International Journal of Emergency Mental Health, Vol. 9, No. 1, pp. 13-23 © 2007 Chevron Publishing ISSN 1522-4821

Line-of-Duty Death: Psychological Treatment of Traumatic Bereavement in Law Enforcement

Laurence Miller
Independent Practice, Boca Raton, Florida

Abstract: *A line-of-duty death (LODD) strikingly brings home the risk and vulnerability of all law enforcement officers and affects the officer's peers, the entire department, the wider police community, and the officer's family. This article will place LODD in the context of general bereavement psychology, as well as describe some of its unique features. A variety of supportive and psychotherapeutic measures will be offered for helping peer and family survivors cope with this type of tragedy. This is one important area where police psychologists and community mental health clinicians can be of tremendous service in applying their specialized training in trauma therapy and grief counseling to the special needs of law enforcement and emergency services. [International Journal of Emergency Mental Health, 2007, 9(1), pp. 13-23].*

Key words: *line-of-duty death, traumatic bereavement, critical incident stress, law enforcement psychology, police psychology*

In the world of law enforcement critical incidents, there are few events more traumatic to officers than the death of a comrade, or *line-of-duty death* (LODD; Blum, 2000; Henry, 2004). In addition to the normal grief and loss reactions that officers feel at the death of someone they worked with and knew, the death of an officer, even in a different department, even in a different city, reverberates with all officers because of the powerful identification factor: "It could happen to any of us." In addition, such deaths are traumatic for the families of deceased officers who have suddenly and often brutally been deprived of a loved one in what is usually the prime of his or her life. This article will describe some of the unique features of LODD bereavement, as well as attempt to understand it within the context of general bereavement psychology. A variety of supportive and psychotherapeutic measures will be offered for helping peer and family survivors cope with this type of tragedy.

Correspondence regarding this article should be directed to:Laurence Miller, PhD, Plaza Four, Suite 101, 399 W. Camino Gardens Blvd., Boca Raton, Florida 33432. (561) 392-8881. docmilphd@aol.com

Line-of-Duty Deaths: Facts and Stats

When people think of mass casualties involving police officers and other emergency service workers, they tend to evoke the September 11, 2001 terrorist attacks on the World Trade Center in New York. This was, indeed, the single dead-

liest day in the history of U.S. law enforcement, with 72 police officers killed in a single incident. But almost as many law enforcement personnel were slain by ordinary criminals around the country in 2001, representing a four-year high in murders of police officers. Every year at least 52 police officers are killed in the line of duty, and 26,000 others are injured in service-related assaults. Overall, since 1960, 2,219 police officers have been killed in the line of duty, and 328,000 more have been injured in assaults. Law enforcement's unpleasant little secret is that a high proportion of officers (43% in one study) are accidentally killed or nonfatally shot by their own gun or a fellow officer's weapon. A smaller proportion die by their own hand. Nevertheless, fewer officers are dying in the line of duty today than were back in the 1970s; this is largely attributable to better officer training, more cops on the street, better use of protective gear, and improved firepower of officers relative to the criminals they confront.

Police are most likely to be slain with a handgun and two-thirds of assailants have prior criminal records. Most police homicides occur at night, with Friday being the most dangerous day, and Sunday the least violent. Most officer deaths occur in the course of making an arrest; the next highest category is during workplace or domestic disturbance calls. The South is the most dangerous part of the US for police officers, with more than twice the number of LODDs occurring there as in any other region. A sizable number of officers also die in job-related accidents, which is a line-of-duty death that does not often get the same attention as deaths at the hands of criminals. Most of these involve car and motorcycle accidents (Anderson, 2002; Blau, 1994; Cummings, 1996; Geller, 1993; Haddix, 1999; Miller, 2005, 2006-b, 2006-c; Smith & Rodriguez, 2006; US Department of Justice, 2003; Violanti, 1999).

Reactions of Fellow Officers to a Line-of-Duty Death

Few events are more psychologically destabilizing to a police agency than the death of one of their own in the line of duty. Blum (2000) describes several stages of the grief reaction to a fellow officer's LODD. In my experience, these do not necessarily occur in chronological "stages" per se, but I have observed these reactions in some form or another in most officers following a LODD within a department (Miller, 2006). Similar reactions have been described by Henry (2004).

Shock and disbelief are often the first reactions to a comrade's LODD. Officers may feel numbed and disoriented and "just go through the motions" of their jobs while trying to grapple with the enormity of what has just happened. Many report that they expect to see the slain officer at his desk or in his patrol car. A few will even reluctantly admit to quasi-hallucinations of the dead compatriot ("I saw Smitty standing in the hall, like he was really there"), which under these extreme circumstances is not necessarily a psychopathological reaction, but a form of sensory-perceptual wish fulfillment.

Telling stories about the deceased is a form of self-prescribed narrative therapy, wherein the officers share reminiscences and experiences involving their deceased colleague. Often, much of this takes place at the local bar. This is not necessarily a bad thing, as long as the alcohol is used moderately and constructively to oil the mechanism of self-expression in a supportive atmosphere, not self-destructively to drown feelings by getting smashed beyond reason and/or drinking alone.

