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Social Workers' Perceptions of the Impact of Trauma on Police Officers

Amber Leigh Copeland
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral study by

Amber Wallace

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Review Committee
Dr. Dorothy Scotten, Committee Chairperson, Social Work Faculty
Dr. Amos Martinez, Committee Member, Social Work Faculty
Dr. Nancy Campbell, University Reviewer, Social Work Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
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Abstract

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MS, Salisbury University, 2014

BS, Salisbury University, 2013

Project Submitted in Partial Fulfillment

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Abstract

Police officers experience trauma in their roles as first responders. Although there are resources to address the psychological and physical impact on police officers, these resources are underutilized. Police officers in active duty endure traumatic events regularly but fail to seek assistance for their physical and mental health symptoms. Officers interact with individuals from multiple disciplines throughout their daily encounters, including social workers. Despite the professional relationship between officers and social workers, some officers remain guarded and minimize their mental health needs. For this project, a focus group was conducted with 9 social workers who have worked with police officers during a critical incident stress management debriefing following a traumatic incident. The social workers shared their perceptions of encounters with police officers, specifically regarding officers' exposure to trauma and the conversation around mental health treatment. Social cognitive theory was discussed in the action research project. A qualitative research method was used to facilitate the action research project. According to the data collected from the social workers, they believe officers are influenced by stigma, a lack of training, denial, and fear. The results will be presented to local police departments to illustrate the impact and exposure of daily trauma on police officers and discuss possible solutions. The findings may be used to initiate positive social changes within the law enforcement field that normalize and increase access to mental health treatment.

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Section 1: Prevalence of Police Trauma and Literature Review

The inspiration behind this study began with my involvement with the local crisis incident stress management (CISM) team. As a CISM trained worker, I have provided debriefing services to a variety of disciplines. The purpose of CISM debriefings is to process traumatic events, normalize responses and provide coping strategies so that the individual can return to their level of homeostasis. Despite the presence of a CISM team in our community, a well-known officer took his own life. This recent tragedy, along with the loss of other officers, motivated me to focus on the trauma police officers endure and explore why so many go untreated.

Researchers have studied the relationship between police trauma and the physical and emotional effects it has on officers (McFarlene, 2010). Among the many interventions that have been suggested to address officers' trauma, CISM debriefings have been identified as an effective intervention to mitigate the effects of trauma (Cardinal, 2018). CISM-trained social workers develop a unique relationship with officers during debriefings, which gives them the ability to share their perceptions surrounding officer trauma. Patterson, (2010), discusses the efficacy of the police and social worker relationship in relation to crises. Social workers were able to provide significant insight into officer traumas.

There are four major sections in this study. In Section 1, I introduce the social problem and how the research addresses the problem, background introduction, problem statement, research question, nature of the study, significance of the research, theoretical framework and ethics and a thorough literature review of the academic resources. The

Section 2 discusses research design, methodology, data analysis and summary. Section 3 is a presentation of the findings and data analysis techniques. Section 4 reviews the implications for change in the field and recommendations for the social work profession.

Problem Statement

Law enforcement personnel are among the first responders who arrive on the scene of traumatic events. The constant exposure to traumatic events affects the physical and emotional well-being of police officers in the field. As a result of the constant exposure, signs of trauma may start to manifest among police officers (Chopko & Schwartz, 2013). Despite the daily exposure, police officers have sworn an oath to protect others from the same trauma they experience. There is an evident correlation between the high stress environment of the law enforcement field and the development of physical and mental health diagnoses (Kaur, Chodagiri, & Reddi, 2013). The trauma experienced by police officers was discussed by social workers during the focus group to consider their perceptions and identify reoccurring themes.

Professionals in the mental health field recognize the importance of providing support to avoid the progression of stress related illnesses. CISM debriefings are intervention protocols used specifically to mitigate the potential negative effects of trauma events (Cardinal, 2018). CISM debriefings were developed by a former emergency service personnel, J.T. Mitchell (Mitchell & Everly, 2001). Mitchell developed the CISM model to address trauma experienced by first responders. The group style model aimed to reduce the risk of posttraumatic stress disorder (PTSD) and identify individuals who required additional follow up psychological services (Mitchell & Everly,

2001). For this project, I asked CISM-trained social workers to participate in the focus group.

A critical incident is a dangerous or life-threatening event that has the potential to impact an individual's ability to manage everyday stress (Higgins, 2016). Police officers encounter critical incidents frequently in the field. According to Higgins (2016), CISM is offered within the department because critical incidents can cause officers to experience a tremendous amount of distress. CISM debriefings are offered within 48 hours of the incident to minimize the impact on officers and promote their well-being. CISM debriefings target large groups of primary or secondary victims such as emergency personnel or tertiary victims like family, coworkers, and community members following a traumatic event (Mitchell, 2015).

CISM debriefings are conducted through a series of methodical steps. The first is the introduction, where CISM staff introduce themselves, address confidentiality, and define expectations of the group (Mitchell, 2006). CISM facilitators do not have to have a clinical background; therefore, trainers often come from a variety of disciplines. The fact phase follows introductions. During this phase, CISM staff ask each participant to introduce themselves and share the role they had in the incident (Mitchell, 2006). Next is the thought phase, where participants are asked to discuss their first thoughts about the incident (Mitchell, 2006). The CISM member will often ask each participant to think about the first thing that came to their minds. In the reaction phase, which follows the thought phase, participants are encouraged to identify the worst part of the situation for them and share one thing they wish they could erase from their memory (Mitchell, 2006).

