OFFICER'S PERCEPTIONS OF COUNSELING FOLLOWING AN OFFICER INVOLVED SHOOTING

by

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DEDICATION

To a man who almost gave the ultimate sacrifice, and the few like him, this is for you.

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I would like to thank all those whose assistance proved to be invaluable in the accomplishment of this research, specifically my wife, Lauren, who has graciously allowed me to pursue my goals in academia while selflessly giving up so much.

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LIST OF ABBREVIATIONS

Abbreviation **Description**

CISM – Critical Stress Management Team

CRT – Crisis Response Team

DSM-VI – Diagnostic and Statistical Manual VI

EMDR – Eye Movement Desensitization Reprocessing

OIS – Officer Involved Shooting

PTS – Post-Trauma Stress

PTSD – Post-Traumatic Stress Disorder

ABSTRACT

To evaluate the effectiveness of counseling received after an officer involved shooting, officers were administered three rounds of questionnaires using The Delphi Method in order to build a consensus about which treatment modalities are most effective and which are not. Results showed that all officers received some form of counseling, whether it be sessions with a psychologist, Critical Incident Stress Management debriefings, or more informal methods. Critical Incident Stress Management debriefing was among the most beneficial method of counseling received by the officers and was recommended for future officers by the participants. Administrative leave was reported to be the least beneficial aspect by respondents. The policies and procedures in place at police departments on handling a critical incident lack a tailored process to reflect what the individual officer needs to recover from the traumatic incident. This research gave an in depth look at what the officer experience and how a post-shooting intervention can be improved.

I. INTRODUCTION

Use of force by police officers, especially shooting deaths of citizens, has become a national debate and burden on law enforcement. “No other nonmilitary service group is required to carry a lethal firearm as a standard part of their daily equipment, nor charged to call upon their discretion and judgement on making split-second decisions to use deadly force in the line of duty” (Burke, 2017, p.115). Part of the occupational role that police officers take on is knowing that traumatic incidents are essentially inevitable and that when they occur, post-trauma stress (PTS) symptoms can sometimes appear. The Bureau of Justice Statistics (McEwen, 1996) and *Washington Post* both report around a thousand officer involved shooting (OIS) deaths in 2015 and 2016. Williams, Bowman & Jung (2016) illustrate that the government databases of recorded officer-involved shootings are faulty and misleading. Reporting of an OIS is completely voluntary for most states in America. Three states in particular; Texas, California and Maryland require mandatory reporting, but those reports might not be completely accurate. The other 47 states have no mandatory requirement to report, which in return, gives the federal databases faulty reports and many classification errors. An average of 960 of officer shootings were reported for 2015 and 2016 (Williams, 2018).

It is likely to assume that most law enforcement officers involved in an officer involved shooting will experience PTS. Many of those officers will suffer PTS to such a severe degree it will be considered a disorder (hence post-traumatic stress disorder) according to diagnostic criteria identified in the Diagnostic and Statistical Manual VI (DSM-VI) (American Psychiatric Association, 2013). The disorder can develop after symptoms continue for a month or more (Taylor, Thordarson, Maxfield, Fedoroff, Lovell,

& Ogrodniczuk, 2003). There is a wealth of research data examining treatment modalities for treating PTSD among law enforcement officers involved in an OIS. Treatments range from peer support group and Crisis Response Teams (CRT), to professional counseling and therapies and more non-traditional treatments such as Eye Movement Desensitization and Reprocessing (EMDR). EMRD is an exposure therapy technique use to relieve PTS symptoms in as few as one session with simple eye movements, focus on negative and positive images and following of a finger. This is typically done one-on-one with a psychologist where many other programs focus on the group and peers such as a CRT which encompass Critical Incident Stress Management teams (CISM).

Research has included experimental studies, clinical treatment studies and qualitative surveys. Research concerning treatments for PTSD among officers involved in an OIS has focused more on the efficacy of particular treatments or therapies rather than specific components of the treatment or therapy that ameliorate or alleviate emotion-based symptoms. For example, officers involved in a shooting meet with peer support officers either one-on-one or in groups to communicate strategies designed to reduce and control emotions, share strategies designed to normalize the experience, and mediate discussions designed to provide a positive framework for mentally processing the OIS event. What is lacking in the research, however, are what specific components of treatments and therapies are more effective or less effective in treating PTSD. Research has provided answers in terms of more gross treatments but has not addressed the internal and micro-components of those treatments that are the key moderators in treating PTSD.

Officer-involved shootings have long been examined by researchers and police psychologists. The circumstances leading up to the officer firing a weapon, to the

shooting itself and the immediate aftermath have been examined, and improvements in both training and counseling have occurred. The split-second decision (Fyfe, 1986) can mean the difference in engaging and shooting an individual or refraining and rely on other tactics. If the decision is made to shoot, the officer's perception can immediately and drastically be altered. The actions of the officer will likely not be established by an objective reality in the mind of the officer. Instead a misconception of what took place will be processed and stored (Klinger & Brunson, 2009). In terms of treatment of an officer after an OIS, it is important to note that each officer will experience different counseling than his or her counterparts. Many different treatment models exist across the country, and no two departments will offer identical treatments, due to many factors such as funds, available resources and the experience of the individuals providing treatment, as well as the officer receiving the treatment. A successful post shooting psychological intervention, and the means of getting there, is determined more by the department and resources available rather than the officer affected by the incident. The officers involved in these shootings need more fine-tuned treatment tailored to the individual instead of a broad-range standard that may or may not be clinically effective. This ensures all officers are getting the necessary help no matter with which agency or department they are employed.

Current literature is silent about which methods of coping mechanisms, psychological exams and general counseling and interventions help best with overcoming these stressors and which do not show much improvement. The goal of this study is to qualitatively further the knowledge of the psychological effects after an OIS and improve upon counseling and treatment. With knowledge gained from this study, a better

understanding of how to deal with emotions, stress and all ailments that come with PTSD and a critical incident can be obtained. By doing so, officers will hopefully have less time on leave, less time recovering and more time back on duty doing their jobs. Research over the psychological effects of a shooting as well as treatment techniques, both old and new, traditional and non-traditional are abundant and very well accepted in their respective fields. A multitude of counseling and intervention techniques exist among police psychologists. Each technique has its own strengths and weaknesses in treating PTSD among a variety of incidents involving officers. These specific techniques mitigate the effects of a traumatic experience, such as a shooting death of a citizen by a police officer. By reviewing and studying the post crisis intervention from the perspective of the officers involved a better understanding can be produced, and future officers can receive counseling that is proven to be effective and efficient. It is important to note that previous research focuses on the outcomes and well-being of officers after an intervention and their lives after. No research exists from the officer during an intervention following a critical incident.