Aside from states of intoxication, another place where officers should feel free to show tears is at the slain officer's funeral. It is here that the proper example of *grief leadership* by upper management can have a powerful healing effect. These tough guys need to see that normal expressions of grief do not make someone a weak person and that showing one's honest feelings in a dignified way is actually a sign of respect for the deceased (Miller, 1995, 1998b, 2000, 2003c, in press).

As time since the funeral passes, many surviving officers continue to experience a feeling of profound *sadness.* Officers may experience a sense of overwhelming fatigue, of feeling "drained" most of the time, of dragging themselves through their shifts. Appetite and sleep may be affected and there may be dreams of the slain officer. It is probably incorrect to label this as depression per se, because this is usually an expectable part of the grief process; however, some officers may actually become clinically depressed if they had a special relationship to the slain officer or if they have had a history of mood disorders or other problems in the past (Miller, 1999c, 2003b).

Sadness may be tinged with *anger*, which may be directed at several shifting targets. Anger at the perpetrator of the officer's death – whether a cold-blooded shooter in a gunshot death or a stupidly careless motorist in a traffic fa-

tality – is common, often fueled by what cops see as the inadequacies of the criminal justice system in redressing this outrage against one of their own. Anger may also be directed toward members of the perpetrator's broader group, such as all lawbreakers or all traffic violators. This may lead to overzealous enforcement efforts on the surviving officers' parts, which in some cases may escalate to abuse-of-authority complaints (Miller, 2004). Even if not leading to work problems per se, a general smoldering resentment may adhere to friends, family members, and the general civilian population who "just don't get it" about the dangerous work police officers do, and who are regarded as spoiled, ungrateful recipients of society's protections that these officers risk their necks to provide.

Some of this anger may be stoked by *survivor guilt*, especially where the LODD incident involved a number of officers on the scene: "There but for the grace of God could've gone I." More rarely, grief over the comrade's death may be admixed with anger at the slain officer himself, where it is believed that he somehow contributed to his own death by impulsivity, negligence, or frankly illicit behavior – especially if his actions also put other cops in danger and/or may now result in more work and stress for the surviving officers: "Dammit, we told Manny to wait for back-up, but he always had to be Mr. First-In;" "What the hell was Jonesy doing in a high-speed chase during a damn thunderstorm? We all could've been killed in that pile-up, and now we're all gonna be investigated;" "I didn't want to believe J.D. was involved in that drug deal, but it looks like the bangers greased him, and now we gotta run this down and fix it."

In still other cases, there may be anger at command staff who assigned the patrol or operation, or more generally at the department or city government for cutting manpower and equipment that might have prevented the death, or for administratively hamstringing the cops' ability to adequately control the scene through the imposition of naively soft policies for dealing with dangerous suspects.

Although most officers in most departments are able to resolve their grief and get on with their life and work, a few are unable to let go of the LODD and may experience a *permanently altered world view* about policing, society, or life in general. A small percentage of these individuals may leave the police profession, but most hang on, although with a radically changed perspective of their job and their role in society. Still other officers work out their distress by becoming disciplinary problems – although, in my experience, it is rare for this to happen in officers who have never had these problems before. In such cases, it is important to determine if the LODD or other traumatic critical incident is the main contributor to the problem behavior, or if it represents the continuation or accentuation of a previously existing and long-standing problem (Miller, 2003b, 2004). In the best cases, surviving officers continue to do their good work as a way of honoring their fallen comrade.

Family Survivors of a Line-of-Duty Death

The untimely death of a loved one under any circumstances is a wrenching experience, and family members of a slain law enforcement officer must undergo the further trauma of investigations, court proceedings, and media exposure, during which they will be forced to relive the tragedy again and again.

To add further stress, not all family survivors of slain officers are treated equally, and the difference typically depends on the cause of death, with families of officers slain by criminal assailants tending to receive preferential treatment over those killed in accidents (Haddix, 1999) or judged to be suicides (Miller, 2005). Perhaps this relates to the warrior-mentality notion that the death of a cop while facing down a formidable adversary is somehow more noble than that caused by a glitch of fate or a personal check-out. Whatever the case, law enforcement agencies must assure that all families get the care and consideration they deserve.

Common Family Reactions to an Officer's LODD

Family members, especially spouses, of slain officers typically show a number of physical and psychological reactions in the aftermath of their loved one's death (Danto, 1975; Niederhoffer & Niederhoffer, 1978; Rynearson & McCreery, 1993; Sawyer, 1988; Sheehan, 1991; Sprang & McNeil, 1995; Spungen, 1998; Stillman, 1987; Violanti & Aron, 1994). Many of these are similar to the symptoms of traumatic bereavement experienced by the slain officer's colleagues, but are usually more long-lasting. That's because the other officers have their own intact families to provide support and, when necessary, they can mentally distance themselves from their preoccupation with their comrade's death by immersing themselves in work and their own family activities. No such respite is afforded family members of the deceased officer, who must live with the tragedy 24/7 and will experience the practi-

cal and emotional effects of the loss for years to come.

For many family survivors, the first news of the LODD strikes a *mortal blow to the self*, evoking their own sense of personal loss. Family members are often preoccupied with the nature of the injuries inflicted on the officer, the brutality of the killing, the types of weapons used, and whether and how much the officer suffered. Families may clamor for information about the identity of the murderer and the circumstances under which the killing occurred. Unlike accidental death, murder always involves a human perpetrator, and the greater the perceived intentionality and malevolence of the killing, the greater the distress of the survivors (Carson & MacLeod, 1997; MacLeod, 1999; Miller, 1998c; Spungen, 1998). Indeed, the psychological distress of family members bereaved by any kind of homicide can persist with undiminished intensity for as long as five years following the murder (Kaltman & Bonanno, 2003).