Mitchell, (2006), then recommends a phase to allow participants to describe the physical and emotional symptoms they have experienced since the incident. Somatic and psychological symptoms that develop because of trauma will be discussed in detail throughout this proposal. The second to last phase requires CISM staff to teach participants how to cope with their symptoms. CISM members may provide resources on coping skills and other follow-up services to promote healthy recovery (Mitchell, 2006). In addition to suggesting various trauma management strategies, CISM staff want to ensure participants that their feelings are common (Mitchell, 2006). Normalizing the thoughts and feelings of participants leads into the last phase, which encourages closure and allows time for additional questions to be asked (Mitchell, 2006). At the end of the debriefing, participants are provided a plethora of local resources to utilize if their symptoms persist or have the desire to engage in other mental health services for support.

Social workers are expected to advocate for equal access to services for all individuals and aim to address barriers that prevent treatment (National Association of Social Workers [NASW], 2017). As a social worker, I adhere to the NASW guidelines and allow the principles to guide my practice regardless of my role. Within my rural community, I possess many roles. I am a CISM-trained social worker who provides emotional relief and support to various disciplines following a traumatic event. According to Chopko and Schwartz (2013), police officers do encounter obstacles which make them reluctant to seek mental health treatment. As a result, a police officer's psychological symptoms may go undetected for months (Colwell, Lyons, Bruce, Garner,

& Miller, 2011). For this project, I explored social workers' perceptions and compared them to themes identified in the literature.

McMahon, Felix, Halpert, and Petropoulos (2009), found that officers who fail to receive mental health treatment following exposure to a traumatic event are more likely to develop psychological and physical symptoms. CISM-trained social workers participated in a focus group to share their views of officer trauma and how they coincide with the literature. More specifically, I explored whether there is a current gap in treatment for officers.

Purpose Statement

The purpose of this action research project was to explore social workers' perceptions of the impact trauma has on police officers and identify barriers to treatment. CISM-trained social workers were asked to reflect on their personal experiences during times they facilitated CISM debriefings for officers. More importantly, I asked them to share their thoughts on officers' responses to trauma and their reactions to suggested mental health resources. The need to explore the detrimental effects on first responders has become increasingly popular among researchers.

First responders are defined as individuals who have direct contact with survivors following a traumatic incident or death. Examples of first responders include police officers, medical services, coroners, emergency department staff, and faith leaders (Norton, 2017). Professionals who respond to traumatic events and witness high rates of violence and death are much more likely to develop PTSD (Whealin and Ruzek, 2008). Ternarian (2015), further supported the notion that frequent exposure to violence and

trauma causes negative psychological outcomes including PTSD, substance abuse issues, marital discord, and somatic complaints.

Definition of Key Concepts

In this study, I focused on social workers' perceptions. I requested participation from CISM-trained social workers to share their views of officers during CISM debriefings. According to the American Psychological Association (2018) definition, *trauma* is an emotional response to a terrible event where shock and denial are typical responses. This term is used throughout the research project to describe the distressing experiences of police officers. Additional themes that are highlighted throughout the literature review include; barriers, stigma, fear, and lack of knowledge. *Barriers* are defined as something that obstructs movement or access, also known as an obstacle (Mariam Webster, 2011). It was interesting to see if social workers shared the same themes as discussed throughout the literature.

Alexander (2009), has found that there is a plethora of unjust opinions of those who suffer from mental illness. Mass media is one of the most significant influences on societies, and when it comes to mental illness the media is really skewed (Alexander, 2009). *Stigma* is a negative perception or stereotype, commonly associated with individuals with psychological problems (Greene-Shortridge, Britt, and Castro, 2007). The relationship between officer trauma and stigma is discussed in depth and further explored throughout the proposal.

The purpose of this research was to examine the perceptions of social workers in regard to how trauma impacts police officers. Specifically, I aimed to better understand

themes social workers identified when facilitating a CISM debriefing following a traumatic event. I identified my personal presuppositions as denial, fear, and lack of awareness. These assumptions have developed from my professional experiences and encounters with law enforcement. Despite my assumptions, I did not introduce them to the group and was interested to see if the social workers shared any similarities.

As a CISM-trained social worker, I have worked with officers firsthand during CISM debriefings. My personal experiences have led me to develop my own presuppositions. Due to the literature and my professional experiences I envision that officers may be fearful to report their symptoms. *Fear* is defined as an unpleasant emotional state consisting of responses to external threats or danger (Miller-Keane, 2003). Faust and Vander Ven, (2014), suspected that officer fears are exacerbated by the fear of being reprimanded by their superiors.

It is essential to consider training and education opportunities regarding mental health and how that attributes to officer's inability to identify signs and symptoms. *Knowledge* refers to the absence or lack of information related to a specific topic (Miller-Keane, 2003). Campbell et al. (2017) reported that officers complete the academy with minimal knowledge provided on mental health issues. Although officers are responsible for up to one third of emergency mental health referrals, they do not receive a great deal of training on mental illness (Campbell et al., 2017). I was curious to see if training and education opportunities for officers would be discussed in the focus group when social workers shared their perceptions they have obtained through their experiences.

The primary goal of this study was to explore social workers' perceptions of the impact trauma has on police officers. The input from social workers is essential for future discussions surrounding access to treatment for officers. Addressing officers' signs and symptoms through mental health treatment also means ensuring a safe and secure environment for the rest of the community they serve. According to the NASW (2017) *Code of Ethics*, social workers are expected to ensure that all individuals are treated equal and able to receive treatment without prejudice.

Research Question

The primary research question of the study is: What are social workers' perceptions of the impact of trauma on police officers? I asked social workers this question in the focus group. I then analyzed data obtained in the focus group to identify themes and address gaps in services. The literature review discussed later in Section 1 will present types of trauma, signs and symptoms and barriers to treatment. As the researcher, I was the voice of the social workers who participated in the study to present the findings. I used the literature and their feedback to suggest strategies to improve the overall physical and mental well-being of police officers who endure traumatic events.