II. LITERATURE REVIEW

Post-Shooting Reactions

Previous research demonstrates that officers experience an array of psychological and physical effects, both short-term and long-term, after being involved in a shooting death of a citizen. Burke (2017) labels four phases of an officer's post-shooting reaction but does not generalize the order or the reactions themselves for every officer. The most immediate phase is the impact phase, which might encompass relief or even exhilaration. Second is the recoil phase, where an officer essentially goes on auto pilot. During this phase, the officer will go through daily motions of the job, becoming distant, detached and preoccupied. Shortly after an officer comes to terms with the reality of a shooting, phase three, the resolution phase can begin. In this phase the officer realizes his actions were justifiable and necessary for his survival. Typically, these three phases tie up an officer's post shooting reactions, and they continue with counseling and intervention. However, adequate resolution sometimes does not occur, and the officer will spiral into a lengthy period of post-traumatic stress. By properly assisting and counseling officers in their recovery, officers can return to as clear a mindset as possible. Miller (2006b) gives a worst-case scenario for inadequate counseling and intervention when an officer suffers a prolonged posttraumatic phase, that might ultimately end his career in law enforcement, or lead to suicide. Mullins (2001) relates PTS and involvement in critical incidents to the high rates of suicide among police officers, and he states that departments can lessen the effects of PTS with "training, training and more training" (p.263) about what to expect after a traumatic incident and that the reactions are normal for an abnormal situation. In cases that are less serious, the officers ultimately return to work after seeking treatment

and regaining his or her professional and emotional senses after a brief period of stress disability (Artwohl, 2002).

Miller (2006b) summarizes officers' reactions following shooting fatalities as a "transitory period of post-incident psychological distress, intermediate response and severe psychological disability, what officers often describe as a 'mental breakdown.'" (p.3) The first of the three reactions, the transitory period of post-incident psychological distress is the least serious and easiest to overcome, usually resolved within a couple of weeks. The officer uses the support of family, peers and colleagues, self-coping methods and a renewal of life goals and priorities. The psychological and emotional stress during this stage does not provide any hindrance of the officers' everyday functioning in society. This reaction typically requires a few sessions of counseling with a mental health professional and a critical incident stress debriefing to mitigate the effects and allow the officer to return to duty. The intermediate response reaction is more intense than the former. PTS symptoms can linger, sometimes unrecognized for weeks or even months following the traumatic incident, which can lead to the symptoms becoming a disorder. Unlike the transitory period of post-incident psychological distress, this reaction might impair the officers daily functioning capabilities and requires more sessions with a mental health professional. Group debriefings as well as peer and family support are important during this reaction phase. The third reaction, described as a mental breakdown, is severe psychological disability. This reaction shuts down the officer's ability to function from day to day. Many cases suggest that this reaction occurs along with a level of helplessness usually brought on by an adversarial investigation and a seeming lack of support from colleagues. Long term treatment with a mental health professional is usually

necessary during the mental breakdown reaction along with medication to mitigate some effects. It is likely the officer will leave police work, but careers may be salvaged by appropriate and effective counseling and treatment. These three reactions phases can potentially be lessened to one phase with adequate and effective counseling. Surveying officers who have gone through one or more of these phases during counseling will give greater insight into these reaction phases and a better understanding of how to treat PTS.

Post Shooting Counseling

On-scene counseling is the first and most immediate response for the officer involved. Paramedics, fellow officers, the on-duty supervisor, a department psychologist (in larger departments), and in smaller jurisdiction, the chief of police will be first on a scene. Not only are they on scene to work, but also for peer support to the officer involved (Miller, 2006a). Peer support is a crucial part of recovery and treatment, so much so that the military has embedded counselors, professionals, and trained peers in the frontlines for combat troops. Since the turn of the century, there has been an increase in research to examine the effects of stress and trauma that law enforcement officials must endure. Psychologists and police administrators have concluded that early and adequate intervention is critical to reduce negative reactions and both acute and prolonged symptoms of PTS that might follow a traumatic event such as an OIS (Honig & Roland, 1998). Horn (1991) found that of officers involved in a shooting death while on duty, 70% will leave their department within 5 years. According to McMains (1986, 1991), early in the 1980s, roughly 95% of officers involved in a shooting death while on duty left their departments within 5 years. This rate fell drastically by the mid-1980s. Larger departments around the country were reporting only losing 3%, while two-thirds

were still leaving smaller departments after an OIS. Still, many departments do not have the resources, nor the means to adequately and effectively treat officers after a shooting (Charoen, 1999). These departments must outsource the task or send the officers out on their own to seek external counseling if needed. Gersons (1989) discovered that 46% of police officers that had been involved in a shooting while on duty, met the criteria for PTSD, while another 46% reported significant symptoms of PTS. It is wise to assume that there needs to be more widespread counseling available for departments and their officers who do not have the means to seek adequate treatment or counseling. According to the Bureau of Justice Statistics, there are approximately 15,000 local police agencies and Sheriff's departments in America with 605,000 sworn officers (Banks, Hickman & Kyckelhahn, 2016). Most officers will never experience a shooting while on duty, but those who do will need proper counseling and will need to know those implementing the counseling know which methods are most beneficial and which are not.

Komarovskaya et al., (2011) studied the relationship between PTSD and killing or seriously injuring someone while in the line of duty among 400 officers. They found through use of self-reporting by multiple scales, screening tests and questionnaires that PTSD is significantly associated with killing or injury someone in the line of duty while only marginally associated with depression. Research like this provides police psychologists and professionals alike the research needed to improve counseling and focus attention on the aspect of post-shooting trauma that needs the most consideration. The effects of a critical incident are likely to impact each officer differently: some return to work as normal operating officers in the immediate stages following the incident, others require more severe mental health intervention and counseling, and a select few

receive little to no counseling at all.

Proven methods of treatment and counseling exist and have shown improvement among officers who have experienced the techniques first hand. These same proven methods also have studies examining why they do not work and sometimes do more harm than good. These methods include CISM teams, individual and group debriefings, EMDR, and exposure therapy. These methods encompass what typically takes place for an officer following an OIS. Not every method will be implemented to its fullest, and some methods will not be implemented at all, but the extent of the counseling received, after what is required by some departments, should be determined by the mindset and psychological state of the officer. McMains (1986,1991) considers that the initial intervention should be a soon as possible so that any chance of long term trauma can be lessened.

Critical Incident Stress Management

Critical Incident Stress Management (CISM) is a crisis intervention service consisting of group debriefings, individual crisis counseling, pre-crisis training and referral for primary and secondary victims. Within CISM lies the Critical Incident Stress Debriefing (CISD). This extremely structured method of group intervention allows a discussion of the traumatic event to take place. These methods have slowly become an essential means of expressing and discussing the traumatic event that took place and show positive long-term results in most studies. A simple debriefing is enough to ease an officer's mind, negate some minor post crisis effects, and give a starting point for recovery. It is necessary to understand the primary goal of CISD and the goal of the final phase of CISM are to determine if further treatment is needed and to what extent, as these

techniques are used to facilitate other more traditional treatment services (Everly & Mitchell, 2000).

