# INTO THE NIGHT

# A police psychologist presents a play-by-play of a barricaded subject/hostage situation

*By Troy Rodgers, Psy.D.*

I'm in my office finishing up some paperwork for the day. It's about 5:15 p.m. when the initial text message comes in: There is a subject who has barricaded himself inside his home with one hostage. According to the initial report, the hostage is the wife of the subject, and the subject is heavily armed and has already fired multiple rounds.

I think briefly how glad I am that the call came in late so that I don't need to reschedule patients again, and then how disappointed I am that I won't be home for dinner. As I drive to the scene, text updates come in about the situation, which started at 11 a.m. A domestic violence incident between a husband and wife escalated and became a hostage/barricade event. I am informed that the husband has a military background, and there is concern that he may have post-traumatic stress disorder (PTSD).

Across the United States, a text like this gets sent out to local, state, federal, tribal, and other police agency officers and consultant mental health providers about 100 times a day. The request is for the most highly trained officers and deputies to respond to an event where the risks are high and the need to mitigate negative outcomes is essential. As consultants in these situations, mental health providers like myself bridge the gap between the field of law enforcement and the science of psychology.

We are asked to assist CNT and SWAT teams in finding solutions to crisis events that have escalated to the brink of destruction or loss of life. In today's world, the mental health consultant is invited to the crisis situation because he or she has a unique skill set and knowledge pertaining to human mindsets and behavior that have become increasingly essential to the performance of law enforcement duties.

In any given year, the staff of the Public Safety Psychology Group responds to 75 to 100 crisis negotiations on-scene. In preparation for these events, we provide multiple, 40-hour basic crisis negotiation classes and at least one 40-hour advanced crisis negotiation class to prepare first responders—the hostage negotiators—to implement their scientific knowledge and insight into dynamic and often unpredictable events. The classes also give us an opportunity to work alongside officers so that comfort and trust can be established before a crisis takes place.

## MAKING AN INITIAL ASSESSMENT

I typically arrive on scene and spend the first 10 to 15 minutes getting up to speed on the situation from the CNT supervisor, the command post information boards, and the responding officers. This initial period is crucial to creating a complete picture of the subject, the current situation, and how our actions or lack thereof may influence the outcome of a volatile situation.

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I want to create a mental picture or assessment of whom we're dealing with, what motivates that person, and what has prompted the current situation: loss of hope, loss of perspective, loss of reality, or loss of control. If I can sneak a peek into their minds or walk in their shoes for a moment, I can share this perspective with the negotiator, who will become the lifeline to a safe resolution of the crisis.

In this situation, we were working with a 40-year-old married man with a military background and a possible PTSD diagnosis. There was initially some information that he had recently been fired from the local VA hospital, but little more.

As I gather information, I start to create a psychological picture of the person to whom we will be talking, and the current mental and emotional state he is in. During this process, we often realize that we are missing pieces of the puzzle and attempt to obtain them, if possible. In this case, a missing piece was the suspect's mental health history, so I called the local hospital to obtain any information we could.

They refused to provide information, citing HIPAA (the Health Insurance Portability and Accountability Act of 1996) and the protection of patient rights. I told the woman about potential exceptions to HIPAA and that a SWAT situation with an armed individual with a hostage is likely to meet the threshold for an exception to the rule. She checked with a supervisor and returned to the line 15 minutes later, informing me that she had called the subject, had a 10-minute conversation, and determined that he was not a threat to himself or others.

At one point she slipped up, telling me that the suspect had been a longtime a patient of theirs, but she refused to provide a diagnosis or treatment information. As we talked (or argued), the subject fired additional rounds from the barricaded house; she dismissed this as "him releasing his frustrations." Eventually, she let me know that the man was fired the day before incident, but was unwilling to provide more information without a signed release from him.

## REACHING OUT TO THE SUSPECT

Contact with the subject was sporadic at best. He answered the phone and talked for a few minutes, then hung up. He was unresponsive to the negotiator's public service announcements issued over a loudspeaker. He didn't answer multiple calls from the negotiator, then all of a sudden, picked up the phone to lecture and yell. This pattern went for about 90 minutes.

During one of his rants, high ground radioed that someone was coming out the front door. A female exited the house and was taken into custody. Shortly thereafter, she was brought back to the CNT staff for debriefing. The CNT team determined that the woman was the victim/hostage. She was angry and upset.