Nature of the Study

This action research project focused on the role social workers have in relation to facilitating CISM debriefings for officers following a traumatic incident. Shannon (2013), suggested that purpose of an action research study correlates with the social work value of promoting change with the target population and in this case on behalf of police officers. The study is qualitative, and the data were obtained through discussion during a

focus group. Focus groups are a data collection method in which the data are collected in a semi-structured interview process (Cohn & Crabtree, 2006). According to Mattinson (2015), focus groups are purposeful and designed to generate solutions for closed questions. It is an effective technique and encourages individual responses (Mattinson, 2015). For the purpose of this study, the focus group was the platform for gathering data from social workers. I explored officer trauma and the perceptions of social workers who interact with the officers during CISM debriefings.

CISM debriefings are facilitated by professionals from a variety of disciplines who have obtained their certification in critical incident stress management. In this case, CISM-trained social workers were asked to participate in the focus group to share their perceptions and experiences. Social workers who are trained in critical incident stress management debriefings were contacted and informed of the study. Their participation was requested but not required. All social workers who volunteered for the focus group were asked the primary research question and encouraged to elaborate on their feedback. Their responses were used to help me better understand officers' reactions to trauma and their opinions on receiving mental health treatment.

Nine social workers volunteered to participate in the focus group. Following the conclusion of the focus group, the responses were collected and coded for further analysis. At this point in the study, each phrase was categorized to develop common themes throughout the data collected. The themes helped me further explore the research question and identify the gaps in services. As a social worker who works closely with police officers, I will use the information from the focus group to initiate conversations

within police departments in the tri-county area on the Eastern Shore of Maryland. This conversation may help address the identified barriers and promote the development of strategies to increase access to treatment for officers.

Significance of the Study

Symptoms of trauma are individualized and do not manifest the same for each person. Individual personalities, details of the event, developmental processes, the meaning of trauma and sociocultural factors can all influence the impact a traumatic event has on a person (Substance Abuse and Mental Health Services Administration, 2016). Warren (2015), recommended that police officers receive education on mental health and substance abuse treatment to improve their job performance. According to Warren (2015), police officers who fail to recognize and address their distressing signs will experience additional emotional and physical symptoms. Officers commonly experience somatic symptoms but are unable to recognize how their physical complaints correlate with the manifestation of a psychological disorder. According to Sijaric-Voloder and Capin (2008), officers may experience hypertension, sleep deprivation, and coronary disease. Mental health professionals are educated to understand the relationship between physical health and mental health. However, due to the law enforcement curriculum that does not focus on mental health concerns, officers are less knowledgeable on such topics. Margolis and Shtull, (2012) suggested that officers lack the ability to distinguish between mental health symptoms and substance induced symptoms. Social workers in the focus group had beliefs that provided additional insight to the literature shared above.

PTSD is a psychiatric disorder that can impact individuals who have experienced or witnessed a traumatic event such as a natural disaster, a serious assault, or an accident (American Psychology Association, 2018). Boffa et al., (2017) suggested that there is a positive correlation between severe PTSD symptoms and higher rates of suicidal ideations and suicide attempts. While not all traumatic reactions will meet criteria for a PTSD diagnosis, untreated symptoms can weaken an officer's emotional and psychological stability (Pavšič Mrevlje, 2018). Gharibian (2015) explained that officers who experienced trauma-related symptoms identified them as somatic pain rather than psychological distress. Mental health symptoms, particularly depressive and anxiety symptoms, are commonly minimized by officers and reported as somatic complaints (Haug, Mykletun, & Dahl, 2004; Simon, VonKorff, Piccinelli, Fullerton, & Ormel, 1999). Gharibian (2015), attributed negative attitudes of officers and society regarding mental health issues to the lack of appropriate symptom identification and reporting.

Officers face erratic and often unpredictable high stress experiences in the line of duty (Faust & Ven, 2014). Police officers are repeatedly exposed to violence, death, and other dangerous situations that threaten their safety. Many officers may require assistance from mental health providers to help them manage the symptoms they develop. Exploring the barriers that prevent officer recovery will help the social workers better understand how to assist police officers in the law enforcement field. Historically, CISM models have been used to address traumatic situations and to identify individuals who need assistance. Critical incident stress management models are designed to minimize the impact of critical incidents that occur in the workplace (Pack, 2013). This study allowed

me to understand police officer reactions to trauma by reviewing the information obtained from social workers who provide direct CISM services to officers.

Exploring the impact mental health symptoms have on police officers may help police departments identify ways to improve their policies to ensure all officers receive treatment if needed. Ensuring treatment for officers may increase their overall well-being which increases their ability to perform job-related duties and adequately serve the community. It may also help identify potential barriers so that departments can take necessary steps to address them. Social workers within this research study have identified barriers they believe hinder treatment for law enforcement personnel. I have used their thoughts to generate ideas about how to better serve that population. In addition to utilizing social workers in the study, the social cognitive theory was the theoretical framework selected to guide the research.

Theoretical Framework

Social cognitive theory was used as the theoretical base of this action research project. This theory was founded on the core features of human agency (Bandura, n.d.). According to Bandura, (2001), agency is defined as intentionally making things happen with one's own actions. The core features of agency include an individual's ability to develop, adapt, and self-renew (Bandura, 2001). Benight and Bandura (2004), described social cognitive theory as a person's ability to control beliefs regarding their own efficacy to manage their functioning and exercise control over events that affect their lives. In relation to social cognitive theory, individuals possess the ability and have the desire to self-regulate and manage their functioning. However, due to the risk factors generated by

traumatic experiences, officers struggle to cope and to appropriately manage their symptoms without intervention. The principles of social cognitive theory may help social workers better understand officer beliefs regarding their abilities to manage their functioning following traumatic events. Understanding social cognitive theory may help social workers recognize an officer's need to demonstrate self-efficacy and acknowledge the impact when they no longer feel in control of their emotions. By understanding the importance of self-efficacy, social workers may be able to enhance officers' ability to manage and cope with the effects of trauma.