At its core, CISM contains seven components; 1) preparation before a crisis ever occurs, 2) demobilization procedures after an incident occurs, 3) acute crisis counseling at the individual level, 4) short, small group discussions (defusings) designed to mitigate acute stress symptoms, 5) lengthier, small group debriefings (CISD) designed to aid in the closure of psychological effects, 6) family crisis intervention techniques, and 7) referrals for primary and secondary victims as well as follow up procedures (Everly, Flannery & Mitchell, 2000). The use of CISM is steadily becoming more widely accepted. Agencies such as the Federal Bureau of Investigation, the U.S. Bureau of Alcohol, Tobacco, Firearms, and Explosives, the U.S. Air Force, the Swedish National Police and even the Airline Pilots Association are implementing this service to its members. (Everly & Mitchell, 1997). Focusing on the pre-crisis state of the individual is of great concern when implementing the CISM team. By resurfacing the independent functions of the individual, the possibility of long term formation of maladaptive behavioral and cognitive patterns is strongly diminished. The core components of CISM and CISD are to be applied as needed. Each incident is different; therefore, each incident requires a unique approach to individuals involved and directly affected. In situations where law enforcement is involved the CISD team is comprised of at least one law enforcement peer and one mental health professional. This allows immediate aid for the involved officer during the briefing. CISD, which is contained within CISM is typically administered 1 to 14 days after a crisis but can be delayed up to three weeks due to severity of crisis. Like CISM, CISD contains seven stages; introductions, facts, thoughts,

reactions, symptoms, teaching and re-entry. The many stages require officers to explain their involvement in the incident (only providing the facts), share their thoughts over it and even illustrate their reactions to the incident during the reactions stage. Later stages normalize the symptoms experienced by individuals involved and teach them how to deal with the stress in their lives. Most significantly, the reentry phase focuses on the officers returning to duty and allows questions to be asked as a final attempt to ease the officers' minds before the debriefing ends and further counseling occurs if necessary. Each stage is a step forward leading ultimately to the officer returning to levels of normative functioning prior to the critical incident. The primary goal of the debriefings is to mitigate acute symptoms, determine if a follow-up meeting is needed and, most importantly, to provide closure.

Research over the past three decades have examined the effectiveness of CISM and more specifically CISD. Similar results are present across many studies involving participants who have gone through various traumatic incidents. Nurmi (1999) evaluated the effectiveness of CISD on law enforcement, firefighters, and trauma nurses who were responding to the rescue of passengers on board the *MS Estonia* ferry off the coast of Finland. Unlike the police and firefighters, the nurses did not receive any critical incident debriefings which resulted in far more stress and anxiety than their counterparts. Of those who did receive the debriefing, 81% found it to be beneficial. Similar studies conducted by researchers yield results that show effectiveness and satisfaction. A study by Carlier, Voerman & Gersons, (2000) showed positive results as well. One control group (*n=82)* was used that did not receive any treatment, and another control group (*n=75)* received treatment prior to department implementation of CISM and CISD. The experimental

group (*n=86)* received the CISD and multiple other test phases and questionnaires that the control group also received. Results from the study showed a 98% satisfaction rate among officers who received critical incident stress debriefing. Leonard and Alison (1994) conducted similar research on 90 Australian police officers. One group received CISD (*n*=60), the other did not (*n*=30). The questionnaire used was more detailed than previously mentioned research. Prior occurrences concerning the shooting incident, on scene peer support from the department and assessment of personal safety during the incident were all evaluated as well as utilization of the State-Trait Anger Expression Inventory (measures the experience, expression and control of anger) and the Coping Scale (Carver, Scheier, & Weintraub, 1989). It was discovered that the group that received CISD fired more shots and killed or injured more people in the incident, scored greater on the Coping Scale and were considerably less angry than the non-CISD group. The group that did not receive CISD was noted to either be ignored by their department or refused to participate. A study of group crisis interventions given to workers of the World Trade Centers in New York City after the events of September 11, 2001 was conducted by Boscarino, Adams and Figley (2005). Evaluations were conducted one-year post incident and again at two years comparing workers who received an intervention against those who did not. The workers who received CISM benefited greatly compared to workers who were not offered the services. Many symptoms associated with a traumatic event were not present among the group who received an intervention. CISD research is limited but continues to gain attention and recognition. CISD is one tool out of many that is used to treat officers involved in a critical incident such as a shooting death of a citizen.

However, despite positive results from numerous studies, research exists showing that CISD is not clinically effective and can result in increased PTSD symptoms and "significant harm" to the individual (Everly & Mitchell, 2000, p.211). Carlier, Voerman and Gersosn (2000) conducted a study over three consecutive debriefing sessions at 24 hours (shortly before the first debriefing), 1 month (shortly after the first debriefing), and 3 months post-trauma (after the second and third debriefings) with 243 officers who were involved in a traumatic incident. A subgroup of officers who were debriefed (N=86) were compared to a non-debriefed internal group (N=82), who declined to participate in debriefings and a non-debriefed external group (N=75), who were involved in a traumatic incident prior to 1992 when no debriefing was available. The subjects were continually monitored and no psychological symptomology was present between the groups at pre-test phase, the 24 hours phase or 6 months post trauma. The difference in morbidity among those who received a debriefing and those who did not was evident at just one-week post trauma with the debriefed subjects displaying "significantly more post-traumatic stress disorder symptomology than non-debriefed subjects" (Carlier, et al., 2000, p.87). Except for the one-week post trauma symptoms, the study went on to conclude that all symptoms had diminished with time, revealing that debriefings are potentially not effective immediately following a traumatic incident or even short term (months after). Other studies have been conducted on debriefings after a traumatic incident with similar results showing little to no difference among debriefed individuals and non-debriefed individuals at given time points after an administered debriefing. Bisson, Jenkins, Alexander, and Bannister (1997), Hobbs, Mayou, Harrison, and Worlock (1996), and Lee, Slade, and Lygo (1996) conducted three separate randomized controlled

studies on individual debriefings. The first study conducted by Lee, et al. discovered the debriefed groups (received 2 weeks post-trauma) displayed no differences when compared to the non-debriefed group at a 4-month follow up. Hobbs, et al. discovered in their study that after receiving a debriefing 24-48 hours post-trauma the symptoms of PTSD and depression were greater among the debriefed individuals than the non-debriefed. The final study by Bisson, et al. revealed that the group debriefed 2-19 days post-trauma in pairs or individually showed no difference among the non-debriefed group, yet at 13 months significant negative differences in symptomology of PTS were present among the group that did receive a debriefing. Carlier, et al., (2000) concluded that individual debriefings show no positive results based off these randomized trials. Addis and Stephens (2008) found similar results after a study of officers involved in a shooting who went through debriefings resulted in more PTS symptoms. They also found a negative correlation of attending a debriefing and how stressful the officer perceived the traumatic incident to be, which likely leads to developing more symptoms of PTS as time goes on.