Family survivors may be seized with an *impulse to action*, an urge to "do something." A deep and justifiable *anger* toward the murderer alternately smolders and flares as the investigation and trial meander along. Even after sentencing of the perpetrator, the anger may persist for years. A common coping dynamic consists of ruminating on fantasies of revenge. Actual vengeful attacks by family members on perpetrators are extremely rare, probably due in large part to the sheer impracticability of getting at the murderer as well as to the basic moral values and common decency of most families, who are not looking to correct one atrocity with another. Some of the anger may be projected onto the department: "You gave him this dangerous assignment. You took him away from me." Most families eventually direct their energies toward efforts to aid in the apprehension and prosecution of the killer, which can be seen as either a help or hinderance by investigators and prosecutors.

Even more common than anger, a pervasive *free-floating anxiety*, or "fear of everything," begins to loom in the survivors' consciousness, beginning with their first news of the slaying and persisting for several years or more. Survivors' heightened sense of their own vulnerability may spur them to change daily routines, install house and car alarms, carry weapons, or refuse to go to out after dark or to visit certain locales. There may be phobic avoidance of anything related to the trauma, including people, places, certain foods, music, and so on. Due to a combination of aversion and anger, family members may shun even well-meaning approaches by departmental representatives, other officers and their families, or anyone associated with law enforcement. They may have an ambivalent relationship with their slain spouse's police artifacts: some spouses may sleep in their deceased loved one's uniform, others may burn it.

Family survivors may experience psychophysiological *hyperstartle responses* to such ordinarily nonthreatening stimuli as TV crime shows or news stories of any tragedy, including noncriminal deaths such as traffic fatalities or fatal illnesses. The survivors' usual range of territorial and affiliative activity becomes constricted as the home is turned into a protective fortress, strangers are avoided, and unfamiliar surroundings are circumvented. All family members may be outfitted with pagers and cell phones, and may have to submit daily schedules of activity, as there develops a compulsive need for family members to be close at hand or reachable at a moment's notice. Older children and adolescents may resent this "babying" restriction of their autonomy and independence.

While some family members come to develop a feeling of support and kinship with fellow bereaved victims and co-victims of tragedy, others experience a profound sense of *isolation and alienation*, feeling like lepers or pariahs, cast out of a pre-trauma state of normal existential comfort that the majority of civilians take for granted to assuage their sense of vulnerability, but which no longer is a coping option for the family survivors of a LODD: "We know better – the world is a cruel and ugly place." Survivors may have frequent *disturbing dreams* of the imagined death of the officer, or wish-fulfillment dreams of protecting or rescuing him. This may be compounded by *irrational guilt* if they somehow feel, however illogically, that they should have "done more" to keep their loved one safe: "He had the flu that day, but he said 'no big deal,' he needed the overtime to cover the trip he planned for us for our twentieth anniversary and was glad to go in. I should never have let him go to work sick for a goddamn stupid vacation – I'll never take a vacation again!"

Everybody's health suffers. Common *psychophysiological disorders* include appetite and sleep disturbances, gastrointestinal and cardiovascular symptoms, decreased resistance to infections, and increased anxiety and depression. A few family members may show classic signs of PTSD.

Aggravating Factors in Family Reactions to a LODD

Certain factors exacerbate the stressful challenges of

families trying to cope with an officer's LODD. "Cop-killed-in-the-line-of-duty" stories are second only to "cop-gone-bad" stories in terms of being media favorites. Indeed, where the media can connect these two themes, the prurient interest level of the story rises exponentially. The elevated visibility and scrutiny of such *high-profile cases* virtually assures that family members will be assailed by the media, using every available channel – phone calls, home visits, mobbing on the courthouse steps, and so on. Even if the family could, for a few blessed moments, forget the tragedy they are going through, there will always be the TV, radio, internet chatter, and so on, to remind them. Alternatively, in low-profile cases, some families may feel that the plight of their loved one and themselves is being totally ignored: "Doesn't anyone even care what happened?"

LODD-bereaved police family members form a small subfraternity within the larger police extended family system (Miller, 2006-c, 2007-a, in press). This may lead to a *contagion effect*, with other spouses and families knowingly or unconsciously avoiding the LODD survivors, fearing the reminder of their own loved one's vulnerability. As noted above, families of LODDs involving accidents may not be afforded the same respect and consideration as those slain by criminal assailants; still less support and greater avoidance may be shown to families of officers known or suspected to have died by their own hand (Cummings, 1996, Miller, 2005).

On the other side, officer LODD survivors may not be fully able to bond with other types of non-police bereaved family members whose loved ones died of illness or other causes. Families of these civilian murder victims may have difficulty relating to the unique stresses that families of law enforcement LODD experience. In some cases, civilian family survivors of homicide may actually resent the LODD families because of the preferential treatment they believe a slain officer's case gets over those of mere citizens. All this serves to heighten the LODD police family's sense of isolation and alienation from any kind of community support.