Individual self-regulation seems to be the primary focus of social cognitive theory. Self-regulation is a crucial component of posttraumatic adaptation and utilizing self-efficacy as a gauge for self-regulatory capacity (Smith et al., 2017). According to the literature on social cognitive theory, it is an individual's ability to display self-efficacy and to manage personal functioning following a traumatic event (Benight and Bandura, 2004). Researchers have indicated that officers who are exposed to frequent traumatic events are at a greater risk of developing psychological and physiological symptoms (Lauvrud, Nonstad, & Palmstierna, 2009). It is understandable as to why it would be necessary for officers to possess the ability to self-regulate to decrease their risk of physical and mental health issues.

In relation to self-efficacy, self-regulatory mechanisms are used by individuals to control their emotions, thoughts, motivations, and actions (Heuvel, Demerouti, & Peter, 2015). I reviewed the literature to explore officer attitudes on self-efficacy, their receptiveness to crisis response, and the barriers that hinder their cooperation. According

to the research, officers are tasked with making informed decisions however if they display too much empathy it will impact their decision-making process (Inzunza, 2015). Inzunza (2015), further explained that social cognitive theory supports police officers' need to be independent and self-efficient regardless of the situations they experience. The principles of social cognitive theory were used to explore the importance of officers to self-regulate when exposed to traumatic events.

Trauma impacts the mental health of individuals long after the original experience (Vander Kolk, 2003). This concept supports the social issue that officers are failing to receive mental health services due to unknown barriers, causing mental and physical symptoms to develop. Vander Volk, (2015), reported that trauma can be reactivated at the slightest glimpse of danger which precipitates unpleasant emotions, intense physical sensations, impulsivity, and aggression. Failing to receive services may result in an officer externalizing behavior such as police brutality, family violence, suicide, or substance abuse (Vander Velden, Kleber, Grievink, & Yzermans, 2010). The research question was developed to better understand why officers are unwilling or unable to seek mental health treatment. Exploring barriers to treatment through the participation of social workers helped me identify the gap in services. As a social worker, I am committed to addressing social issues and advocating for individuals I serve.

Ethics and Values

There is an evident need to explore the barriers that hinder police officers from receiving mental health treatment. As a social worker, I am bound by the NASW (2017) Code of Ethics to identify social issues and advocate for those in need. The law

enforcement field can be physically and mentally exhausting. Without appropriate treatment, police officers are likely to experience symptoms of trauma (Chopko & Schwartz, 2013). It has been suggested that the manifestation of mental health issues is caused by officers internalizing their stress.

There is a significant correlation between the high stress environment of the law enforcement field and the development of physical and mental health diagnoses (Kaur, Chodagiri, & Reddi, 2013). However, police officers can be guarded and ambivalent about disclosing their symptoms. There is a "code of silence" or "unspoken concern" that exists among law enforcement professionals preventing them from expressing their feelings (Kaariainen, Lintonen, Laitinen, & Pollock, 2008).

For a plethora of reasons, officers feel uncomfortable reporting symptoms. Therefore, it is important that social workers acknowledge officers' difficulties and advocate for their right to seek mental health treatment. The NASW (2017) Code of Ethics encourages social workers to advocate for populations who are unable or unwilling to advocate for themselves. Porter and Prenzler (2016), reported that the code of silence promotes officer misconduct and unethical decision making. Due to the "code of silence," officers internalize thoughts leading to unhealthy coping strategies. Advocating for the rights of officers would mean increasing access to resources, normalizing disclosure, and challenging the code of silence mentality among officers.

According to the NASW (2017) Code of Ethics, a social workers' primary goal is to help people in need and to identify social problems. As a clinical social worker, I have witnessed police officers refuse mental health treatment. However, the same officers who

refused treatment reported frequent nightmares, changes in mood, and knowing at least one colleague who has died by suicide. The lack of access to treatment for officers is a significant social problem in my community. The value of social justice expects social workers to advocate for oppressed and vulnerable populations, address discrimination, and ensure access to resources (NASW, 2017). The value of social justice directly correlates with the social problem because many officers feel vulnerable seeking treatment and asking for help.

The NASW (2017) Code of Ethics promotes respecting the dignity and self-worth of the person being served. This is an important value to be mindful of because not all officers who need mental health treatment want mental health treatment. Although social workers aim to help people in need, all individuals, in this case police officers, have the right to make their own decisions regarding treatment. Social workers can do their due diligence by educating and providing resources to officers without influencing their decisions. Respecting the dignity of officers means remaining neutral. This approach decreases pressure to seek treatment experienced by officers and increases comfortability with social workers.

Feeling comfortable with social workers is the first step in rapport building. Positive interactions between police officers and social workers is essential. The NASW (2017) Code of Ethics states that social workers must value all human interaction and develop trusting relationships to facilitate social change. The social workers in the focus group who have positive relationships with officers shared insightful information related to officer ambivalence regarding treatment. Forming trusting relationships with police

officers is crucial and proved to be helpful when social workers shared their encounters with law enforcement personnel.

It would benefit police officers to be open and honest with social workers during CISM debriefings. Police officers often struggle to trust anyone outside of their department, let alone disclose intimate and personal feelings. Integrity is defined as the social worker's ability to behave in a trustworthy manner (NASW, 2017). This value reinforces the obligation to respect an officer's right to confidentiality. Officers want to know that the information they share in confidence will not be shared with anyone else. This value also reinforces my obligation to act ethically and professionally throughout the research process. It was imperative that I was transparent and completely open with the social workers. This helped strengthen our relationship and instilled trust. Furthermore, it was important that I refrained from imposing my own presuppositions on the social workers and allowed them to generate their own ideas free of bias.

Competency is another value identified in the NASW Code of Ethics (2017) that correlated with this project. Traditional law enforcement culture idealizes machismo and action-oriented behavior (Steinkopf, Hakala, & Hasselt, 2015). I was expected to abide by this value and research the law enforcement field to enhance my understanding of their profession. By increasing my knowledge, I acquired a basic understanding of police officer culture and how that impacts their access to treatment. This knowledge provided a foundation for the project and allowed me to guide the discussion during the focus group.