Eye Movement Desensitization Reprocessing

Eye Movement Desensitization and Reprocessing (EMDR) is a non-traditional and often criticized method of psychotherapy that assists people to recover from the negative symptoms and emotional distress related to a critical incident. The focus of EMDR is post-traumatic stress and mitigating the effects in a short period of time with techniques of exposure therapy. The treatment is somewhat controversial due to claims that it can treat patients with long term traumatic effects in only a few treatment sessions. The client is asked to place in their mind an image of their trauma, negative emotions and

self-cognition, and any physical sensations related to the traumatic event. The client is then told to move their eyes back and forth rapidly for 15 to 20 seconds, following the motion of the therapist's fingers. After this step, the client reveals the images, emotions, cognitions and physical sensations that emerged. These procedures continue until the client reports a desensitization to the traumatic events and a positive self-cognition. Psychotherapy used to take years before any real benefits were noticeable. With EMDR, that time is drastically reduced when compared to CISM, debriefings, relaxation techniques or cognitive behavior therapy. The research studies conducted on the effectiveness of EMDR have yielded results that show success. Initial reports by Shapiro (1989) concluded that EMDR was effective after only one session with clients showing signs of decreased anxiety and increased validity of perceived positive cognitions. Shapiro randomly assigned 22 participants who had either combat or sexual trauma to either one session of EMDR or a control group with no EMDR. The control group was instructed to recall their traumatic event, place an image in their head and follow the steps of EMDR but without the eye movement. It was reported that EMDR resulted in more significantly positive behavioral changes as measured by the participants and their significant others. More than 30 studies have produced results showing that 84%-90% of participants no longer suffered from PTSD after merely three 90-minute sessions. According to Shapiro (1999) four meticulously controlled studies over EMDR mitigated the symptoms of PTSD of 84 to 100% of single-trauma victims after the equivalent of three 90-minute sessions.

Unlike critical incident stress management, EMDR is tailored to the participant from phase one. The first phase of eight is coined Client History and Treatment Planning,

which evaluates and places focus on the clients' readiness and allows for the therapist to develop a plan that will best fit the needs of the client. Stage two of EMRD is the preparation or stabilization stage which builds a relationship with the therapists and allows for the patient's symptoms to be explained and is intended to educate the individual as well. The third phase begins the processing of the incident and allows the clinician to assess the sensory, cognitive and affective components of the memory. The individual visualizes the negative memory and expresses a positive belief, then rates how the positive belief feels when paired with the negative one. This provides a baseline as well as a treatment goal. Phase four begins the eye movement. The individual begins to focus on both the positive and negative images as well as anybody sensations, while following the therapist's finger side to side for 15 seconds. Auditory simulation can be used as well, such as a metronome. After the 15 seconds are up the patient is asked what they see now. Typically, this phase is repeated several times until a Subjective Unit of Disturbance (SUD) is 0 (neutral). The fifth phase begins when negative memory and images can be retrieved without concern or stress and is followed by the sixth when the patient describes whether there are any feelings or emotions that are still present while focusing on the images. The final two phases, seven and eight, focus on the future and the effectiveness of the treatment. Phase eight, reevaluation, is the first phase of each EMDR session following the initial session. Patients are also encouraged to keep a journal, logging their dreams, emotions, insights and any thoughts and feeling pertaining to the traumatic incident. Depending on the requirements of the patient, EMDR can be effective in as quickly as a handful of sessions or take as long as a few months (Shapiro & Maxfield, 2002). Many psychological reactions to a traumatic incident and PTS will

include difficulty sleeping, misperceptions of time, tunnel vision, sound reductions, feeling of numbness, reflections about the incidents, crying, sadness and nausea. These reactions to a traumatic incident can last months or even years. Klinger (2002) studied the physical responses, emotions and mental health of officers during four critical time periods post shooting. 1) within 24 hours after the incident, when most often officers showed elation, specifically exhilaration from firing their weapon, joy from surviving the experience and lastly, deep satisfaction for doing their job correctly 2) two days to a week 3) two weeks to three months and 4) after three months had passed. Klinger found that from among 113 cases, 48 officers felt a sense of anxiety over possibly being involved in another shooting later in their careers. With a single session of EMDR, these reactions can be negated, and the officer can return to normal daily cognitive and social functioning in a much faster manner than if EMDR was not implemented.

Exposure Therapy

Mitigating PTS with prolonged exposure has been an effective technique for decades used on both first responders and warfighters. Tolin and Foa (1999) found that prolonged exposure therapy was best received by those who are at high-risk to exposure of traumatic events, such as an OIS. Emotional processing, a type of exposure therapy that allows the individual to connect new, more rational and realistic beliefs to the fear and can become more familiar with the fear and how to cope. The treatment of PTSD and psychotherapy provided by police psychologists requires quick and professional knowledge. A successful intervention is key to rejuvenating an officer's morale and willingness to return to work after such a crisis. A successful intervention includes psychological services, peer support, reinforcement of professional competence and an

opportunity to learn and grow (Miller, 2006b). PTSD has many underlying theories that pertain to an officer after an involved shooting and a successful recovery. Foa and Kozak (1986) established the emotional processing theory that first related to anxiety disorders but recently has been associated with fear structures that when activated trigger psychological, cognitive and behavioral reactions. Typically, these reactions are appropriate in response to danger, but can become pathological in certain situations (Bisson 2009).

The psychological, cognitive and behavioral reactions, when gone unnoticed can lead to a gentle stimulus, such as a soft touch, an emotional movie clip or unexpectedly being startled becoming linked to fear and psychological arousal. Horowitz (1986) defined the theory of cognitive processing that argues an individual cannot comprehend a traumatic experience, in this case an officer-involved shooting and resorts to mobilization of their defense mechanisms. Foa and Meadows (1997) demonstrated two effective standard treatments of exposures and cognitive methods to be used when treating PTSD; the modification to the maladaptive attitudes towards behaviors, events or symptoms and the constant exposure to traumatic information such as EMDR. Conway and Pleydell-Pearce (2002) claimed the problem with traumatic memories is that they are poorly integrated and elaborated into the general autobiographical knowledge base. By incorporating new and incompatible information the invalid information in the traumatic memory becomes corrected. There are many techniques and processes that pertain to PTSD and recovery. The theories mentioned encompass the primary responses and emotions officers will experience after being involved in a traumatic event. Psychological effects of a traumatic event can linger over an individual for years following the incident,

sometimes the officer may live for extended periods with an unrecognized stress disability (Artwohl, 2002).

Conclusion

Proper treatment is crucial to bringing the individual back to functional levels of psychological, emotion and social cognitive abilities. As previously mentioned, research reveals that the officers involved in shootings are not getting treatment and help that will most benefit the single officer. Instead the officers are receiving what is known to help officers as a whole. Stratton, Parke, and Snibbe (1984) surveyed Los Angeles County deputy sheriffs involved in shootings and found that roughly 60% believed a few days of mandatory leave was beneficial to their well-being. These findings show that the need for more personal counseling and techniques are needed when almost half (40%) of participants surveyed could agree that mandatory time off work was not beneficial. On the other hand, officers who believe that a few days off after a traumatic incident is useful, the amount of time allowed by most departments may not be enough. Loo (1986) determined that the average amount of time for normalization after a trauma event was 20 weeks, with extremes as short as one week and as long as a few years.