Family Coping Strategies in a LODD

Grief work is the term often used for the psychological process that moves the survivor from being preoccupied with thoughts of the murdered victim, through painful recollections and resolutions of the loss experience, to the stage, where possible, of integrating the experience into one's world-meaning system (Parkes, 1975; Parkes & Brown, 1972). Those who appear to adapt best to painful and traumatic experiences generally seem to possess a range of available coping strategies and resources that permit them greater flexibility in dealing with the particular demands of the traumatic event (Aldwin, 1994; Bowman, 1997; Calhoun & Tedeschi, 1999; Miller, 1998a; Silver & Wortman, 1980). In fact, psychotherapists may capitalize on the individual's and family's natural coping processes to aid them in their grief work and eventual resolution of the trauma.

Following a LODD, police families may employ a range of coping strategies to help themselves make it through the aftermath of the death (Sheehan, 1991; Violanti, 1999). Some try to *mentally distance themselves* from the experience, at least for brief periods of time, by immersing themselves in work or family responsibilities. The myriad and picayune details surrounding the arrangements for funerals and financial matters in the wake of the death can abet a temporarily adaptive intellectualization process that protects the survivor against being emotionally overwhelmed.

To this end, many families who describe feeling drained and beaten by their own emotional storms make a *conscious effort to exert self-control* whenever they can, keeping their feelings to themselves, especially in front of outsiders. Paradoxically, this may cause well-meaning others to urge them not to "hold back" and to "let it all out," when that's exactly what the family members may have been doing for the past 48 hours, and now crave some composure so they can feel normal even for a brief time.

Many families *seek social support* and are able to accept sympathy, understanding, and advice from friends and family members. On the other hand, some withdraw from people and *isolate themselves.* Others become irritable and snappish, and eventually alienate potential sources of support. Children may complain that their surviving parent is "taking it all out on us." Many survivors are so cracked and scarred emotionally that they fear any kind of human contact will cause them to lose what little emotional control they have and "split wide open." Others are still dealing with rage and resentment at how "other people just get to go along with their damn lives because their spouse wasn't a cop."

Psychological Interventions for Family Survivors of a Line-of-Duty Death

The principles of psychological intervention with family survivors of a LODD represent applications of generally validated principles of critical incident debriefing, grief counsel-

ing, and bereavement therapy to the special population of law enforcement families (Green, 1993; Kirschman, 1997; Lindy, Grace, & Green, 1981; Miller, 1995, 1998b, 2006-a, 2006-c, 2007-a, in press; Mitchell & Everly, 1996, 2003; Rynearson, 1994, 1996; Sprang & McNeil, 1995; Spungen, 1998; Violanti, 1996, 1999; Worden, 1991).

Line-of-Duty Death Debriefing

Mitchell & Levenson (2006) have recently elaborated a specialized law enforcement debriefing model for officers coping with a LODD. They point out that on the day of the LODD, a full seven-phase critical incident stress debriefing, or CISD (Mitchell & Everly, 1996, 2003), is probably far too emotionally overwhelming for most personnel who have just endured the death of a colleague and friend. Accordingly, this more extensive intervention is postponed for three to seven days following the slain officer's funeral.

In the interim, the immediate post-LODD debriefing is modified into a streamlined, five-phase protocol that is conducted on the day of the death and usually lasts between 30 and 45 minutes. Its objectives are to disseminate accurate information about the incident and its aftermath and to prepare the personnel to face the turmoil of the next few days, as they go through the funeral and mourning process. Additionally, it is helpful in guiding people in self-care and "buddy support" as they deal with the loss of a colleague. The phases of the modified LODD debriefing are:

Introduction. This is kept as brief as possible. In general, for intradepartmental debriefings, everybody pretty much knows everybody already.

Fact phase. Missing or ambiguous information is almost always more stressful that the "grim facts," no matter how unpleasant those may be. Officers who were present during the LODD are asked to briefly describe what happened so that others can obtain at least the most basic and pertinent facts of the situation.

Reaction phase. The participants are asked, "What are you having the most difficulty with right now?" The rationale is that the overall "worst part" of the situation (as is asked in the traditional debriefing model) typically cannot yet be solicited because, at this early point, most of the officers are still emotionally raw and/or numb and haven't had time to come to grips with what the overall worst part may be. For many, the worst part will occur during or after the funeral.

Teaching phase. The teaching phase is used to prepare officers for the funeral and to encourage them to do things that will help them to take care of themselves as they cope with this loss.

Reentry phase. For the most part, this is a question, answer, and summarization process to help officers move into the next phase of the tragedy.

Psychotherapy for Bereavement: Support and Control

Spungen (1998) cites Getzel and Masters' (1984) delineation of the basic tasks of family bereavement therapy after death by homicide: (1) helping the family understand and put into perspective the rage and guilt they feel about their loved one's murder; (2) helping survivors examine their grief reactions and other people's availability to them so that they regain their confidence in the social order; (3) helping the family accept the death of their relative as something irrevocable yet bearable; and (4) assisting members of the immediate and extended kinship system in establishing a new family structure that permits individual members to grow in a more healthy and fulfilling manner.