This action research project adhered to the NASW Code of Ethics and supported the principles and values discussed in the code. The social workers who participated in

the project explored barriers that hindered police officers from receiving mental health treatment. Each social worker received an informed consent form, explaining the logistics of the research study and its purpose. Providing informed consent is a requirement of the NASW (2017) Code of Ethics and helped ensure the participants were treated fairly without prejudice.

According to the NASW (2017) Code of Ethics value of service, social workers are expected to help people in need and address social problems. The focus of this project is an evident social problem that impacts officers, their families, and the community. Ethical Standard 1.01 discusses social worker's commitment to the client and expects them to advocate for the client's best interest (NASW, 2017). My primary objective was to collaborate with social workers to discover their perceptions of trauma and how it impacts officers. I was dedicated to finding potential solutions for officers to increase access to services.

To better meet the needs of officers, I needed to educate myself on their culture. Ethical Standard 1.05, regarding cultural competence and social diversity, emphasizes the importance of understanding the population social workers serve (NASW, 2017). This standard was crucial to this study because police officers have a culture of their own that must be understood to best meet their needs. As stated previously, I was diligent and researched the law enforcement field prior to the facilitation of the focus group. Ensuring cultural competence improved my ability to understand officers' behaviors and what influences it.

The NASW (2017) Code of Ethics was established to protect clients and to ensure professional conduct among social workers. I followed the NASW Code of Ethics throughout this research process to guarantee professionalism and ethical behavior. Due to the nature of their work, police officers often require external support. This project reflected the NASW Code of Ethics because it identified a social problem, advocated for a vulnerable population, and had an end goal to promote social change within the community. The law enforcement profession continues to be explored to better understand obstacles, stressors endured and the overall physical and emotional impact of the job. There is a plethora of resources that strive to describe the experiences of officers in the field.

Review of Professional and Academic Literature

Study Methodology: Action Research

Much of the academic literature gathered to support this proposal was found on Walden University's library website. Social workers are the target population and focus group participants. Due to the prominence social workers have in this project, I searched for articles in the Social Work Abstracts database. This database provides information produced by the NASW and highlights theory, practice, and social issues.

The similarities between the social work field and sociology field encouraged me to search in the SociINDEX with Full Text database for social work-related literature. SociINDEX with Full Text was an appropriate database because it discusses sociology, criminology, and social work-related data. Although social workers were the research participants, their perceptions were used to further explore barriers to treatment for police

officers. I also used The Criminal Justice Database to gather the background information necessary to suggest there is a gap in services. This database provided information on the criminal justice system, law, and drug enforcement.

The key terms I selected to explore my topic were used for searches in each database listed above. Once in the database, I used both lines separated by the word and to narrow my search for articles closely related to my topic. The key words I used consistently were; *police officers, mental health,* and *trauma*. However, I used several other terms to help me gather additional information to develop smaller subheadings throughout my review: *coping skills, symptoms, denial, fear,* and *education*. Each of these terms helped me obtain additional information to elaborate on the literature.

Police officers experience daily trauma in the field. As a result, they are susceptible to physical and mental health symptoms that impact their professional and personal lives. The significance of trauma experienced by law enforcement personnel affects job performance which inevitably impacts the communities they serve. According to the NASW (2017) Code of Ethics, it is imperative that social workers work to identify social problems and help those in need. As the researcher in this project, I acknowledged the impact of trauma on police officers and aimed to use social workers to explore potential solutions to bridge the gap in services. Throughout the literature review, I will discuss external stressors, internal stressors, signs and symptoms of trauma, effects of trauma, the presence of police culture, barriers to treatment, and treatment recommendations for addressing officer trauma. Among many factors that may impact an officer's wellbeing, the stressful nature of the job cannot be overlooked.

Job Stressors

Law enforcement professionals have been identified as a high-risk population for developing severe mental and physical health problems (Steinkopf et al., 2015). In addition to trauma experienced in the field, police officers encounter internal and external stressors that impact their functioning. According to Steinkopf et al., (2015), officers perceive internal and external stressors to be more stressful than their police duties. Operational and organizational stressors have been proven to play a role in the well-being of officers and have produced negative changes among personnel over time (McCormack and Riley, 2016).

McCormack and Riley (2016), suggested that chronic exposure to these stressors will inevitably lead to the development of a mental health diagnoses. The presence and severity of stressors varies depending on the policies of each department. Extra-organizational stressors can be acute or chronic and have negative outcomes on the individual and the organization (Biggs, Brough, & Barbour, 2014). Steinkopf et al., (2015), identify stressors to include; the community (attitudes of community members, traffic stops), the department (peers, administration, nepotism) and general nature of the job (shift work, domestic violence calls).

Officers are at a greater risk of developing mental health problems because of occupational stressors and maladaptive coping skills that are reinforced by police culture (Steinkopf et al., 2015). Examples of negative coping skills may include self-medicating with substances or working excessively to forget about their feelings (Solan & Casey, 2003). Maladaptive coping skills tend to enhance the negative symptoms rather than

reduce stress (Chopko, Palmeri & Adams, 2017). The inability to identify stressors may lead to maladaptive coping skills discussed above such as alcohol consumption (Yun & Lee, 2015). Denial, behavioral disengagement, and self-blame have been found to have negative effects on physical health of individuals who experienced a traumatic event (Boyraz et al., 2016).

Common occupational stressors that officers encounter include; physical danger, violence and the death of others (Wills & Schuldberg, 2016). Occupational stressors often cause adverse reactions, increasing the likelihood of a PTSD diagnosis (Walker et al., 2016). Officers are expected to adapt and cope with trauma they experience throughout their career (Chopko et al., 2017). Time constraints and occupational structures of the job also impact an officer's functioning. Yip et al., (2016), indicated that police officers who arrive early to their shifts and work long shifts are at a greater risk of adverse physical and mental health outcomes. The stressors lead to negative outcomes for officers, higher rates of depression and will continue to accumulate over time (Papazoglou & Andersen, 2014).