Internal and micro-components of interventions and therapy in the treatment of PTSD are the factors and data that will reveal what is being done right and what could be improved upon to better suit the officers that suffer PTS from involvement in a critical incident. A qualitative study that surveys officers who have been in this situation will shed some light and hopefully provide useful insight into the counseling process from an officer's perspective. Proper care of an officer after a shooting is very important and has lasting effect on the individual and their social clarity. The need for an analysis of

treatment and counseling from the perspective of the officer's first-hand accounts of the process are what is required to evaluate the interventions and counseling process and build upon what is already established and known to be effective in recovery after a critical incident. This will ensure that officers are not leaving their departments due to psychological matters pertaining to the intervention nor are letting their social skills and cognitive functions suffer due to inadequate treatment. Every technique, method and style of intervention and counseling has research-based evidence proving that it works, generally. Whether is it CISM, large group debriefings, EMRD, small group therapy, or just simple peer support, there are properties of each that are not as effectives as the others, and this might be hindering effectiveness of treatment. Providing first-hand officer-based feedback to police psychologists, clinicians, and practitioners the treatment process can be evaluated from a different point-of-view and potentially become more efficient. No two officers react the same, whether mentally or physically, to a traumatic incident, some display little to no reaction, while others show signs of suffering and other symptoms (Charoen, 1999). Many methods and techniques of counseling have shown both positive and negative effects on officers and others who have experienced a traumatic event. Debriefings are the most discussed and the most debated with research backing both the effectiveness and the ineffectiveness of this method. The results of studies on other techniques have generally shown positive results such as EMDR, and exposure therapy. It is safe to say that counseling of officers and handling of PTS has drastically improved and is likely only get better, with McMains (1986, 1991) reporting by the mid-1980s only 3% of officers were leaving police work after involvement in a shooting, this a small fraction of the percentage that were leaving their departments just

years prior. These studies mentioned previously tie up what is known and has been researched in terms of police officers and PTS treatment and counseling.

III. RESEARCH QUESTIONS

Studies prior to this have only covered how to handle an OIS and the impact on officers' psychological health. The questions asked were established to further understand the officers' experiences throughout the counseling and mandatory leave period following a critical incident involving a shooting death. The intent of the research is to fill in the gap between post shooting procedures and what the officer believes to be most beneficial on their road to a full recovery. By studying the counseling and intervention techniques from an officer's perspective, the system might benefit from the knowledge obtained and fine-tune techniques to match. This study is intended to cover three phases: 1) What were the officers' perceptions and feelings during counseling? 2) What did the officers find most beneficial to recovery of their overall well-being? and 3) Did the officer feel fit for duty before returning to patrol? These major themes will provide insight into the counseling process and likely break down the methods to a micro level showing which method within each technique benefits each officer. A hypothesis has not been developed as this as an exploratory analysis and the data received will lead the research. It is likely, though, that the treatments and counseling officers are receiving is being administered effectively, and each officer is provided the help they need to return to duty.

IV. METHODOLOGY

Subjects

The unit of analysis for this research was officers involved in a justified shooting in America prior to 2013. The numbers have fluctuated from year to year but are still very prominent. According to a private database retrieved from Williams (2018) through Texas State University, shooting deaths by the police have amounted to 964 deaths in 2014, 1,013 in 2015 and 996 in 2016; totaling 2,973 officers battling the stressors and psychological impact that follow what less than one percent of fellow officers will ever do during their careers. This database is as up-to-date as possible and is compiled from media reports, official records, newspapers and any other reliable source on the matter. The database confirms these officers are spread across approximately 900 departments throughout the nation. Due to the nature of the research subject, officers must have been cleared for active duty prior to 2013. The five-year timeframe will ensure that the officers are of sound mind, have completed a psychological evaluation, are fit for duty and that most major symptoms of the incident have been mitigated. This also ensures that the questions asked will likely not cause any psychological stress to the participants. The subjects chosen where sought out by professionals in the field of criminal justice. The participants chosen are open about their OIS and have no issues with data being concluded on their experiences. Conducting a qualitative study for this data is based off the previous studies that lack certain knowledge from the officers themselves and their experiences while going through counseling.

The Delphi Technique

This research project was designed to address the key question of the internal and micro-components of treatments and therapies in the treatment of PTSD. This study required officers who have been involved in an OIS as participants, and then were administered the Delphi Technique (hereafter referred to as Delphi). Delphi is an established qualitative research method that relies upon subject matter experts (SMEs) to provide narrative data (which can then be content analyzed) to address the research question(s) (National Tactical Officers Association, 2011). It is an iterative process whereby SMEs take part in several rounds of open-ended questioning. Except for the initial set of questions, the questions asked in each subsequent round are contingent upon the answers provided in the initial question set. The initial question set will query SMEs about what specific treatments or therapies were used with them following their OIS event. SMEs will be asked to provide detailed narratives regarding what was done, how it was done, what they remember about treatment or therapy sessions, and what they believed helped and what did not help them overcome PTSD issues. Based on their responses, question sets will be developed, and SMEs re-questioned regarding specifics identified in their initial question set narratives.

Several Delphi sessions took place during the research. Delphi is based on expert opinions of the matter at hand. The feedback provided through Delphi is typically based of the participants expert knowledge on the subject. The characteristics of Delphi allow experts from different states and regions the freedom to complete the questions on their own time.

Delphi studies possess advantages and disadvantages just like any other method of research. The lack of any predisposition to show bias, to be affected by reputation or experience of others, or show unwillingness to favor the group opinion is a great advantage of Delphi (National Tactical Officers Association, 2011). This method essentially allows for the participants to have no contact with others involved in the study, remain anonymous and remove many risks, unwanted results and quality factors that come with other methods of survey such as nominal group technique. (Hasson, Keeney & McKenna, 2000). Sumsion (1998) suggests that maintaining a 70% response rate from participants is sufficient in Delphi.

There is variation within the Delphi method, but all consume a few the same characteristics:

- Participants are "panelists," or subject matter experts that are selected for their expertise on a particular topic.
- A general purpose to cultivate a variety of potential program alternatives.
- It is often two or more sessions of questionnaires known as rounds.
- Round 1 surveys are used to build round 2 and so forth.

Delphi is especially valuable for topics with limited research, such as treatment and counseling of officers involved in a shooting. Studies of this methodology can be aimed to measure a variety of opinions on a topic or to steer the experts towards a consensus. The primary objective of this study is to gather opinions of treatment and counseling methods and base a consensus of the data collected to better understand the intervention process experienced the officers point-of-view.

The first round was an open-ended questionnaire that provided baseline data to build subsequent questionnaires. The thoughts and opinions collected during this round were content analyzed, reviewed and used as the survey instrument for round two. Round one was used to gather basic knowledge of the counseling each officer received and assemble a consensus of methods and techniques used from differing departments. Participants were asked about specifics such as the use of CISM, peer support groups, debriefings and anything their department might have implemented. The department policies and procedures for handling an OIS were questioned in terms of fairness and effectiveness. In other words, round one was designed to formulate assumptions. This data provided a basic overview of what takes place during counseling as well as what is mandatory and what is not.