One basic element of all effective psychotherapy is to provide *support.* In cases of LODD bereavement, this encompasses emotional, educative, and material support. In addition to regularly scheduled sessions, psychotherapists should be *available* by phone or beeper for family members who just need to reach out for a few words during periods of crisis. Mental health clinicians should *educate* family members on the nature of the grief process and identify and normalize the sometimes baffling and frightening symptoms and reactions that family members may experience. Therapists should offer *realistic reassurance* that families can live through this, but stay away from comments that suggest that the experience will be "resolved" or that families will "get over" the loss any time soon. At this early stage of the traumatic bereavement, there is no way families will believe this, and they may resent what they perceive as a trivializing of their pain by suggestions that it is something that can be "gotten over with."

Trying to help families achieve some measure of control in the midst of such an emotional maelstrom may seem like an impossibly daunting task, but sometimes the place to start is with *physical control.* Most survivors will be on high physiological alert, experiencing anxiety, panic, dizziness, head-

aches, stomach distress, sleep disturbances, ruminating thoughts, impaired memory and concentration, and other signs and symptoms. Training family members in relaxation, biofeedback, meditation, or other self-regulation exercises that reduce arousal can show them that they can control at least something – their own bodies. This may give them the confidence to try to gain increasing degrees of control over other chaotic aspects of their now-upside down lives (Miller, 2007-b).

Some survivors cope by maintaining a *steely reserve*, an unnatural calmness of mood, speech, and behavior that may well reflect an innate stoicism of character, but may also be a typical posttraumatic sign of emotional numbing. In the early stages, this should be accepted, since this rigid emotional splint may literally be the only thing that is holding the person together. As time goes on, therapists should gently guide the explorative process to gradually unbind the emotionally constricted survivor, but always in the context of respecting the individual's ability to handle the emotions, and always with the ultimate goal of increasing, not diminishing, the person's sense of control (Miller, 2007-b).

Other survivors may want to vent and, indeed, the therapist's office may be the only place where they feel safe enough to do so. With such individuals, therapists need to remember the difference between *venting* and *spewing*. The former is a cathartic, albeit sometimes painful, expression of suppressed emotions that leads to a feeling of relief and possibly greater insight and control. The latter is an unproductive emotional regurgitation that often heightens distress, clouds understanding, and leaves the person feeling even more out of control. Therapists have to monitor and guide the expressive process so that it heals, not hurts (Miller, 2006-c, 2007-b).

Psychotherapy for Bereavement: Guilt and Anger

Two especially important issues that are often intertwined in the coping process after a LODD are *guilt* and *anger.* In an attempt to make some existential sense out of their loved one's death, family members may blame themselves for their officer's fate. As unfair to oneself as some of these self-reproachful rationales may seem to others ("If we didn't have a fight the night before, he wouldn't have left work so early the next morning, and then he wouldn't have been the one to make that fatal traffic stop"), families may cling to these pseudoexplanations to provide at least some kind, any kind, of meaning. Being angry at oneself is one way to seize a form of psychological control of the situation, and some of this internalized anger may be projected outward onto the police department, the criminal justice system, or society in general.

Or vice-versa. Sometimes there is a legitimate basis for the family's anger that is partly expressed outward, and partly internalized. Maybe the criminal really was let out of jail too early. Maybe the city really should have authorized funds for body armor for law enforcement personnel instead of spending all that money on a damn stadium. Maybe the media really are acting like slime in calling the house every five minutes and ambushing the family outside their home or business. Maybe those blissfully stupid and uncaring civilians really do have absolutely no clue and don't care about the sacrifices made every day on behalf of their safety by police officers and their families.

Therapeutically, even legitimate, righteous anger must be handled carefully, allowed to come out at a controlled pace in the venting-not-spewing format noted above. Guilt feelings should also be acknowledged, and it is usually a vain exercise to try to stir someone out of the self-reproachful viscosity that is temporarily allowing their psyche to stay glued together. Having the individual explore the reasons for his or her feelings can often delicately guide them into a more realistic view of causation and responsibility. Equally important is helping the family – when they are ready – to channel guilt and anger feelings into productive activities that may actually make a difference in how the system works and may serve to memorialize the slain officer.

One way to do this is to help the family members *reconfigure their respective family roles* in the absence of the missing loved one. Aside from all the other stresses associated with the traumatic LODD, different family members will have to pick up new and different responsibilities, from paying the bills, to preparing meals, to mowing the lawn, to helping with homework, to participating in social functions. The stresses associated with these role shifts should be expressed and acknowledged, and the therapist should support and assist family members in making these transitions.

Related to this are *grief and closure exercises* that enable the family to master and integrate the traumatic bereavement, partly through *memorialization activities* that allow planning for the future while honoring the past. For example, pictures and other mementos of the deceased officer can

serve as comforting images, reviewed in the therapy session to summon nurturant, positive imagery that may counterbalance the grotesque recollections of the bereavement by homicide. Similar memorializing activities include writing about the deceased, drawing pictures, or creating a scrapbook. Again, none of this should become an unending, unhealthy, all-consuming preoccupation, although in the early stages, some leeway should be afforded to allow the memorializers to "get it out of their systems." If possible, family members should collaborate in these personalized memorial rituals and projects as a way of forging a renewed sense of meaning and commitment within the family structure.

