

Police Officer Suicide: Causes, Prevention, and Practical Intervention Strategies

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ABSTRACT: *More police officers die by their own hand than are killed in the line of duty. This article outlines the facts and statistics about police officer suicide and discusses the range of possible contributory factors to officer burnout, depression, and suicide. It then describes the range of prevention strategies that police agencies can employ to minimize this tragedy, including identification of risk factors, sensitivity to overt and subtle cues of officer distress, and proper utilization of counseling and referral services. Next, the article offers practical guidelines for dealing with officers in states of impending or acute suicidal crises. Finally, the importance of suicide prevention and intervention in the context of comprehensive mental health services for all public safety workers is highlighted. [International Journal of Emergency Mental Health, 2005, 7(2), pp. 101-114].*

KEY WORDS: *police officer suicide, crisis intervention, police psychology, suicide prevention*

One of my friends and colleagues, a senior law enforcement official and continuing education instructor, starts out one of his seminars by posing the following question: “Which individual is more likely to kill you during your service career than all other groups combined?” Responses tend to come in along the lines of, “drug dealers,” “crazy persons,” “traffic stops,” “gang members,” and so on. The correct answer always surprises the officers: *yourself*.

Similarly, of all the topics in my Police Academy classes, the subject of police officer suicide is the one that elicits the highest number of both wincing and jokes, because this is a topic that hits close to home, that strikes at the heart of this special vulnerability that almost every officer feels at one time or another during his or her career (Henry, 2004; Miller, in press-a; Toch, 2002). Of course, most officers in distress

find other ways to deal with their problems, some healthy, some less so, without taking the ultimate plunge into oblivion. But, as more than one officer has told me in a moment of candor, “Hey, we’ve all *thought* about it.”

Police Officer Suicide: Facts and Stats

Police work is a dangerous business, but not only for the reasons most people think. While officers share some features of suicide risk with the general population, other facts and statistics apply more specifically to the law enforcement profession (Baker & Baker, 1996; Bongar, 2002; Cummings, 1996; Hill & Clawson, 1988; Loo, 1999; Mohandie & Hatcher, 1999; Quinnet, 1998; Violanti, 1995).

The suicide rate for law enforcement officers is two to three times the rate of the general population, and three times as many officers kill themselves – about 300 annually – as are killed by criminals in the line of duty. This makes officer suicide the single most lethal factor in police work. The true rate might even be higher, since many deaths of “undetermined cause” may in fact represent disguised suicides.

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Suicide rates for U.S. police officers have been increasing since the 1920s, and are even higher in several other countries studied. Officer suicide rates tend to be higher in demographically diverse areas of the U.S. and other nations. Interestingly, the suicide rate among the Royal Canadian Mounted Police tends to be about half that of other agencies studied (Loo, 1986), perhaps because of a combination of demographic homogeneity of the force plus the high status and honor accorded this elite law enforcement agency.

Suicidal crises rarely occur in isolation, but are most commonly seen in officers with prior histories of depression, or in those who have recently faced a combination of debilitating stressors, leading to feelings of hopelessness and helplessness. Often, there is a slow, smoldering build-up of tension and demoralization, which then abruptly accelerates, culminating in a suicidal crisis. It is not uncommon for there to be a pattern of such mood cycles over the course of the individual's lifetime. Nevertheless, suicidal crises in officers, as with most persons in acute distress, tend to be short. This means that timely intervention can literally make a life-or-death difference.

Like most people, officers commit suicide as a maladaptive response to intolerable personal, family, and/or work situations they feel they cannot resolve. Unlike many people, however, cops tend to be very personally invested in their professional role as law enforcement officers, and therefore react strongly when this image is threatened. In many cases of suicide, there has been a cumulative effect of several stressors, often involving a combination of relationship and work problems – the two pillars of self-esteem that most officers rely on.

Alcohol complicates depression and suicidality for two reasons. First, during a crisis, alcohol impairs judgment and increases the risk for impulsive behavior. Second, a history of alcohol abuse is often associated with a parallel history of mood disturbance and other impulsive, erratic, and even violent behavior, such as stalking and intimidation, domestic violence, workplace aggression, or abuse of force on patrol (Miller, 2004).

The good news is that, with appropriate treatment, about 70 percent of depressed, suicidal persons, including officers, improve considerably within a few weeks. This does not mean that depressed moods and suicidal thoughts won't ever occur again, but a history of successful psychological treatment provides a support resource that the individual

can rely on, if and when the next crisis occurs. The most effective treatments for depression combine medication and psychotherapy, the former to stabilize the subject's emotional state, and the latter to explore reasons for the depression, examine alternatives to suicide, substance abuse and other destructive behaviors, to reinforce coping skills and mobilize social support systems to forestall or mitigate future crises, and generally to provide the person with a sense of hope and positive self-regard.

Predisposing Factors for Police Suicide: Law Enforcement Personality and the "Cop Culture"

Certain features of police work distinguish it from other occupations in terms of the intensity and personal identity-investment that characterize most officers. Accordingly, certain aspects of the so-called "police personality" and "cop culture" of most law enforcement agencies can, paradoxically, both buffer and exacerbate an officer's response to stress (Allen, 1986; Blau, 1994; Cummings, 1996; Henry, 2004; Miller, 1995, 1998, 1999b, 2003b; Mohandie & Hatcher, 1999).