Round two (built from data in round one) allowed participants to review the summarized data about counseling. Participants justified why certain techniques and methods are more popular than others and provided rationale for those opinions. A "rank order" is given to items to establish priorities and to "validate consolidation." Participants were asked about the amount of treatment received and if they believe they would have benefited from more. The training and preparation from the department provided to the officers on how to handle an OIS as well as mental health follow-ups were asked about as well. Survey two finished with the participants answering if they felt fit for duty when returning to work.

Round three is like round two in that panelists are typically asked to amend judgments or "to specify the reasons for remaining outside the consensus" (Pfeiffer, 1968, p. 152). This round allowed panelists to further clarify which methods and

techniques were most beneficial and the relative importance of each. Only a minor increase in consensus can be formed from this round. Round three provided a breakdown of the specifics of each method and what is more beneficial than another aspect of the same method. This round also gave panelists their last chance to revise which methods and techniques they believed to be best and submit their final considerations. The final round provided the greatest consensus and no further rounds were required. Once all rounds are completed, the data received was analyzed and a final report was crafted. The questions asked in this final round were more personal and opinion based. The participants are subject matter experts, so opinions were valued and included in the data. The officers were asked more specifically about interventions, peer-based activities, administrative/department involvement and what can be done to better prepare and treat officer in the future. To finalize a consensus, questions regarding the most and least beneficial aspects of counseling were asked again. After answering a question about mental health follow-ups in round two, round three let participants answer what they would have liked to be addressed in a mental health follow-up and when they would like to be approached.

See appendix for a full list of questions.

Ethics

A full board review by the Texas State University Institutional Review Board was conducted where the protection of the participants was questioned. After a short session, the research project was reviewed, and any concerns brought up were addressed and handled. Celesta Harris a psychologist for the Texas Department of Public Safety was

notified and asked to be a source of help in case a participant felt the need to talk to a trained professional and address any issues brought up by the research questions.

V. IMPLICATIONS

This research study will provide feedback for police psychologists and departments that might begin to implement tailored interventions determined by the officer and the traumatic incident that was experienced, rather than by what the department believes to be best. By allowing the department to determine what resources are utilized in counseling, the officer might struggle with emotions and returning to duty. Not every officer will respond the same way to the counseling received by other officers. By tailoring interventions to the officer, they can become more effective, more efficient, and allow the officer to return to duty in a timelier manner than previous 'standardized' counseling methods allowed. This will also allow peace of mind that the officer received the counseling needed and long-term effects while on the job will be unlikely. Knowing what methods are most effective can help police psychologist better understand how to effectively treat an officer and ensure that they are fit for duty.

VI. RESULTS

Implementing the Delphi Technique requires subject matter experts, so few participants were needed for this research project. A total of 8 respondents provided data and a response rate of 75% over the course of three separate surveys. A response rate of 75% per survey was needed for the data to be valid when implementing Delphi.

All participants reported receiving some sort of counseling (whether immediate or days later) and all but three (about 40%) were required to speak to a psychologist, whether departmental or external. Fifty percent reported receiving a debriefing, with one participant being trained in CISM but receiving no debriefing. The extent of counseling received was limited for about 90% of officers, and that limited counseling was said to be all that was needed by only one officer. When asked about any techniques used during counseling (CISM, multiple debriefings, peer support activities, EMDR, etc.) respondents' reports claim that one officer received no such techniques during counseling, while one other officer reported various relaxation techniques during a meeting with a psychologist. CISD was reported for 50% of participants, with one single officer receiving only a tactical debrief (used to better understand the situation and be more tactically prepared next time).

Departmental policies were in place for handling OIS for 75% of officers surveyed, however they were limited in most cases. One officer claims there were no set policies, but the department was very helpful. Another officers reported policy had changed recently, and since he had been involved in three shootings in a very short amount of time his "department told me (unofficially of course) that I couldn't work the

streets any longer and to find a home before they found one for me." Meaning he needed to find a desk job and not work patrol anymore.

When asked what was most beneficial during counseling and mandatory leave, respondents reports were mixed. One officer's response to the benefits of mandatory leave was, "Didn't have it, the incident still haunts me to this day." Only one officer reported the debriefings as the most beneficial while other officers stated, "the group debrief made things worse for me."

> "I am not a fan of the invite everyone debriefs. Personal exposure to the incident should be broken up and different groups debriefed together. The trigger puller should not be in the same debrief as the dispatcher. All this did was piss me off and most of the time people are only there, so they can say that they were in the debrief with the officer."

Although these are not positive answers, the respondents answered honestly. Those that did provide positive feedback gave data showing that 40% of respondents claimed the backing and support of the agency was most helpful. One officer reported that talking to others who have been in similar incidents helped him heal and move on. Another single officer, when asked about the most beneficial aspects of counseling and leave reported that he did not receive mandatory leave, only a debriefing where the victim of the incident he was involved in spoke to the team, and that he still has feelings from the incident. About 40% of respondents were given the option of time off, but refused to take it, and returned to work the very next business day, while all other respondents did not clarify if mandatory leave was offered, turned down by the officers themselves, or never even an option during their counseling.

When asked what was least beneficial during counseling and mandatory leave, one respondent claimed, "being sent home for 10 days is punishment," and another officer stated he was "off for too long…and then when I did return to work I was put on admin duty and no one knew what to do with me." Other respondents reported not having a true negative experience, just that some things were better than others. One officer places the CISM team as more help than the meeting with a trained psychologist while another reports his "counselor" was inexperienced, and he felt all they did was go through the motions.

When asked if respondent felt more counseling would have been beneficial, 50% of respondents believe they would have benefited from more counseling while the other 50% believes what they received was adequate.

When asked if a second visit, or even a first visit (for the 40% that were not required) with a psychologist would have helped, 40% who had a first visit claimed no further counseling would have benefited them more than the first session, while another 40% said a first visit would have helped normalize results and being able to communicate their feelings about the incident. One officer reported that "perhaps it could have helped me to better deal with the anger and wearing my emotions on my sleeve over the cumulative years." Another stated that a first visit "would have been nice if I was able to sit down and just talk. We did talk as a team, but I would have liked the one on one time." One officer who did receive a first session with a psychologist reported that,

> "If I had been dealing with issues such as nightmares, emotional turmoil, or guilt, I can easily see how additional session would have been beneficial. In my particular situation, I believe I was mentally well-prepared for the possibility of being involved in a shooting, and I did not experience these issues."

Ten percent reported receiving face-to-face sessions or a few telephone conversations, which were helpful, but there are still triggers that are dealt with.

When questioning whether the officer's departments and agencies prepared them psychologically and emotionally to deal with the outcomes of an OIS, 50% reported that they received no such training or classroom time covering the subject and what to expect after an OIS. One officer reported that "my police academy was more academically focused. It met the basic requirements set forth by the state, but it lacked in certain mindset, values and physical skills enforcement that I feel is essential to have in any academy." Another stated, "my agency did a good job of training us, mentoring us and making us feel like as long as what we did was right and for the right reasons they'd have our back."