Finally, although some families do manage to forge a *posttraumatic growth experience* out of the LODD of their loved one (Bear & Barnes, 2005; Calhoun & Tedeschi, 1999), psychotherapists should be cautious not to turn this into an expectation, which can risk further demoralizing an already-reeling family by giving them one more thing to feel bad about – that they weren't able to extract a "growth experience" from their tragedy. However, when family members indicate an ability and willingness to take this existential step, therapists must be willing an able to guide them along this path (Miller, 1998b).

Children and LIne-of-Duty Death

The death of a parent or other close relative from any cause has a special impact on children, and this applies poignantly to children of officers killed in the line of duty (Williams, 1999). As with all untimely deaths, children must cope with the loss of the parent and the disruptions in family routines, living standards, and family roles that this entails. At too early an age, children are faced with the existential reality of life's fragility and impermanence and the fact that bad things can happen to good people unexpectedly at any time.

Effects of LODD on Children

Unlike the anticipated death of a loved one from a long illness, death that is sudden and unexpected leaves no chance to say goodbye or to take care of *unfinished business.* Death that additionally is violent and traumatic can leave bereaved children with mixed feelings of shame and horror.

The palpable distress of the surviving parent, as well as his or her distraction by numerous activities and responsibilities following the officer's death, may cause children to *fear that they will be abandoned,* either because the parent has "better things to do," or because their last remaining caretaker will die too.

Compounding the distress, the high media attention afforded a law enforcement LODD virtually assures that families, including children, will be subjected to *endless replays and retellings* of the event that keep the traumatic memories stingingly fresh in everyone's mind long after bereaved families of more "ordinary" deaths have had a chance to apply the balm of time and regain their bearings.

Psychotherapy with Child Survivors of LODD

Williams (1994a, 1994b, 1999) has outlined a set of psychological principles for dealing with children of LODD officers that are similar to those that have been found effective more generally in treating traumatically bereaved children and families (Crenshaw, 2005; James, 1989; Johnson, 1989; Miller, 1998b, 1999a, 1999b, 2003a, in press). First, *accurate information,* at a level and in a tone that is appropriate for the child in question, should be provided. Contrary to popular belief, children are hardly ever reassured by dismissive "there-there, it's nothing for you to bother about, everything will be alright"-type answers to their questions about the most jarringly traumatic event in their lives (Yalom, 1980). On the contrary, such ambiguity only adds to their anxieties and amplifies their fearful fantasies about what may have happened to the deceased parent.

As much as possible, the surviving parent and other family members should strive to create as much of a *semblance of normalcy* as possible, so that the child does not feel that his or her whole world has been completely tossed on its head. At the same time, as noted above, adults should not go too far in the opposite direction of pretending that "nothing's wrong," because, clearly, the child will be aware of the overall atmosphere of grief and stress hanging over the family. Such mixed messages can only further confuse and frighten children.

A much healthier response is to *model mature strength under pressure:* adults should strive to let their children know that it is okay to grieve and that the adults are hurting too, but that they will not break under the pressure, and that, above all, they will be there to protect and take care of their children as needed. This is, in fact, the family version of *grief*

leadership shown by supervisors in law enforcement agencies where a fellow officer has been slain.

As discussed earlier, children can be encouraged to participate productively in *memorialization activities* by helping with funeral and other memorial arrangements – at an age-appropriate level, and only if the child wants to – as well as writing stories, drawing pictures, making a photo scrapbook, and other activities to remember the slain parent.

Finally, the help of the *child's school* should be enlisted by informing teachers and school officials about the bereavement, providing classmates with age-appropriate information, helping the other kids know how to make the returning child feel safe and welcomed, and by trying to make the classroom an oasis of stability and normalcy, a haven apart from the turmoil that may be going on at home in the first few months and years following the traumatic bereavement.

Administrative Policies and Actions for Family Survivors of a Line-of-Duty Death

Police agencies have been criticized for neglecting or abandoning the bereaved spouse and family after a line-of-duty death by failing to provide adequate follow-up support services (Sawyer, 1988; Stillman, 1987). Surviving officers and their wives may dislike interacting with the widow of a slain officer because it reminds them of their own and their loved one's vulnerability and mortality, the *contagion effect* noted previously. Both police administrators and mental health clinicians can encourage the sharing of grief responses with others who have walked in the same shoes as an adjunct to more formal psychotherapeutic grief work (Blau, 1994; Regehr & Bober, 2005; Miller, 2006; Sprang & McNeil, 1995; Spungen, 1998). Recently, a number of law enforcement family self-help support groups, such as *Concerns of Police Survivors (COPS)* and others, have begun to respond to the challenge; survivors should be urged to consult local directories and websites (Kirschman, 1997). A cop's life encompasses all those around him or her in police family and home family alike. Each deserves proper consideration, support, and respect.

Conclusions

A line-of-duty death slams home the risk and vulnerability of all law enforcement officers and therefore may be reacted to by a paradoxical combination of morbid fascination and numbed avoidance by members of the immediate and extended police family. Police psychologists and community mental health clinicians can be of tremendous service to surviving officers and their families by applying the principles of trauma therapy and grief counseling to the special needs of the law enforcement community.

REFERENCES

Aldwin, C.M. (1994). *Stress, coping, and development.* New York: Guilford.

Anderson, C. (2002). Report: Police slayings increase. *South Florida Sun-Sentinel,* December 3, p. 3A.