The police culture reinforces a professional ethos that resonates with the personal philosophy many officers already bring to the job from their own family and cultural background. Notably, this often includes a black-or-white, good-or-bad, all-or-nothing, life-or-death perspective on the world and the people in it. Shades of gray are often regarded as the bleeding colors of washed-out conviction and resolve, and this includes the officer's self-perception of his status as a law enforcement professional and as a human being. Not that all officers think and act like robocops, but when it comes to matters of personal honor and collegial prestige, two primary qualities that almost all working cops adhere to are self-reliance and infallibility. Many officers believe that they should be able to handle most situations with a minimum of help and that "you're only as good as your last screw-up."

At the same time, most officers have a strong craving for approval. Part of the gratification the police role bestows lies in the respect it garners among civilians, as well as the camaraderie felt among brother officers. In addition, many officers obtain great comfort and support from their families, which often is the one venue where they can both physically and emotionally hang up their cop uniform – "get out of the bag" – and relax with loved ones. Most of the time, this unstable alloy of self-reliance and need for social approval provides a

thick but rigid psychic shell of protection against assaults to the officer's self-esteem.

Unfortunately, this orientation leaves little room for acceptance of fallibility or error: thus, another phrase, "failure is not an option," is heard so often in police circles as to have almost become a derisive cliché. An officer's brittle shell of self-esteem may shatter into a suicidal crisis if breached by a barrage of professional or family stresses, especially a combination of the two. For such officers, shame is a far worse emotion than fear, and losing the respect of their peers or the support of their family is perceived as more critical than losing a limb or a lung to a suspect's bullet. Hence, life in the face of these kinds of crises may be literally intolerable.

To make matters worse, a distressed officer, wishing for some kind of human connection, but reluctant to accept it for fear of appearing weak, may recoil from the well-meaning support offered by others. After several failed attempts to reach out, the sympathy of these erstwhile supporters may be exhausted, and they may then react with predictable counter-avoidance: "Okay, if you don't want our help, go deal with it yourself." The officer, who is probably not even consciously aware of his role in pushing away the very human contact he craves, now sees the reactive antipathy of others as "proof" that he is abandoned and all alone in the world, perpetuating the vicious cycle of isolation-rejection.

The rigidity that may characterize many officers' thinking even in the best of times becomes exacerbated during times of stress, leading to a variety of cognitive distortions that impair his ability to think himself out of the jam, chief among them a heightening of dichotomous thinking. The all-or-nothing value system becomes further internalized ("If I can't get myself out of this mess, I must *really* be a screw-up"), as well as projected onto others ("All those people I thought I could count on – when push came to shove, they bailed on me, too").

Another feature of the police personality and cop culture puts officers at risk for suicide. By virtue of temperament and training, most officers are action-oriented and are used to responding rapidly and decisively in critical situations. But what is certainly an asset in quickly controlling a dangerous suspect on patrol or making a snap judgment call in a hostage situation, may prove a distinct disadvantage in situations that require more contemplation and analysis. In such cases, action, in the absence of sufficient judgment or knowledge, degenerates into rudderless impulsivity, and the

imperative to "do something" may propel the officer into self-destruction if this appears to be the "only way out" of the jam.

Cop-culture and police-personality factors affect not just how an officer interprets his situation, but also how he is likely to respond to it. Besides decisiveness, a feature of the law enforcement officer response style is aggressiveness, in the sense of being proactive and knowing when to use appropriate force and authority to control a dangerous situation. This may include the use of deadly force if there is no other choice, and for a suicidal officer who feels personally threatened by a crisis state – as much as by any weapon-wielding suspect on the street – aggressive action against the self may represent the "only choice" he sees.

And then there's the gun. Obviously, immediate access to a powerful firearm characterizes the police profession and increases the danger of impulsive self-directed violence. Even the ordinary citizen who owns a gun typically does not have this weapon at his side constantly, as do most police officers. And yet, a good number of officers choose to take their own lives by other means, such as medication overdoses, auto crashes, or asphyxiation. As well as can be reconstructed, the rationale seems to be one of not wanting to dishonor their profession by using their service weapon, which is a more likely attitude in cases where the suicide has to do primarily with personal matters, rather than job issues. However, in cases where the officer feels the department has betrayed or abused him, he may make a point of using his service weapon as a stark symbol of how "this job has killed me." In still other cases, an officer may choose to use his gun precisely because in his mind, this represents a "soldier's death," the modern equivalent of falling on one's sword.

Preventing Police Suicide

Invoking the principle that "the best form of crisis intervention is crisis prevention" (Miller, 1998; in press-a; in press-b), law enforcement agencies can do much in the initial stages of selecting and acculturating their officers to mitigate the predisposing factors for officer stress, depression, and suicide (Baker & Baker, 1996; Mohandie & Hatcher, 1999; Mohandie, Piersol, & Klyver, 1996; Zelig, 1996).

Psychological screening is an important part of the selection process for new officers to ensure that these officers possess a reasonable degree of psychological stability and

maturity. Periodic reassessments should also be part of the personnel standard operating procedure to assure that budding problems don't sprout unobserved into major crises. This also presupposes an efficient, nonstigmatized referral system for dealing with officers in psychological distress, so that any problems observed can receive appropriate treatment in a supportive atmosphere. One way of reducing stigmatization and encouraging troubled officers to come forward for help is via education about police stress, depression, and suicide, provided by means of inservice programs or outside continuing education.