Police officers are repeatedly exposed to traumatic incidents (McCanlies et al., 2017). Many factors have been identified that increase an officer's risk to developing a mental health disorder. Understanding the potential risk factors will help prevent psychological symptoms and decrease the negative effects associated with the traumatic event (McCanlies et al., 2017). However, managing job-related trauma becomes complex for officers who have experienced their own trauma.

Faust and Vander Ven (2014), indicated that nearly 80% of officers who responded to Hurricane Katrina lost their homes, making them victims as well. Any significant history of trauma should be reported to the department prior to an officer joining the police department (Watson & Andrews, 2017). Officers with a history of trauma may require more assistance to prepare them for the field. Traumatic encounters in the field may trigger the emotions and feelings of previous traumas (Papazoglou & Andersen, 2014). Additional triggers may exist within the interior of the department. To be more specific, some departments may display pictures of fallen officers who were killed in the line of duty as a sign of respect. However, this symbolism may trigger vicarious responses for officers who have not yet sought treatment for their own traumas (Papazoglou & Andersen, 2014). Typical job duties put officers at risk; however, being present in the community exposes them to additional challenges.

Community Violence

As mentioned above, police officers who have a history of personal trauma are more inclined to be overwhelmed by traumas of the job. Mental health reactions following community violence vary based on race, poverty, and educational experience (Galovski et al., 2016). This directly correlates with the notion that officers' past personal experiences can impact their susceptibility to the effects of trauma. However, researchers have not explored the importance of specific demographics when predicting negative mental health outcomes (Galovski et al., 2016). According to Galovski et al. (2016), community members reported higher rates of PTSD and depression than law enforcement, however they also reported higher rates of previous mental health treatment

(Galovski et al., 2016). This relationship suggests that community members are more likely to report symptoms and engage in treatment. The lower rates reported among officers may be explained by their inability to identify side effects or fear of reporting symptoms. Despite the lower reported rates of PTSD among officers, Galovski et al., identified a connection between community violence and distress experienced by law enforcement which was recently illustrated by the Ferguson protests.

Officers endure multiple variations of trauma that hinder their functioning. Community violence is defined as intentional, malicious violence that occurs outside of the home, in a defined community (Galvoski et al., 2016). Galvoski et al. (2016), discussed previous studies that identified a correlation between community violence, PTSD and depressive symptoms. In addition to purposeful acts of violence, officers are exposed to natural disasters as first responders. Faust and Ven (2014), acknowledged the impact of natural disasters on first responders and how detrimental it is to their mental health.

Exposure to natural disasters has been linked to psychological issues, job dissatisfaction, job disengagement and high turnover rates (Biggs et al., 2014). Faust and Vander Ven (2014), suggested that PTSD among officers is more widespread than in the past and increases when officers respond to disasters. Biggs et al., (2014), explained that natural occurring and human made disasters are harmful to individual and organizational performance. Biggs et al., also indicated that positive work outcomes can be obtained by providing the following: supportive work culture, supportive organizational responses to employees personally affected and recognition for work performed during disaster relief

efforts. Employing these strategies may help minimize the impact of natural disasters on officers.

Community violence and natural disasters impact entire communities. To address officer stress relating to community services, research identifies self-efficacy as a necessary tool for adapting to mass violence (Smith et al., 2014). Self-efficacy allows individuals to perceive threats as benign (Smith et al., 2014). Officers have the possibility to come across countless threats throughout each shift. However, benign threats reduce psychological reactions (Smith et al., 2014). Smith et al., (2014), reported that higher levels of posttraumatic stress undermine self-efficacy and create higher grief symptoms. Higher grief symptoms were associated with increased rates of disrupted worldviews (Smith et al., 2014).

The researchers above have emphasized the importance of self-efficacy among officers. Studies show that individuals with lower self-efficacy rates were less likely to cope with traumatic events (Smith at el., 2014). Self-efficacy varies among officers and is viewed as a protective factor. Smith et al. (2014) suggested that self-efficacy can be weakened by traumatic events and posttraumatic stress symptoms. Self-efficacy is crucial for officers who have experienced violence within the community. It is equally important for other inevitable tragedies like natural disasters.

Natural Disasters

Biggs et al. (2014), reported that exposure to natural disasters and work outcomes is particularly a concern for emergency personnel. The effects of natural disasters have been highlighted above, but the lack of training to prepare officers was not introduced.

Biggs et al., recognized that the argument can be made that emergency personnel are trained to handle such events. However, their training does not make them impervious to trauma exposure. When police officers do not receive the necessary treatment, they put themselves and the community at risk (Steinkopf et al., 2015). The impact of trauma does not dissipate over time but instead accumulates larger health concerns (Papazoglou & Andersen, 2014).

Disasters occur suddenly, affect large portions of the community and place a large burden on economic and public service resources (Biggs et al., 2014). Emergency personnel who respond to disasters face many risks. Work-related consequences such as natural disasters have been known to impact mental health outcomes (Biggs et al., 2014). Due to the negative impact of responding to disasters, required sick leave increased for police officers responding to natural disasters (Biggs et al., 2014). Due to the increasing prevalence of major disasters, it is important to emphasize the importance of employee resources especially following a natural disaster (Biggs et al., 2014). Biggs et al. (2014), reported that organizational morale and support mitigated effects of disaster on psychological outcomes for officers.