I watched as negotiators helped her process her experiences of the last few hours. They got a floorplan of the home from her and a description of the weapons inside. They asked about the subject's state of mind, his current intentions, and the reason for the conflict. She periodically asked officers to shoot her husband to end her pain, saying that she just wanted the man out of her life.

My job at this point is to observe and analyze verbal and nonverbal information for missing details, inaccuracies, fabrications, or anything that could be of use in resolving the situation peacefully. After a few minutes, the victim asked if she could leave—she had a birthday party to attend down the street. She emphasized that she fully consented to officers entering her home, and she hoped that they could take her husband into custody safely.

## WEARING MULTIPLE HATS

The role of a psychologist or mental health consultant in these situations is always changing. In one moment, you're a coach for the negotiator; the next, you're a consultant for the tactical commander. Then you're an expert on mental illness and emotional crises, or you're working to gather intelligence and other useful information. In many ways, your job is to step back and watch from a distance as the situation's emotional roller coaster evolves. By stepping back, you offer perspective, insight, and sometimes, a glimpse of the roadmap to resolution.

As the barricade situation progressed, the tactical commander approached me to discuss options. He initially mentioned his team's thoughts about tactical options, then enquired whether I thought the deployment of tear gas would aid the situation or provoke additional anger and aggression. He discussed safety concerns and any possible issues with how the teams would function. He confirmed that I supported the plan discussed by the tactical personnel, and I worked with him on a timeline for the process.

The support offered in this case was based on our understanding of the subject's current mindset, his personality, and our interpretation of his personal crisis. The tactical commander also wanted my take on the status of the negotiation process and whether we were making any headway. Throughout the event, he checked in with me as a component of his decision-making matrix.

From the command post (which is typically a few blocks from the target location), we heard the sound of multiple, unexpected gunshots, but it was unclear what was happening. There was no plan relayed about any tactical deployment. Within moments, a report came over the radio from high ground: "The subject is exiting the home with a weapon in his hand … he appears to be raising the weapon toward officers … shots fired … subject is down."

I immediately thought to myself "suicide by cop." For years, we have been studying this phenomenon and its frequency, etiology, and effect on the officers we work with. At this point, we don't know how to stop it; all we know is that when individuals feel hopeless and helpless, they do irrational things. We know that our mitigation efforts (negotiation, time to vent, and active listening) are often successful, but this time, the CNT approach didn't work. We took solace in knowing that the hostage was rescued and no officers were injured, but at the end of the day, a life was lost.

## MANAGING THE AFTERMATH

I walked out of the command post that day and saw the hostage victim talking to the local media about her experience. Her mood had shifted from angry to remorseful. She detailed her suffering and emphasized how close she was to her husband. Tears were running down her face, and she said she would never recover from the loss.

Then I called in an additional colleague. Since the situation became an officer-involved shooting, someone else from our team would need to come out to check on the shooter. I walked around to touch base with the fatigued SWAT team members and ran into the negotiator, who asked if she could have done anything differently.

We talked about the uncertainty of what we do and the fact that there is no definitive roadmap for success, then prepared for interviews. As we talked, the CNT sergeant came up to make sure we had a recording of all phone-based negotiations, worried about what would come—scrutiny, questioning, praise, judgment, and unpredictable public opinion.

Normally, the SWAT team, the CNT team, and the initial responding officers would circle to debrief on the incident. They would process what took place, the errors, the successes, and the overall "feel" of the event. As a psychologist, I'm asked about strategy from a psychological and crisis-negotiation perspective, what we heard on the phone, and how the incident proceeded.

Since this event ended in a shooting, we suspended the normal learning/healing process in order to prepare for a criminal investigation, media reports, and potential civil litigation. The teams had time to reflect until they could be interviewed and go home.

It's 9:15 p.m. when I drive home. I pick up an iced tea from McDonald's to get a last burst of caffeine energy. I call my wife to let her know I'll be home soon, but the conversation is interrupted by another text. There is a suicidal subject threatening to jump off a highway overpass. I guess I'll be home a little later than expected.

*(Editor's note: This chronology is derived from a combination of multiple SWAT events the author and his colleagues have participated in over the last 15 years. It is not a description of a single event or situation, but instead an example illustrating the many aspects of such a situation.)*

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