Finally, healthy law enforcement organizations contribute to the overall psychological health and resilience of their officers by reinforcing fair practices and open communication among levels of the organization (Peak, Gaines, & Glesnor, 2004; Thibault, Lynch, & McBride, 2004). This applies to virtually all public and private organizations, not just law enforcement agencies (Miller, in press-b).

Police Suicide: Risk Factors

A major part of prevention involves identifying and dealing with risk factors. Risks for suicide can be divided into general risks, and risks specifically related to police officers (Allen, 1986; Bongar, 2002; Cummings, 1996; Mohandie & Hatcher, 1999; Packman, Marlitt, Bongar, & Pennuto, 2004). With regard to the former, there appear to be some demographic and clinical descriptors that put some individuals at special risk for suicide. Of course, if anyone threatens suicide, it should never be discounted just because the person or the threat doesn't fit the "right profile."

Typically, Caucasian males of older age are at increased risk for suicide, largely because they are at increased risk for depression. A family history of suicide is a risk factor, as is a personal history of previous suicide attempts. A subject who is currently depressed, psychotic, or abusing substances, or who has a past history of these syndromes, is at increased risk. Recent significant changes in mood are also a danger sign. Subjects who live alone or are otherwise isolated may have no interpersonal resources to draw on when they become overwhelmed.

Subjects who have experienced a recent loss, either personal or job-related, are at risk, as are those struggling with a current medical crisis. The anniversary of a past loss or

trauma may trigger a depressive, suicidal episode. Subjects who ruminate on past traumas or injustices may get themselves into an angry-depressed feedback loop that may spur impulsive violence, either outer- or self-directed.

Some of the specific risk factors for police suicide overlap with general risk factors, while others are more unique to the police role. Officers who are under criminal or administrative investigation, especially if this represents the culmination of an otherwise shameful episode in the officer's career, may fear the loss of status and identity of the police role, and for some overly emotionally-invested officers, this may be too much to bear.

Officers may also become despondent because they feel they let their fellow officers down in a crisis situation, "froze" during a dangerous encounter, or failed to "pull their own weight" on an assignment. The shame and despair is magnified exponentially if the presumed lapse of performance led to the injury or death of another officer or innocent civilian.

For both police and the general population, *current intent and/or plan* are the two red flags that clinicians use to determine whether someone is an immediate suicide risk. Is the subject idly ruminating about what the world would be like without him, or is he intending to end his life right now? Has she been making "final plans," such as giving away prized possessions or sending letters or e-mails apologizing to people for the wrongs she's done? Does he have vague ideas of how to die, or a well-thought out plan? Also important is the factor of *means and methods*: if a subject talks about going out in a "blast," does he indeed have ready access to firearms or explosives? Has she been treated for chronic pain and have a collection of narcotic medications waiting to be swallowed?

Police Suicide: Warning Signs

Beyond taking note of general risk factors, supervisors, fellow officers, family members and friends can all be valuable resources in identifying officers in distress who may be at more immediate risk for suicide. Cues and clues may be verbal or behavioral, often mixed (Allen, 1986; Cummings, 1996; Mohandie & Hatcher, 1999; Quinnet, 1998). While not all suicidal officers will show all of these signs, even a few such cues should raise sufficient concern for a supervisor to take action.

Verbal Cues

Threatening self. Verbal self-threats can be *direct*: “I’d be better off eating my gun;” “That’s it – I give up.” Or they may be *indirect*: “It’s a hell of a thing not to be needed in this world;” “Enjoy the good times while you can – they never last.”

Threatening others. Often, self-loathing is wholly or partially transmuted into hostility toward others, especially toward those believed to be responsible for the subject’s plight. Verbal threats can be either *direct* – “I oughta cap that damn lieutenant for writing me up” – or *indirect*: “People with that kind of attitude deserve whatever’s coming to them.”

Surrendering control. As noted earlier, suicidal crises are rarely all-or-nothing. A person in distress may be wrestling with the question of whether life is worth living, and at the same time be frightened of his or her own impulse to end it. In such cases, the individual may “passively” resist the suicidal impulse by ceding some measure of control to others. For a chronically ill person in pain, this may mean handing over his narcotic medication to a spouse or friend to keep himself from popping the whole bottle in a spasm of despair. For most police officers, it is their gun that is the constant lethal companion, so these officers, if the job allows it, may prefer to place some distance between themselves and their weapon: “As long as I’m on desk duty this week, can I keep my weapon in my locker? It’s a pain in the butt to lug it around the station.” Or the surrendering of control may be less specific and broader in scope: “Things are getting too hairy out here; I think I may need to check into the Bug Hilton to get my head together.”

Throwing it all away. A person who feels hopeless may lack the desire or resolve to actually take his or her own life, but may nevertheless feel he has “nothing to lose,” and so begins to talk about actions that are clearly out of bounds, a kind of passive suicide: “I’ll drink or smoke what I want, on or off duty. So what if I test positive? What are they gonna do – fire me? Arrest me? Shoot me? – ha-ha. Anyway, who gives a damn?”

Out of control. This is probably the clearest and most unequivocal verbal clue to suicidality, next to actually threatening oneself: “If that Review Board burns me again, that’s my last strike, and then I can’t tell you what kinda hell’s gonna break loose.”

Hostile, blaming, insubordinate. This can be subtle and sarcastic: “Yeah, right, Sarge, I’m really gonna check the spelling on that damn report – wouldn’t want the department to get any paperwork demerits.” Or it can be spewingly overt: “Screw you – this mess is all your fault and I’m not going down alone for this!”

