriefing and follow-up aftercare for officers involved in critical incidents; and training for management in identifying officers who may be suffering as a result of exposure to traumatic events. It is this author's belief that critical incident debriefing will stand the test of time as the standard of care for law enforcement officers.

Overview of Officer Aftercare Programs

Police officers are inherently distrustful of mental health services. Although job-related stress increases in proportion to levels of violence and traumatic exposure, officers are less likely to seek help than the average person. While many occupations give rise to a variety of stressors, most do not constitute the closed and guarded culture of law enforcement. No matter how "numbed out" police officers appear (and they are champions at the art of emotional cover-up), they are not impervious to the psychological assaults of their work. Therapists cannot be of real help until they come to understand the danger that accompanies the police on every tour of duty.

It appears that the acceptance of the need for mental health services for police officers emanated less from an overall understanding of an "occupational stress" perspective and more from the emotional sequelae of several traumatic and highly publicized incidents involving police officers. Although employee assistance programs (EAP's) have existed since the 1940's in business, industry and government, it was not until 1968 that the Los Angeles Police Department became the first law enforcement agency to employ a full-time police psychologist, Dr. Martin Reiser. His duties were all-encompassing and included: treatment for officers and their families, testing, hostage negotiations, and management consultations. Among the many articles and books that he authored, Reiser's most noted work was published in 1972 entitled, "The Police Department Psychologist."

As a result of an increased awareness about the deleterious effects of traumatic exposure, many departments provide some form of psychological services for officers and their families. Counseling programs consist of three basic options: “in-house” programs staffed by department employees; contracted “external” programs that offer services independent from the police department; and a combination of both these models. Many departments also use police peer counselors who have been trained to provide critical incident debriefing. Rybicki and Nutter (2002) found that nearly 55 percent of the departments they surveyed offered some form of peer support program. (It has been this author’s experience that officers derive comfort, support, normalization, and validation from fellow officers who have also been involved in shooting incidents.) While all of these models have their advantages and disadvantages, departments should select a program that fits their unique needs and funding resources.

What Do Officers Want From A Counseling Program?

In a 1998 survey of 150 police officers of the Metropolitan Police Department in Washington, D.C., the following characteristics of a police counseling program were selected as the most important: (They are listed in order with the most important first.)

1. Licensed professional therapists who are completely separate from the Department to ensure strict confidentiality.
 2. Long term counseling for me and my family for as many times as we need.
 3. Therapists who have many years of experience with the Metropolitan Police Department.
 4. On-going stress training for officers and management.
 5. Private, comfortable offices far removed from any police facility.
 6. Free services.
 7. Debriefings and mandatory counseling after critical incidents, like shootings.
- (Anderson, 2004)

These results were similar to those reported by Marketa K. Ebert, Ph.D. (Ebert, M., 1986). An employee assistance counselor for Ann Arundel County, Maryland, Dr. Ebert administered a needs assessment survey to 74 Ann Arundel County police officers. Officers were asked to check all applicable factors out of a list of 14 that would make it easier for them to seek help. They are listed below in order of importance.

Preferences of Police Officer Sample Regarding Psychological Help. N=74

<i>Factor</i>	<i>Total Number of points</i>
Strict confidentiality	117
Costs partially or fully covered by the department	87
Professional has no connection with the police department	65
Ready availability and flexible hours	55
Office located away from headquarters	50
Professional shows interest in police work	48

Program available for the entire family	36
Peers' positive attitude toward psychological help	26
Mandatory counseling following high stress situations	25
Supervisors' positive attitude toward psychological help	19
Personal acquaintance with professional	14
Services provided by a member of the clergy	13
Professional employed by the police department	11
Services provided by police officers trained as counselors	10

Not surprisingly, in both surveys, officers' responses exhibited concerns related to privacy and confidentiality as well as therapist competence. The most crucial issues to be considered for the success of any law enforcement program are program structure and staffing, program location, and the program's relationship to the department. To ensure that the best interests of the officers are served, counseling components should be separate from evaluative units. (For a more detailed description of programs for law enforcement agencies, see "Developing a Law Enforcement Stress Program for Officers and Their Families," by Peter Finn and Julie Esselman Tomz; published by the National Institute of Justice under Contract #OJP-94-C-007; 1997).

The Metropolitan Police Employee Assistance Program (MPEAP)
901 East Capitol St., S.E.
Washington, D.C.

The Metropolitan Police Employee Assistance Program (MPEAP) combines the advantages of both the "in-house" and "contracted" programs. Instituted in October, 1988, it is a joint union/management program under Article 45 of the collective bargaining agreement between the Metropolitan Police Department in Washington, DC and the Fraternal Order of Police Labor Committee. Operating as a free, comprehensive, long-term, counseling program for police officers and their families, the MPEAP also provides services to police officials and their families. The four full time therapists, employees of Dr. Beverly Anderson Associates, Inc., provide a full range of services only to law enforcement officers and their families in a private location far from any police facility. Neither the Department nor the Union has access to records or information about officers seeking help. General Order 201.28 makes critical incident debriefing mandatory for all officers involved in shootings and other traumatic incidents. The staff of the MPEAP does not perform fitness for duty evaluations. A separate police and fire clinic program performs that function.

MPEAP therapists are on call 24 hours a day and respond to officer-involved shootings and critical incidents. To date, the MPEAP has provided counseling and debriefing to over 6500 officers and their families and critical incident debriefing to approximately 800 officers involved in shootings. It has also trained over 10,000 officers, police officials, family members, and community groups. In 1991 it was chosen as a model for all law enforcement agencies by the United States House of Representatives Select Committee on Children, Youth, and Families in the hearing, *On the Front Lines-Police Stress and Family Well-Being*.

Dr. Beverly Anderson's career encompasses over 20 years experience in the delivery of psychological services to law enforcement officers. She is a qualified legal expert in the field of trauma in law enforcement and has consulted to over 17 law enforcement agencies, and has instructed at the FBI Academy and the FBI National Academy. Dr. Anderson provided expert testimony on stress in law enforcement officers and their families for the Select Committee on Children, Youth, and Families. She created the term "Police Trauma Syndrome" to describe the long-term cumulative effects of traumatic exposure in police officers and has authored several assessment scales specifically for the law enforcement community. Dr. Anderson has been a featured guest on *Good Morning America*, *Good Morning America Sunday*, *CNN*, and on several news documentaries to include, *Beyond the Badge* and *Behind the Badge*. Questions or comments can be directed to Dr. Anderson at (202)546-9684 or E-mail address BAnder4879@aol.com.

Recommended Reading

1. *Copshock: Surviving Posttraumatic Stress Disorder (PTSD)*, by Allen R. Kates, Holbrook Street Press, Tucson, Arizona, 1999.
2. *I Love a Cop: What Police Families Need to Know*, by Ellen Kirschman, Ph.D., The Guilford Press, New York, 1997.
3. *Into the Kill Zone: A Cop's Eye View of Deadly Force*, by David Klinger, Josey-Bass, San Francisco, CA, 2004.

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