Bear, T.M. & Barnes, L.L.B. (2005). Postttraumatic growth in survivors of law enforcement officers killed in the line of duty. *Study conducted with the membership of Concerns of Police Survivors (COPS).*

Blau, T.H. (1994). *Psychological services for law enforcement.* New York: Wiley.

Blum, L.N. (2000). *Force under pressure: How cops live and why they die*. New York: Lantern Books.

Bowman, M. (1997). *Individual differences In posttraumatic response: Problems with the adversity-distress connection.* Mahwah: Erlbaum.

Calhoun, L.G. & Tedeschi, R.G. (1999*). Facilitating posttraumatic growth: A clinician's guide.* Mahwah: Erlbaum.

Carson, L. & MacLeod, M.D. (1997). Explanations about crime and psychological distress in ethnic minority and white victims of crime: A qualitative explanation. *Journal of Community and Applied Social Psychology, 7,* 361-375.

Crenshaw, D.A. (2005). Clinical tools to facilitate treatment of childhood traumatic grief. *Omega, 51,* 239-255.

Cummings, J.P. (1996). Police stress and the suicide link. *The Police Chief,* October, pp. 85-96.

Danto, B.L. (1975). Bereavement and the widows of slain police officers. In E. Schoenberg (Ed.), *Bereavement: Its psychological aspects* (pp. 150-163). New York: Columbia University Press.

Geller, W.A. (1993). Put friendly-fire shooting in perspective. *Law Enforcement News, 18*, 9.

Green, B.L. (1993). Identifying survivors at risk. In J.P. Wilson & H. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 135-144). New York: Plenum.

Haddix, R.C. (1999). Responding to line-of-duty deaths. In L. Territo & J.D. Sewell (Eds.), *Stress management in law enforcement* (pp. 287-296). Durham: Carolina Academic Press.

Henry, V.E. (2004). *Death work: Police, trauma, and the psychology of survival.* New York: Oxford University Press.

James, B. (1989). *Treating traumatized children: New insights and creative interventions.* New York: Free Press.

Johnson, K. (1989). *Trauma in the lives of children.* Alameda: Hunter House.

Kaltman, S. & Bonanno, G.A. (2003). Trauma and bereavement: Examining the impact of sudden and violent deaths. *Journal of Anxiety Disorders, 17,* 131-147.

Kirschman, E.F. (1997). *I love a cop: What police families need to know.* New York: Guilford.

Lindy, J.D., Grace, M.C. & Green, B.L. (1981). Survivors: Outreach to a recalcitrant population. *American Journal of Orthopsychiatry, 51,* 468-479.

MacLeod, M.D. (1999). Why did it happen to me? Social cognition processes in adjustment and recovery from criminal victimization and illness. *Current Psychology, 18,* 18-31.

Miller, L. (1995). Tough guys: Psychotherapeutic strategies with law enforcement and emergency services personnel. *Psychotherapy, 32,* 592-600.

Miller, L. (1998a). Ego autonomy and the healthy personality: Psychodynamics, cognitive style, and clinicial applications. *Psychoanalytic Review, 85,* 423-448.

Miller, L. (1998b). *Shocks to the system: Psychotherapy of traumatic disability syndromes.* New York: Norton.

Miller, L. (1998c). Psychotherapy of crime victims: Treating the aftermath of interpersonal violence. *Psychotherapy, 35,* 336-345.

Miller, L. (1999a). Treating posttraumatic stress disorder in children and families: Basic principles and clinical applications. *American Journal of Family Therapy, 27,*21-34.

Miller, L. (1999b). Posttraumatic stress disorder in child victims of violent crime: Making the case for psychological injury. *Victim Advocate, 1*(1), 6-10.

Miller, L. (1999c). Psychotherapeutic intervention strategies with law enforcement and emergency services personnel. In L. Territo & J.D. Sewell (Eds.), *Stress management in law enforcement* (pp. 317-332). Durham: Carolina Academic Press.

Miller, L. (2000). Law enforcement traumatic stress: Clinical syndromes and intervention strategies. *Trauma Response, 6*(1), 15-20.

Miller, L. (2003a). Family therapy of terroristic trauma: Psychological syndromes and treatment strategies. *American Journal of Family Therapy, 31,* 257-280.

Miller, L. (2003b). Police personalities: Understanding and managing the problem officer. *The Police Chief,* May, pp. 53-60.

Miller, L. (2003c). Law enforcement responses to violence against youth: Psychological dynamics and intervention strategies. In R.S. Moser & C.E. Franz (Ed.), *Shocking violence II: Violent disaster, war, and terrorism affecting our youth* (pp. 165-195). New York: Charles C. Thomas.

Miller, L. (2004). Good cop – bad cop: Problem officers, law enforcement culture, and strategies for success. *Journal of Police and Criminal Psychology, 19,* 30-48.

Miller, L. (2005). Police officer suicide: Causes, prevention, and practical intervention strategies. *International Journal of Emergency Mental Health, 7,* 23-36.

Miller, L. (2006-a). Critical incident stress debriefing for law enforcement: Practical models and special applications. *International Journal of Emergency Mental Health, 8,* 189-201.

Miller, L. (2006-b). Officer-involved shooting: Reaction patterns, response protocols, and psychological intervention strategies. *International Journal of Emergency Mental Health, 8,* 239-254.