Defeated. This may express itself as hopeless demoralization without necessarily being suicidal: “I’ve had it. I’m burnt. I’m ready for the Prozac Squad.” Or still subtle, but with a more suspiciously dangerous intent: “I’ve had it. I’m burnt. I’m ready for a permanent vacation.” Or more overtly lethal: “I’ve had it. I’m burnt. I’m ready to go home and smoke out.”

Morbid attraction to suicide or homicide. The officer may collect news stories about suicide or other violent deaths, talk about people who have killed themselves, and develop a morbid fascination with death and dying: “You know the story about that cop in Ohio who killed his family and himself? I know how that poor bastard felt.”

Overwhelmed. “My wife just left me, my checks are bouncing, I’m drinking again, the Internal Affairs ferrets are gonna be crawling up my butt tomorrow – I just can’t take all this.”

Out of options. “I did everything I could, and now I’m losing my house and my family, and I’m going to jail? No way that’s happening, no friggin’ way.”

Behavioral Cues

Gestures. This can be any kind of pantomimed self-destructive or other-directed action, which for police officers, most commonly consists of an inappropriate display of their weapon or surrogate. This can range from the officer just “fooling around” by putting his fingers in the shape of a gun to his head with a forced grin, to actually putting a cocked weapon to his head, chest, or throat with a “serious-as-a-heart-attack” expression on his face.

Weapon surrender. The officer gives his firearms to his partner or supervisor to hold for him, or locks them up somewhere.

Weapon overkill. This is the exact opposite pattern: the officer begins carrying more than one backup weapon, or begins to keep especially powerful weapons in his vehicle or on his person, ostensibly “for protection.”

Excessive risk-taking. The officer enters into dangerous situations without his weapon, with insufficient precautions, or without waiting for backup. Or, risk-taking may express itself more prosaically as reckless driving or neglecting health issues.

Boundary violations. This involves flouting departmental rules and generally stepping on the wrong departmental toes with a “so-sue-me” attitude. The most common examples include using departmental vehicles, office equipment, and computers for personal use. In some cases, this escalates to frank insubordination.

Procedural violations. This is similar to the above, and involves putting the officer’s career in jeopardy by frank violations of departmental procedure, such as excessive force, drinking, sleeping, or AWOL on duty, latenesses and absences, violations during training exercises, and an overall attitude of “just asking for trouble.”

Final plans. This may include making or changing a will, paying off debts, increased interest in religion, giving away possessions, or excessive donations to charities.

Surrendering control: In some cases the officer actually checks into a psychiatric facility, which may in fact be a healthy interim strategy.

Intervention with the Potentially Suicidal Officer

As a colleague, supervisor, or clinician, you may have identified an officer who is sufficiently depressed and demoralized to be considering taking his own life. He may not be actively suicidal at this point (the topic of the next section), but appropriate intervention at this stage might well forestall a more dangerous crisis to come (Allen, 1986; Mohandie & Hatcher, 1999; Quinnet, 1998).

Identify and Marshall “Natural Resources”

If the officer appears reluctant to discuss the issue with you, then you should make every possible effort to find friends, relatives, clergy, or other people that the officer trusts and has found a valuable source of support in the past. This is especially true for officers who fear the stigma of being “shrunk” by a mental health professional. This is also the rationale behind the Peer Counselor programs instituted in many departments (Finn & Tomz, 1999; Toch, 2002).

Officer: My life is getting more and more out of control. I don’t know how much longer I can stand it.

Intervener: Have you talked to anyone about this?

O: Who the hell cares about my problems?

I: I seem to remember, a couple of years ago, you had something bugging you.

O: Yeah, that damn Review Board was breathing down my neck.

I: What did you do then? Did you talk to anybody about it?

O: Captain Smith was an okay guy. He helped me keep my head on straight while they were dragging the thing out. Also, my cousin Eddie had just shipped in from Desert Storm, and we hit it off because he had been through some similar stuff in the military.

I: What about ringing up these guys now?

O: Smitty retired last year and is off on some island somewhere.

I: What about your cousin?

O: Well, it’s been a while. I guess I owe him call, anyway. But I don’t want to just call him out of the blue bitching about my problems.

I: Just plain call him. If your current situation comes up in the conversation, deal with it. If not, just some friendly jawboning with someone you trust can take the edge off, you know? Besides, you’re doing him a favor, too, by calling him, right?

O: Yeah, okay, this might be a good time to reconnect anyway.

Clarify Internal State

A prominent emotion during states of depression is confusion. Potentially suicidal officers are probably already skewing their perceptions and interpretations in the direction of helplessness and hopelessness, while dismissing or discounting any positives. Interveners should try to create a more favorable balance by identifying and separating out areas of self-deprecation and despondency vs. self-worth and hope. The first step is to try to find out what the officer is thinking, which may be no small feat with officers who are accustomed to “suffering in silence.”

I: You're not looking so great lately. What's going on?

O: Nothing I can't handle.

I: I realize that, but I know you a long time, so just to humor me, give me a clue.

O: I don't even know myself. One minute I think everything's under control, and then it all looks like crap.

I: Can you give me some examples of the "under control" parts and the "crap" parts?

O: I'm just getting everything going on the job, putting in extra time, getting my performance ratings up; then I get home and catch hell from the wife for never being around. And this is after she's complained that there's not enough money coming in to cover the bills. So, then I crash and feel like nothing I do ever works out.