About 60% of the respondents reported that they felt they were treated fairly during counseling amongst others who have had the same experience. However, one officer (at a time other than during his critical incident) felt that "the department was worried about civil liability and could have provided better treatment than they did for officers under investigation for the shootings."

All respondents state that they did not receive a follow-up from their department or agencies, while 100% of respondents stated they felt fit for duty when returning to work.

When asked what department policies and procedures should be in place, one officer suggested mental health follow ups be mandatory, another stated that the department could provide better feedback on what to expect and provide timely updates on the investigation of the incident.

> "Counseling – I believe there should be another mandatory visit maybe 6 months after the event. The counselor will have another look at the officer and can maybe detect any changes (positive or negative) since seeing him/her immediately after the event."

Others reported that all persons involved in the incident, from patrol to tactical operators, and crisis negotiators should receive the same counseling and peer assistance. Comprehensive policies related to the use of force, the investigation of the officer, and the handling of post incident care for the officer were suggested as well. One officer suggested

> "we should have mandatory mental health follow ups. Definitely for those involved in deadly force incidents, but I believe these check-ups should be mandatory for all employees throughout their career. The line between being in a deadly force situation and not is very thin."

The final of round of surveys where meant to form a consensus from the participants and to finalize what they believe is most beneficial, least beneficial and any recommendations for future treatments of officers.

When asked what specifically can be done for other officer in the future, respondents suggested CISM debriefings, peer support and the department making sure the officer does not feel alone and that their backing is provided. Officers reported,

> "I think Departments could better provide feedback on what to expect during the investigation and provide timely updates on the status of the investigations. Leaving an officer that has done no wrong in the dark about their investigation subjects them to all kinds of emotional stress from gossip and media reports."

> "Administrative support must be immediate. Following that, peer support/activities need to continue, especially if the involved officer is placed on some sort of administrative leave. A lot of times, an officer who is placed on leave can be the last to know regarding the investigation and its progression. Administration and peers need to continue to touch base and check in with the involved officer."

> "CISM training should be given to every officer/deputy. They should be made aware of what is natural and what is problematic when it comes to their own mental health."

Data from survey two showed that no officers in this study received a mental health follow-up, so respondents were asked what they would like to be addressed during a follow-up and when. Officers reported,

> "I think that follow-up appointments should be conducted even after the individual has been cleared to return to duty. An annual follow-up at minimum could help to catch someone who is having issues long after the event."

> "Counseling needs to happen as early and often as needed. Again, there is a balance between forcing someone to seek counseling (to take the stigma away from it) in order to ensure they are evaluated by a professional and allowing someone to manage themselves as they feel appropriate."

Respondents reported that initial support should be immediate and that follow-ups should occur "early and often." A three month and a six-month timeframe was suggested as well for follow-ups to occur. Also, allowing the officers' peers to be involved with the follow-ups, not just administration or psychologists. When asked what should be covered during the follow ups, officers reported being informed on the investigation and any legal issues was important. Being evaluated for changes from the initial intervention, and long-term coping mechanisms were suggested as well by a majority of respondents.

From an administrative/departmental standpoint, officers where asked what specific things should be done after an OIS occurs. Participants reported that awards, ceremonies or even just positive feedback for what the officer did, and complete support of the department was important to them. On top of what can be done by the department, participants were also asked what could be done to ensure the officer is ready to return to active duty. Varying responses were provided to this question. One officer suggested

more training be implemented, specifically force on force training to ensure the officer can still act the way they should during a conflict. Incorporating scenario-based training periodically and to prepare the officers both mentally and physically was reported. Leaving it up to a case-by-case basis was also suggested to fit the needs of the officer to what department resources can do. One participant stated

> "I think the time off, mental health visits should become regular maintenance checks/tune-ups. The cumulative effect of all the shit we deal with takes a toll. It builds up… They need to have scheduled mental health check-ups so it doesn't appear they are reaching out. It removes the stigma and helps keep the officer running at optimal capacity throughout a career."

To gather a consensus, participants were asked once more what was most and least beneficial during their counseling. Officers were first asked what was least beneficial (or even made things worse) and the majority reported nothing during counseling made things worse, yet one officer reported the group debrief made it worse and had no real benefit, while another officer reported,

> "As a trained CISM person, I understood the ground rules of these debriefs. I know they aren't meant to get into tactics, etc… Some of the people involved in our debrief took comments made in the debrief and spread rumors around. I didn't care what childish games they wanted to play, I wanted us to do better for our own safety next time, but I was turned off by the CISM concept at that point."

Conversely, what benefited the majority officers during counseling was not a single method or technique, rather just the process as a whole was said to be more beneficial than not. One officer stated that what benefited him was,

> "taking me at my word and moving on. Not prolonging the process if it clearly didn't need to be. Being a person who talked to me instead of a therapist."

Another officer state that CISM was "the most valuable."

Officers where asked what they would recommend during counseling and a consensus on CISM was reported.

> "Although I am not well educated on the concept I have heard positive things regarding CISM. If a form of counseling is mandated by policy I would recommend CISM as that."

When asked if there were there any specific debriefings or peer related activities that were especially helpful to you, one officer reported a tactical debrief and another reported,

> "A formal debrief was held by our team. It was nice to sit and hear from others what they thought. The single most helpful aspect of peer related activities were the one-on-one or small group conversations I had with others who were there. There were things I didn't realize happened that they were able to shed light on. Hearing them express their appreciation for the actions taken was helpful. A handful of officers still make subtle references to appreciating me taking the action I did as to why they were not seriously injured or killed or for how an innocent third person's life was saved."

When asked if there were any informal ways to help prepare officers to return to duty after an OIS. peer support was largely reported, as well as a trip to the shooting range to ensure the officer can still pull the trigger.

Lastly, officers where asked in general, what can be done to better prepare or assist officers in the future for exposure to a critical incident. CISM and reality-based training were reported as well as just believing in what you do and allowing officers who have "been there" to share their experience. Officer responses were,

> "first thing is no matter the first appearances of the shooting (good or bad) do not let the officer feel alone. Sending an officer home for 10 days with no contact from the world he knows leaves an impression in his mind that something is wrong."

> "Counselors rarely (if ever) have been involved in something like this, so it seems difficult for them to relate or believe they can empathize. Work

> with who the person actually is and where they are at…not where a book suggests they might be. In the absence of experience, they, like everyone else, are left with books and articles they've read on what to expect. The person sitting in front of them is handling the incident the way they are. Work with that instead of trying to force this interaction into the counselor's own theoretical box."

It is also important to note that no respondent knew what Eye Movement Desensitization Reprocessing (EMDR) was.