Miller, L. (2006-c). *Practical police psychology: Stress management and crisis intervention for law enforcement*. Springfield: Charles C Thomas.

Miller, L. (2007-a). Police families: Stresses, syndromes, and solutions. *American Journal of Family Therapy, 35,* 1-20.

Miller, L. (2007-b). METTLE: *Mental Toughness training for law enforcement*. Flushing, NY: Looseleaf Law Press.

Miller, L. (in press). Stress management and crisis intervention for law enforcement and mental health professionals.

In F.M. Dattilio & A. Freeman (Eds.), *Cognitive-behavioral strategies in crisis intervention* (3rd ed.). New York: Guilford.

Mitchell, J.T. & Everly, G.S. (1996). *Critical incident stress debriefing: Operations manual*. (rev. ed.). Ellicott City: Chevron.

Mitchell, J.T. & Everly, G.S. (2003). *Critical incident stress management (CISM): Basic group crisis intervention* (3rd ed.). Ellicott City: ICISF.

Mitchell, J. & Levenson, R.L., Jr. (2006). Some thoughts on providing effective mental health critical care for police departments after line-of-duty deaths. *International Journal of Emergency Mental Health, 8,* 1-4.

Niederhoffer, A. & Niederhoffer, E. (1978). *The police family: From station house to ranch house.* Lexington: Heath.

Parkes, C.M. (1975). Determinants of outcome following bereavements. *Omega, 6,* 303-323.

Parkes, C.M. & Brown, R. (1972). Health after bereavement: A controlled study of young Boston widows and widowers. *Psychosomatic Medicine, 34,* 449-461.

Regehr, C. & Bober, T. (2005). *In the line of fire: Trauma in the emergency services.* New York: Oxford University Press.

Rynearson, E.K. (1988). The homicide of a child. In F.M. Ochberg (Ed.), *Posttraumatic therapy and victims of violence* (pp. 213-224). New York: Brunner/Mazel.

Rynearson, E.K. (1994). Psychotherapy of bereavement after homicide. *Journal of Psychotherapy Practice and Research, 3,* 341-347.

Rynearson, E.K. (1996). Psychotherapy of bereavement after homicide: Be offensive. *In Session: Psychotherapy in Practice, 2,* 47-57.

Rynearson, E.K. & McCreery, J.M. (1993). Bereavement after homicide: A synergism of trauma and loss. *American Journal of Psychiatry, 150,* 258-261.

Sawyer, S. (1988). *Support services to surviving families of line-of-duty death*. Maryland: COPS, Inc.

Sheehan, P.L. (1991). Critical incident trauma and intimacy. In J.T. Reese, J.M. Horn & C. Dunning (Eds.), *Critical incidents in policing* (pp. 331-334). Washington DC: Federal Bureau of Investigation.

Silver, R. & Wortman, C. (1980). Coping with undesirable life events. In J. Garber & M. Seligman (Eds.), *Human helplessness* (pp. 279-340). New York: Academic Press.

Smith, K. & Rodriguez, I. (2006). A tragedy in a split second: Broward law officer struck, killed by car. *South Florida Sun-Sentinel,* February 17, p. 4B.

Sprang, G. & McNeil, J. (1995). *The many faces of bereavement: The nature and treatment of natural, traumatic, and stigmatized grief*. New York: Brunner/Mazel.

Spungen, D. (1998). *Homicide: The hidden victims. A guide for professionals*. Thousand Oaks: Sage.

Stillman, F.A. (1987). *Line-of-duty deaths: Survivor and departmental responses.* Washington DC: National Institute of Justice.

United States Department of Justice, Federal Bureau of Investigation (2003). *Uniform crime report: Law enforcement officers killed and assaulted, 1990-1993.* Washington DC: U.S. Government Printing Office.

Violanti, J.M. (1996). The impact of cohesive groups in the trauma recovery context: Police spouse survivors and duty-related death. *Journal of Traumatic Stress, 9,* 379-386.

Violanti, J.M. (1999). Death on duty: Police survivor trauma. In J.M. Violanti & D. Paton (Eds.), *Police trauma: Psychological aftermath of civilian combat* (pp. 139-158). Springfield: Charles C Thomas.

Violanti, J.M. & Aron, F. (1994). Ranking police stressors. *Psychological Reports, 75,* 824-826.

Williams. M.B. (1994a). Intervention with child victims of trauma in the school setting. In M.B. Williams & J.F. Sommer (Eds.), *Handbook of posttraumatic therapy* (pp. 203-220). Westport: Greenwood Press.

Williams. M.B. (1994b). Impact of duty-related death on officers' children: Concepts of death, trauma reactions, and treatment. In J.T. Reese & E. Scrivner (Eds.), *Law enforcement families: Issues and answers* (pp. 111-119). Washington DC: U.S. Printing Office.

Williams. M.B. (1999). Impact of duty-related death on officers' children: Concepts of death, trauma reactions, and treatment. In J.M. Violanti & D. Paton (Eds.), *Police trauma: Psychological aftermath of civilian combat* (pp. 159-174). Springfield: Charles C Thomas.

Worden, J.W. (1991). *Grief counseling and grief therapy: A handbook for the mental health practitioner.* New York: Springer.

Yalom, I. (1980). *Existential psychotherapy.* New York: Basic Books.