I: So you've been able to turn the work situation around. That shows that when you put your mind to something, you're able to get it done. Seems like you *can* handle things, but that doesn't mean it never gets to you.

Reduce Sense of Isolation

As with most forms of crisis intervention, just helping the person feel like he or she is not all alone in the world can have a heartening effect. Reducing isolation can occur in two main ways that sometimes overlap: commiseration and support.

Commiseration relies on shared experience: "I've been there, and I've gotten through it, and so can you." *Support* lets the distressed person know that others are there for him or her, that even if we haven't been through the same experience ourselves, we'll try to understand, empathize, and help in any reasonable way we can. Such empathy is possible because, while the unique life circumstances of individual traumatic crises may differ from person to person, the emotional responses and coping strategies that human beings use are near-universal (Regini, 2004). Accordingly, there is bound to be something in the intervener's experience that may allow him or her to relate to the officer in distress on some level. And if not, just knowing that someone is on their side can be immensely reassuring in times of crisis.

I: Listen, I've had an easy run of it so far, no critical

incidents I've been involved in, no beefs with the brass or fights at home, so I'm not gonna give you a speech. But, hey, if you want to talk to me, I'm here. You don't have to go through all this in a bubble, you know.

O: Okay, thanks.

I: Besides, you ought to talk to Raul in Automotive. He went through a similar thing about a year and a half ago, and he's a nice guy. In fact, he's helped a few guys out from time to time.

O: Yeah? I didn't know that. Okay, thanks, I'll think about it.

Encourage Active Problem-Solving and Realistic Alternatives

Sometimes, the best way to break through a depressive, potentially suicidal crisis is for the person him- or herself to take some corrective action, and thereby achieve a measure of self-efficacy, competence, and confidence. But the depressed officer may need some encouragement or even concrete guidance to break the inertia of despair. On the other side, be careful not to push the officer to do more than he can realistically accomplish in his present state of diminished capacity, because you don't want to risk further demoralizing the officer if he feels that what you're suggesting only further serves to prove how ineffectual he's really become.

I: Well, have you tried sitting down with your wife and talking about this?

O: You kidding me? You know how many times I've tried that? She just gets mad or hysterical and storms off. It's hopeless!

I: Okay, so much for the direct approach. But you told me she overdramatizes the financial pressures and that, with your overtime, you're actually bringing in more than enough to cover the bills, and then some. Why don't you write up a little budget statement that documents this, and e-mail it to her? You know she's gonna read it, at least out of curiosity, and that way you get your point across without a face-to-face blow-up. And even if she doesn't believe it, at least you know you did everything possible to try and resolve the situation.

O: Yeah, it's worth a shot. She spends all her time on the computer, anyway.

Intervention with the Actively Suicidal Officer

Sometimes the first chance you get to intervene with a depressed, suicidal officer is when a crisis has already developed. The officer is actively considering suicide, and your task is to keep him or her alive long enough to get appropriate follow-up care. The intervention strategies discussed here derive from the basic principles of crisis intervention (Dattilio & Freeman, 2000; Gilliland & James, 1993; Greenstone & Leviton, 2001; Kleepsies, 1998; Miller, 1998), applied to the special needs of police officers in distress.

Define the Problem

As noted previously, some personal crises relate to a specific incident, such as an officer who learns of a spouse's affair or separation, or who has been involved in a traumatic critical incident (Miller, 1999a, 2000, 2003a). Often, however, a crisis state will evolve cumulatively as the result of a number of overlapping stressors, until it hits the "breaking point." In such cases, the officer himself may be unclear as to what exactly led to the present crisis state. Furthermore, this confusion typically adds to anxiety and a sense of being overwhelmed, which is particularly destabilizing for officers who are already struggling with control issues. Feeling this sense of control slip away can escalate to panic and despondency in a rapidly-spiraling vicious cycle.

Thus, one immediate task is to help the subject clarify in his or her own mind what exactly has led to the crisis state. This often involves a set of focusing and clarifying questions, similar to the internal state clarification noted above for the potentially suicidal officer. But now, in the actively suicidal state, there is increased specificity and urgency to the intervention.

O: I can't stand it anymore. My life is out of control. I don't see any way out.

I: What's out of control?

O: Everything, man, everything. Nothing goes right, everything's turned to crap.

I: Can you give me an example?

O: Everything, the job, my wife – it's all going to hell.

I: [Focuses] What's going on with the job?

O: I work like a slave all year, put in for extra overtime, volunteer for the Chief's pet programs, and then they

tell me the city says there's no more raises, overtime, or bonuses this year – that's after we already put the down payment on the new house.

I: Is that what's making you feel this way?

O: That's part of it, yeah. And then the wife, she's all over me because now she's scared we'll lose the house. So it's nonstop screaming and crap. And on top of that, Internal Affairs is now reopening my file because of some more bogus complaints.

I: [Clarifies] So you got caught by surprise with the no-raise thing and the investigation, and now all the family plans are backed up? And everybody's walking around like a raw nerve?

O: Right. Plus, I avoid going home to the fighting, so I'm spending more time at Paddy's, so I come home crooked, and that leads to more battles. And sooner or later, someone's gonna finger me for a drunk, and that's gonna add to my jacket. I can't take this man, I'm getting ready to suit up.