VII. DISCUSSION

Summary of Findings

The results of this research show that something is being done to assist officers in recovery after a traumatic incident, but a personal touch is still lacking. Previous research on CISM and CISD, showed that it worked for some officers and indicated no positive results for others (Bisson, Jenkins, Alexander, & Bannister, 1997; Everly & Mitchell, 2000; Hobbs, Mayou, Harrison, & Worlock, 1996; Lee, Slade, & Lygo, 1996). The use of EMDR is not as widespread as the previous research would suggest. EMDR has shown positive results (Shapiro 1989, 1999) in a small amount of time. It would be wise to implement it in treatment for the sole reason of possibly getting the officer back to work quicker and spending less time recovering from the trauma. The more time spent slowly recovering from a traumatic incident the more likely post-traumatic stress is to turn into a serious and debilitating disorder. Every participant received a different type of counseling and treatment that varied significantly. However, just because each treatment was different did not indicate it was tailored to an individual. Instead, the type of treatment was dictated by the department. An officer in one department received beneficial treatment and was able to return to work and move on, while another officer received subpar treatment and still suffers nightmares and anxiety from their OIS. Conversely, every participant surveyed was still employed with an agency/department. This shows that even the subpar counseling some officer receive was still enough to mitigate the most serious long-term effects and allowed the officer to return to normal social and cognitive abilities and be deemed fit for duty. Research conducted by McMains (1986, 1991) indicated that the rate of officers leaving their departments after an OIS is declining. With

common treatment modalities, it could be suggested that even today, the number of officers leaving their department after an OIS is still declining. The results of this study follow on the heels of previous research about different techniques and their effectiveness. CISM was favored and suggested by participants as research suggests (Carlier, Voerman & Gersons, 2000; Nurmi, 1999) and showed to make things worse by only one officer (Everly & Mitchell, 2000). The implementation of mental health follows-ups should be a concern for departments to ensure their officers continue to recover and if any long-term effects are present, the department can intervene and get the officer the help that is needed. The results also point towards peer support being a major role in an officer's recovery and is a source of help the department does not have to necessarily implement, as it typically happens organically within the department and the involved officer's close friends. The lack of a tailored approach to counseling does not show to produce any negative effects (short term or long term) on the officers, but still, a more personal approach could benefit the officers in more ways than one and allow for them to continue their careers as a police officer with little to no PTS.

Treatment Frameworks

Treatment frameworks across departments are inconsistent. There is no set standard of intervention for an officer, whether it be after an OIS, a mass casualty event, a fatality wreck, or any other number of scenarios an officer might experience while on duty. The treatment being administered varies drastically from department to department. Those who have experienced an intervention after an OIS, had no idea what to expect, as it is unclear beforehand what the department will do to help. Few officers have been trained in CISM or other peer related activities that are designed to counsel and assist

other officer after a traumatic incident. More training and education for officers willing to learn and support other officer will be an invaluable tool for a department to have as a resource. The research results from this study show that department policies do in fact exist but are more in place to protect the department and the officer from legal matters, rather than a focus on the officer's well-being and psychological aftermath of an OIS. If a larger department with the funds and resources available, implemented a clear and straightforward policy (that can be adopted by smaller departments across the nation) an officer who experiences an OIS and the PTS that might follow, can know they will receive the intervention they need and can be certain the department will do everything possible to ensure they are fit for duty before returning to work.

Future Directions

With more time, more participants, and more in-depth surveys, a research project like this one could obtain even more valuable data on interventions after an OIS. A more widespread view of the counseling received around the nation could have an impact on the way an OIS is handled in the future. The results of this study show a glimpse of the methods and policies in place to assist officers and would be a starting point for a department to analyze their own methods of handling an OIS and implement a more individua approach. It could be assumed that a more tailored approach to counseling might cost a department more in time and money than a 'one size fits all' standard, but the mental and psychical well-being of officers on the streets should be of the utmost importance to an agency.

APPENDIX

Survey One

Describe the shooting incident
Describe the counseling you received following the incident
Describe any techniques of treatment that were used during counseling. Such as, but not limited to, Critical Incident Stress Management Team (CISM), Eye Movement Desensitization and Reprocessing (EMDR), multiple debriefings, etc.

Describe in detail your experience with the department's personnel and policy processes for handling the critical incident you were involved in

Describe in detail what benefited you the most during counseling and mandatory leave

Describe in detail what was least beneficial during counseling and mandatory leave

Year of Incident. _____
Age at time of incident _____
Years of service at time of incident. _____
Estimated size of department. 1-49____ 50-99____ 100-499____ 500-749____ 750+____

Survey Two

Please answer each question to the best of your ability.

Do you believe you would have benefited from more counseling? Specifically, how so?
How would a second visit (or a first visit) with a psychologist have benefited you how?
Please specify an indicate whether you are talking about a 1st or 2nd visit.
Did your department prepared you, emotionally and psychologically (whether from cadet class or informally as your career progressed) to be involved in a shooting and the psychological outcomes?

Amongst others who have experienced an officer involved shooting, do you believe you were treated fairly?

What department policies and procedures should be in place to handle a future incident?

Did your department perform mental health follow ups?

No___ 0-6 months___ 6-9___ 9+____
If so, describe in detail the experience.
Did you feel fit for duty when returning to work?

Survey Three

Survey 3

Based off of feedback and responses from the first two surveys I have compiled these questions in order to form the final survey. We are beyond personal experiences and instead, wanting to gain data in what is personally believed to work best and what should be done in the future for other officers.

1. Based upon your experience, what specifically can be done for other officers involved in a similar incident?
   Please try and give specific recommendations for any suggested actions, whether administrative, counseling, peer support activities (including CISM), etc.

2. Interventions can include administrative actions, counseling, peer related activities (including CISM), or others.
   How long after an incident should any type of intervention take place?
   Indicate when any initial interventions should occur, as well as any further interventions. Your answers may address several types of activities, not just one.

3. Based upon your experience, what specifically should be addressed or covered during initial interventions?

3a. Based upon your experience, what specifically should be addressed or covered during a follow up or later interventions.

4. From an administrative/department standpoint, what specific things should be done for an officer involved in a critical incident? Please be as specific as possible

4a. Specifically, what types of things can be done administratively/departmentally to ensure an officer is ready to return to duty?

4b. Were than any specific administrative/departmental strategies that were especially helpful to you?

4c. Were than any specific administrative/departmental strategies that were NOT beneficial or helpful (or even made things worse)?

5. From a counseling standpoint, what specific things should be done for an officer involved in a critical incident? Please be as specific as possible

5a. Were there any specific counseling strategies that were especially helpful to you?

5b. Were there any specific counseling strategies that were NOT beneficial or helpful (or even made things worse)?

5c. Other than what you experienced, are there other counseling strategies you would recommend?

6. Debriefings or peer related activities (including CISM)

6a. Were there any specific debriefings or peer related activities that were especially helpful to you?

6b. Were there any specific debriefings or peer related activities that were NOT beneficial or helpful (or even made things worse)?

6c. Other than what you experienced, are there other debriefings or peer related activities you would recommend?

7. Are there any informal things that can be done to assist an officer and prepare them for a return to duty?

8. Are there any activities that can be undertaken to better prepare or assist officers in the future for exposure to a critical incident? This might include activities undertaken prior to the event.

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