The dynamics of the police culture and its departments significantly impacts officers and their behavior. Traditional law enforcement culture values machismo, action-oriented behavior and authoritarianism which can be problematic in personal relationships (Steinkopf et al., 2015). As emphasized above, trauma exposure in the field impacts the officer and their families. To be more specific, it may be difficult for officers to switch roles from officer to spouse during a minor disagreement leading to domestic

violence and an increase in relationship problems (Steinkopf et al., 2015). Steinkopf et al. (2015), discussed the importance of addressing relationship problems because research indicates that a healthy marriage is a protective factor against suicide. Officers may begin to struggle with the ability to appropriately manage conflict with individuals in their personal lives.

Neuroimaging on the brain shows that traumatic events experienced by officers alters their memory and decision-making abilities (Mercadillo et al., 2015). While officers may be able to identify some symptomology, they are not clinicians and may not be able to identify the full range of symptoms associated with a mental illness (Morabito and Socia, 2015). Recent disasters created a unique matrix of stressors on officers who have not had the appropriate training to deal with disorders they developed as a result of trying to cope with daily traumas (Faust & Ven, 2014). Faust and Ven (2014), also report that little research has been conducted to understand how academies prepare cadets who will be required to insert themselves into dangerous situations.

Dangerous Situations

Due to the dangerous nature of the job, it is imperative for officers to have the cognitive ability to protect themselves and others around them. Individuals who display aggression prior to police arrival and continue to demonstrate hostility toward officers are more likely to assault an officer (Ellrich & Baier, 2016). The presence of drugs or alcohol increases the likelihood of impulsivity and aggression towards officers (Ellrich & Baier, 2016). It is common for police officers to be confronted with aggressive or drunken clients (Ellrich & Baier, 2016). Officers respond to a variety of unpredictable and

potentially dangerous situations. In addition to individuals who are under the influence, Ellrich & Baier (2016), identify domestic disturbances as one of the most dangerous situations an officer can respond to.

Officers with high rates of neuroticism and risk taking, lower levels of agreeableness, consciousness, extraversion and openness to experience are more likely to be targets of violent victimization (Ellrich & Baier, 2016). Despite personality traits that may put them at risk, officers are expected to serve the public to the best of their ability. Mercadillo et al. (2015), reports that society views police officers as aggressive and associates them with antisocial behaviors. Ellrich & Baier (2016), further explains that 22.6% of violent victimization occurs because of the officer's attributes. Officers with high levels of extraversion may be less likely to take precautions for their own protection (Ellrich & Baier, 2016).

McCormack and Riley (2016), state that consequences of long-term exposure to policing is poorly researched. However, this may be explained by police culture that discourages officers from reporting their symptoms and negative outcomes. Marchand et al. (2015), report that police culture does in fact hinder officers from being open psychologically or physically vulnerable. It is suggested that officers may have underreported their symptoms due to the fear of personal and professional consequences because of the stigma associated with mental illness (Faust & Ven, 2014).

Misconceptions of Mentally Ill Individuals

Prior to entering the field, proper training is crucial to ensure officer safety. Police officers often respond to mental health crises in the community but are inadequately

trained, leading to mistreatment or abuse (Oh, DeVylder & Hunt, 2017). Officers and the individuals they encounter are privy to abuse. The American Public Health Association identified police violence as a critical, underexamined public health issue (Oh, DeVylder & Hunt, 2017). Law enforcement personnel respond to a variety of calls among a wide demographic population. Police interactions with the mentally ill are viewed as dangerous (Morabito & Socia, 2015). Contact with the mentally ill population has been represented as a major threat to police safety (Morabito & Socia, 2015). However, mental health symptoms alone are not responsible for injuries on officers, until combined with substance abuse issues (Morabito & Socia, 2015).

Responding to individuals who have a mental illness may seem intimidating to some officers. Morabito & Socia (2015), suggest that the law enforcement field is to blame for the criminalization of the mentally ill, stemming from their ignorance or discrimination against that population. This is concerning considering police officers are usually the first point of contact with these individuals (Oxburgh et al., 2016). Cullen & Pratt (2016) recognized the need to continue to identify areas of the police field that are highly impacted by stigma and discrimination. Studies show that crime rates are affected by police behavior when they are dispatched to a call. Police attitudes significantly impact how the public responds when approached.

In a previous study, officers arrested more mentally ill individuals than the rest of the population because they perceived the behavior to be disrespectful rather than medical (Morabito & Socia, 2015). The inability to identify mental health symptoms leads officers to treat individuals differently. Cooperation from others is most likely to be

elicited by an officer's ability to be reasonable, disarming, focused and consistent (Cullen & Pratt, 2016). Morabito & Socia (2015), suggest that symptoms may be notable to a trained professional but not to an officer who perceives the behavior as deviant. It is evident that how people are treated matters and influences the outcome of their interaction with law enforcement (Cullen & Pratt, 2016).

As stated above, individuals who are under the influence and those involved in a domestic dispute have been identified as two of the most dangerous situations to respond. There is a common misconception that individuals with mental illness are also dangerous. Morabito and Socia (2015), state that police officer's perceptions of mentally ill individuals are responsible for their expectations even though they may not be an accurate depiction of that population. According to Morabito and Socia (2015), only 4% of crime is committed by mentally ill individuals in the United States.

Individuals diagnosed with schizophrenia are viewed as more violent than the general population (Morabito & Socia, 2015). This preconceived notion may be responsible for possible mistreatment of individuals with mental illness. A lack of education on mental illness is another potential explanation. Crisis intervention team, CIT, is an officer based, pre-booking approach with officers who are trained to be first responders for individuals with mental illness (Morabito & Socia, 2015). CIT can be used as a tool to help officers manage the unpredictable behaviors of the mentally illness (Morabito & Socia, 2015). Proper training will also help protect officers from dangerous behaviors and reactions of individuals they approach. Officers are trained to identify symptoms and act as liaisons to the mental health community (Morabito & Socia, 2015).