Ensure Safety

You're not going to solve all of the officer's problems in this one encounter. What you want to do is make sure he survives this crisis so he can avail himself of follow-up services. For now, assume that if the officer contacted someone at all, or is even willing to talk when you arrive, that he has not made the irrevocable decision to end his life right here and now. Your job is to use this wiggle room productively. At the very least, try to encourage the officer to put even a few short steps between the thought of a self-destructive behavior and the act of carrying it out.

I: Is there anything in there with you that could hurt you?

O: I got my service Glock with a full mag. Yeah, that could hurt someone.

I: Any chance of you putting the gun away while we talk?

O: So what, so you can all bust in here and drag me away to the nut house?

I: Actually, I just want to make sure you're safe. If you're gonna do something, then you're gonna do it, but for right now, how's this? How about popping out the

mag and the cap in the chamber, and putting everything on the table in front of you. That way, if you really want the gun, it's right there, but at least you'll give yourself a second to think about it.

O: Yeah, right, and the minute I take the mag out, you bust in and get me. Hey, I wasn't sleeping in that class, either, man.

I: Okay, I understand. Then how about at least putting the safety on? It takes, what, half a second to flip the switch back? Nobody's gonna do anything to you in half a second.

O: I'll think about it.

I: Thanks.

This approach can be applied to other potential means of suicide. For example, the officer can be asked to put a knife on the table instead of holding it to his throat. He can be encouraged to keep the lid on the pill bottle while you're talking. If he's standing on a building ledge or on a curb beside heavy traffic, he can be encouraged to take just one pace backward, and so on.

Provide Support

This is just what it sounds like: letting the officer know that you're on his side. Remember, this does not mean you necessarily have to agree with a distressed subject's reasoning or point of view – and it's usually counterproductive to pretend you do when you don't – but a little empathy and commiseration can go a long way in establishing trust and encouraging a nonviolent resolution to the incident. It may also elicit some insight into issues that underlie the present predicament or that may have led up to it.

But remember, the goal of crisis intervention is not psychotherapy per se. You don't want to disregard a subject's important feelings and thoughts about his or her situation, but be careful to keep the conversation reasonably focused on resolving the present crisis, gently suggesting that the larger issues can be dealt with later – which of course implies that there *will* be a "later."

I: Family and job stresses – they all just piled up, huh?

O: What a pile, yeah, that's a good way to put it. It seems my whole life, no matter what I do, nothing works out, everything turns to a pile of crap.

I: When a lot of crap happens at once, it can seem like that's all there ever was, even if there was some good stuff tucked away in there.

O: Good stuff, what good stuff? Good stuff is for other people. I get crap.

I: I hear you man. You sound like a guy who's tried to make it work, but sometimes too many things get in the way.

O: That's it – like there's friggin' curse on me or some thing.

I: Hey, I'm not gonna give you any magical fairy dust speech, but sometimes curses can be broken.

O: Yeah, how?

I: I'm also not gonna pretend I have a pre-cooked answer for you, but sometimes looking at things in a different way, trying things out you didn't do before, sometimes just staying away from certain people or situations – things like that. At least it may be worth a shot. But right now, all I'm saying is I hear where you're coming from, I hear a world of hurt, and I'm hoping I can help you can get things together for yourself.

O: I dunno, man, but hey, thanks anyway.

Examine Alternatives

Often, subjects in crisis are so fixated on their pain and hopelessness that their cognitive tunnel vision prevents them from seeing any way out. Your job is to gently expand the range of nonlethal options for resolving the crisis situation. Typically, this takes one of two forms: accessing practical supports and utilizing coping mechanisms.

Practical Supports. Are there any persons, institutions, or agencies that are immediately available to help the officer through the crisis until he or she can obtain follow-up care? Of course, you want to be reasonably sure that these support people will assuage, not inflame, the situation until professional help is obtained. Support systems or persons can consist of trusted relatives, friends, coworkers, supervisors, clinicians, clergy, and so on. Always be mindful of the risks and liabilities of relying on these support people instead of professional responders, and be prepared to make the call to commit the officer involuntarily if he truly represents an imminent danger to himself.

O: I already told you, I'm not going to no damn hospital to be locked up and pumped full of drugs.

I: Okay, let's leave the hospital out of it. I know you told me about your problems with the Department and your wife, but is there anyone you know out there who's on your side, who could stand up for you and help you out?

O: I got a brother who's a good guy, but he lives across the country. Besides, I don't want my family involved in this.

I: Okay, anyone else, anyone more local, someone you trust?

O: I dunno, maybe my friend Mike. We were in the service together, and we got to be buddies. Then I didn't see him for about five years, until he moved to town about a year ago.

I: If Mike agreed to look after you for the rest of the weekend, till things cool off, would that be okay with you?

O: Yeah, we've been through some stuff together, he'd understand.

I: Okay, then, if we call Mike?

O: Sure, go ahead.

Coping Mechanisms. These can consist of cognitive strategies, religious faith, distracting activities, accessing positive images and memories of family, and so on. You can appeal to both present and past coping mechanisms. For subjects who are feeling hopeless, it is often useful to recall past crises that were resolved without violence or self-harm. This shows that it's at least *possible* to get through the present crisis, and possibly come up with an even better solution this time than last time, so that the officer can prevent things from getting this bad again.

The caution here is that the subject may think that this present crisis is far worse than anything that's ever happened in the past – and sometimes this may be true – in which case, comparison with past, smaller crises may only serve to highlight the hopelessness of the present “big one.” The intervener may therefore have to be creative in putting the present crisis in perspective.

O: I dunno, all these plans – what's the point? It's not like anything's gonna change in a couple of days. I'll

still be under the same pile, no matter what.

I: You said something earlier about how you've had bad crap happen many times before. Can you give me an example?

O: I dunno, lots of things.

I: Can you think of something specific?

O: What is this – a test? Okay, about six years ago, I got fired from a job for stealing tools. Only it wasn't me that stole them, it was another guy who hid the tools in my locker, but they found them on me before the other guy could retrieve them, so he just sat back and let me take the rap. They were ready to fire me and press charges. I could've gone to jail.

I: What'd you do?

O: I filed a grievance, and luckily we had a decent union on that job that backed me up with a lawyer. To make a long story short, they ended up finding that although the “evidence against me was compelling,” quote-unquote, the investigation technically didn't follow all their own rules and protocols, so we worked out a deal where I'd resign without a severance package, but the charges wouldn't go on my record. Even though I wasn't guilty, I took the deal, since I needed to find another job. That's how I got my next security job, which led me to apply to the Police Academy and I wound up in this department.

I: So you went from almost being busted to becoming a cop. It was terrible to be falsely accused, but you handled it, you used your brains and your willpower, and you made it come out the best way possible. When you put your mind to something, you're able to work it out.

O: Well, I had some help....

I: Hey, everybody gets a little help, nobody does anything all by themselves. How'd you get your head through it all, knowing that the other guy did it?

O: That was probably the hardest part, knowing that the little turd was sitting there laughing. God, I wanted to mess him up! But I knew if I did anything like that, they see it as proof of my own guilt, plus I'd go to jail for sure. So I kept telling myself to be a stand-up guy, don't back down, see it through, and maybe someday

what goes around comes around, but I don't think I really believed that.

I: You kind of talked yourself through it. And you kept yourself from doing something you knew would hurt you in the end.

O: Yeah, I guess so.

I: You think you could do something like that now, at least till we get a chance to figure out the whole deal? I mean, just to get yourself and everyone safely through the next couple of days?

O: I dunno, maybe I could try.

Make a Plan

Again this involves a combination of both practical supports and coping mechanisms. It also may involve making short-term plans and long-term plans.

I: Okay, I want to make sure I have everything straight. I'm going to call Mike and see if you can stay with him till Monday morning. You're just going to kick back, watch the ballgame, and avoid the bars, okay? You haven't done anything with the gun, it hasn't been fired, you didn't threaten anybody with it, so just holster it for the weekend or put it in a lockbox, and everything's cool with that. I suggest you tell your wife where you'll be, so she doesn't worry, but tell her you need some time to chill, and you'll contact her Monday. But first thing Monday morning, I want you to contact our EAP or go over to County Clinic so you can get some help in dealing with this, all right?

O: Now I gotta see a shrink for the rest of my life.

I: Maybe not even for the rest of the month. But you may need a couple of sessions just to straighten things out. Besides, the Department may require a fitness-for-duty evaluation and maybe mandatory counseling, so you might as well score some points by taking the initiative on your own.

O: It's gonna be a long weekend, man.

I: Hey, I respect what you're doing, it's not easy. But, look, you already got yourself beyond having to go to the hospital, and that's a matter of trust between us. Just tell yourself what you've told yourself in the past. You're a stand-up guy. You're not gonna give up till

you work things out at work and at home, right?

O: I guess so.

I: Guessing will turn to knowing real fast, once you get the ball rolling.

Obtain Commitment

Finally, make sure the officer understands the plan and is reasonably committed to following it.

I: We on the same page, man?

O: Yeah, okay.

I: All right, just so I'm clear, tell me what we agreed on.

O: What, you don't believe me?

I: Just so I'm clear in my own head, okay?

O: [Repeats the plan].

I: You're cool with this, you're gonna do it, right?

O: Yeah, yeah, I'll do it, I'll do it.

I: I'm proud of you, man. I'll call Mike and the Clinic, and then I'll check up with you on Monday, okay?

O: Yeah, yeah, whatever.

I: Okay??

O: Okay, okay [laughs]. Jeez, what a pain in the ass.

Of course, none of this is a foolproof script or formula, but applying the basic principles of crisis intervention in an atmosphere of sincere concern and respect can not only save an officer's life in the short term, but perhaps even nudge that life and career in a more productive long-term direction.

Post-Crisis Mental Health Intervention

Fitness for Duty and Return to Work

The general principles of psychotherapy with law enforcement officers have been covered elsewhere (Blau, 1994; Miller, 1995, 1998, 1999a, 1999b, 2000, in press-a; Russell & Biegel, 1990; Sewell, Ellison, & Hurrell, 1988; Silva, 1991; Solomon, 1995), and most of these apply to the treatment of officers following a suicidal crises, with a few special considerations (Allen, 1986; Baker & Baker, 1996; Cummings, 1996; Mohandie & Hatcher, 1999; Quinnet, 1998; Violanti, 1996).

One obvious issue relates to fitness-for-duty (FFD) of

an officer whose emotional state has gotten sufficiently precarious to propel him to the brink of death. In many cases, this will be a formal departmental issue (Rostow & Davis, 2002, 2004; Stone, 1995, 2000). But in some cases, officers may consult outside psychologists or other therapists privately, and the suicidal episode may have been quietly resolved without the department being aware of it. In other cases, the department does know about the episode, but essentially trusts the psychologist to treat the officer any way he or she sees fit, and to “make the right call” if there is any safety or performance issue.

Some police psychologists have addressed the issue of a separation between the administrative evaluation and clinical treatment aspects of the psychologist’s role (Blau, 1994; Flanagan, 1986; Mohandie et al., 1996; Scrivner, 2002; Sewell, 1986). After all, if an officer is eager to return to work, there may be an understandable motivation to “tell the shrink what he wants to hear” in order to get a clean bill of mental health. A preferable arrangement would be to have one psychologist perform the initial FFD evaluation, turn the officer over for treatment to a clinical therapist, perhaps through the department EAP, and then have the officer re-evaluated by the first psychologist after he or she has completed treatment with the clinician. An added benefit of this arrangement is that the two professionals can literally “compare notes,” which reduces the chances of the officer running a deceptive game on either professional.

However, many departments don’t have the luxury of this division of labor, so one police psychologist may have to do it all. In such cases, the psychologist should be sensitive to the clinical, administrative, confidentiality and liability issues involved in treating distressed officers.

Special Psychotherapeutic Issues

Certain practical matters are especially important to address in treating an officer following a suicide attempt or gesture. Foremost are the twin issues of safety and responsibility. Inasmuch as the best prediction of future behavior is past behavior, it is likely that officer will experience another emotional downturn some time in the future. And inasmuch as the best form of crisis intervention is crisis prevention, the therapy process should establish a system for identifying the triggers to a depressive episode and aborting the spiral of despair that may again impel the officer to consider taking his or her own life.

For example, individuals in crisis may be encouraged to address the tailspinning cognitive distortions of the FIT model (Acosta & Prager, 2002), i.e. that the dire circumstances or problems currently being experienced are (1) not necessarily *Forever*: they are not permanent conditions, but will pass or can be resolved; (2) not necessarily *Innate*: they may reflect the influence of external factors, not just be the direct result of immutable inner faults; and (3) not necessarily *Total*: they comprise a subset of life, not the whole of life itself.

This gives the subject realistic hope that the situation can be improved, and the process is best accomplished by delineating as concrete and practical a protocol for self-management as possible. This can then be applied to any crises that begin to develop down the road.

Therapist: The next time things get hairy for you, what are you going to do?

Officer: I think I’ll be able to handle it a lot better.

T: You probably will, but to make sure that happens, give me a rundown of the plan we discussed.

O: Okay, if I start getting real depressed or angry, I’ll call your office and make an appointment. If it’s at night or the weekend, I’ll call my friend Mike or, if it’s real bad, I’ll page you. In the meantime, I’ll stay away from the booze – Jeez, doc, that’s the hardest part.

T: Just for my own clarification, how will you know when you’re getting “real depressed or angry?” And what kinds of things are likely to set you off? What will you do when these things happen?

O: This *is* a tough test, isn’t it? All right, if my asshole lieutenant starts riding me, I’ll use the interpersonal coping skills we rehearsed to try and “de-escalate” the situation – I know you like that word, doc – and if things get out of hand, I’ll take a few minutes to chill and get my bearings. I’ll remember our discussions about what really makes a man a competent, responsible man, and I’ll use all those coping skills we’ve talked about for the last couple of sessions. If my wife is supportive, I’ll accept her help on its own terms, but if she’s too ticked off or stressed out, or whatever, to be there for me, and especially if it looks like things are getting to the point of fighting at home, I’ll de-escalate there, too. Oh yeah, and I’ll remind myself that I’ve felt hopelessly out of luck before, but I was able to resolve it in the past and can do the same now. Is that it?

T: That's about it. Now the key is to put it into practice when you need it. Sounds like you'll be successful.

Conclusions

The general principles of crisis intervention can be productively adapted to the intervention and treatment of police officers in distress, as long as the clinician is willing to gain some familiarity with the police culture and the men and women of law enforcement who inhabit it. What may be unique about police psychology is the wide range of individuals that may be called upon to deal with a given crisis – mental health clinicians, police supervisors, peer counselors, fellow officers, and so on. Thus, this is one area where a cross-fertilization of ideas and expertise between psychology and law enforcement can be especially productive.

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It aims to increase awareness of the public health significance of suicide and suicide attempts, to make suicide prevention a higher priority on the global public health agenda, and to encourage and support countries to develop or strengthen comprehensive suicide prevention strategies in a multisectoral public health approach. The report provides a global knowledge base on suicide and suicide attempts as well as actionable steps for countries based on their current resources and context to move forward in suicide prevention.

@article{Miller2005PoliceOS, title={Police officer suicide: causes, prevention, and practical intervention strategies.}, author={Laurence Miller}, journal={International journal of emergency mental health}, year={2005}, volume={7 2}, pages={. 101-14 } }. Laurence Miller. More police officers die by their own hand than are killed in the line of duty. This article outlines the facts and statistics about police officer suicide and discusses the range of possible contributory factors to officer burnout, depression, and suicide. It then describes the range of prevention strategies that police agenc Police officer suicide: Causes, prevention, and practical intervention strategies. International Journal of Emergency Mental Health, 7, 101-114. [Reprints available from the author: send request and mailing address to docmilphd@aol.com]. Miller, L. (2006). Practical Police Psychology: Stress Management and Crisis Intervention for Law Enforcement. Springfield, IL: Charles C Thomas. [Learn more about this book at www.ccthomas.com].