Officers acquire their stigmatizing ideas of mental illness from television and movies (Morabito & Socia, 2015). The CIT certification allows officers to become educated on mental illness and increases their ability to serve that population effectively. If the stigma persists it can lead to discrimination, avoidance, and exclusion (Morabito & Socia, 2015). Stigma prevents individuals from accessing criminal justice services if they are experiencing legal issues (Morabito & Socia, 2015). This is similar to the way officers feel about seeking mental health services. Training for police should be included to identify individuals with a mental illness which will ultimately help officers better serve the community (Morabito & Socia, 2015). It is important that officers are equipped to work with a variety of populations to ensure their safety and the safety of others.

Social Stressors

Police officers experience stress in their personal lives that compounds the impact of work -related traumas. The high stress environments of the law enforcement field contribute to high rates of suicide, divorce, substance use and domestic violence among officers (Schabile & Six, 2016). Steinkopf et al., (2015), indicates higher rates of alcohol use, depression, cardiovascular disease, cancer, PTSD, relationship problems and suicide are higher among officers than the general population. Alcohol has been identified as a strong predictor in secondary traumatic stress (Craun & Bourke, 2015). Alcohol use tends to increase among law enforcement after witnessing the trauma of others (Craun & Bourke, 2015). Individuals with the presence of a mental health diagnosis and a substance use disorder is referred to as co-occurring. Co-occurring diagnoses complicate officer symptoms because there are two disorders to treat instead of one.

Faust and Ven (2014), suggest that PTSD has a detrimental effect on officers and how they conduct themselves professionally and personally. There is an evident correlation between trauma and an individual's physical and mental well-being. Sleep disturbances were found to correlate with general work stress rather than critical incident stress (Chopko et al., 2015). However, Steinkopf et al. (2015), state that 33% of officers report sleeping less than 6 hours in a 24-hour period due to shift work and the stress of the job. Steinkopf et al. (2015), associated sleep deprivation with other negative reactions such as; cardiovascular disease, cancer and suicide. There is a need to improve how officer's symptoms are addressed and how to introduce the integration of effective treatment options.

Negative Reactions

McCormack and Riley (2016), indicate that constant exposure to work-related trauma impacts a police officer's ability to cope and increases their chances of developing a mental health disorder. There are two traumatic categories that impact an officer; threat to self and harm to others (Chopko et al., Adams, 2017). Officers who experienced a threat to their personal safety showed increased levels of negative reactions compared to the threat of others (Chopko et al., 2017). Officers may experience both types of traumatic categories in the line of duty.

Although officers indicate higher levels of negative reactions when their own safety is jeopardized verses the safety of others, Smith et al. (2015), reports that persistent grief symptoms may develop when officers experience a traumatic loss of life of another. The presence of a threat to self or threat to others is unpredictable but it impacts the

overall well-being of officers (Marchand et al., 2015) According to Smith et al. (2105), information processing theories report that traumatic events disrupt the worldviews of individuals which results in negative outcomes unless their views are reconciled (Smith et al., 2015). Pinto et al. (2015), believe the individual's interpretation of the traumatic event is responsible for the development of PTSD rather than the incident itself. Regardless of how negative outcomes are produced, trauma exposure is prevalent and experienced at a high frequency by police officers (Chopko et al., 2017).

Examples of traumatic events include exposure to violent offenders, hostage situations, horrendous crime scenes and hostile civilians (Andersen & Papazoglou, 2014). According to Chopko et al. (2017), negative effects vary and differ among different types of trauma. For example, officers who work with victims of sexual assaults are exposed to significantly more traumatic material (Turgoose et al., 2017). Turgoose et al. (2017), further explains that officers who work with these trauma victims are at risk of developing psychological symptoms due to the nature of the cases. Direct contact with victims has a significant impact on officers. According to Galvoski et al. (2016), there is a clear correlation between community violence, PTSD and depressive symptoms. Police officers are exposed to a magnitude of traumatic events that impact their functioning.

Inherent acts of community violence may result in increased levels of anger, PTSD and depression (Galovsk et al., 2016). McCanlies et al. (2017), reports that the general population of those struggling with PTSD is 3.5% however, officers diagnosed with PTSD ranges from 7-19%. Despite the percentage of officers diagnosed, Jo et al.

(2018), reports that PTSD diagnoses vary depending on an individual's personality traits. There are many factors that contribute to the development of a mental health disorder.

In addition to higher rates of PTSD diagnoses, officers have higher suicide rates than the general population. In 2012, 126 officers committed suicide (Faust & Ven, 2014). Stanley, Hom and Joiner (2015), agreed that police officers are at a greater risk for attempting and dying by suicide. Despite these statistics, mental health effects of community violence with officers has only been assessed in isolation (Galovski et al., 2016). There is limited research on community violence and how it impacts officers. There is also a gap between studies that compare the impact of community violence on civilians to the impact it has on police officers (Galovski et al., 2016).

Posttraumatic Stress Reactions

The frequency and severity of trauma exposure affect posttraumatic reactions and other aspects of mental health (Chopko et al., 2015). Faust and Ven (2014), report that overall, 40.5% of first responders developed acute stress disorder, depression, or PTSD. Faust and Ven (2014), indicate that PTSD was associated with higher rates of comorbid psychiatric disorders, functional difficulties, somatic symptoms, and the perceived need for mental health care. Exposure to traumatic death alone can cause intrusive and avoidant behaviors, hostility, and physical symptoms (McCormack & Riley, 2016).

Trauma in policing can be experienced directly and vicariously (McCormack and Riley, 2016). Approximately 35% of officers exposed to isolated traumatic events develop posttraumatic stress symptoms and 10% develop other types of psychopathology (McCormack and Riley, 2016). Identification of events most likely responsible for PTSD

symptoms is vital in improving psychological support to personnel who have experienced trauma (Wills & Schuldberg, 2016). Higher levels of posttraumatic stress may prohibit individuals from processing deaths that occur because of a traumatic event (Smith et al., 2014). Traumatic events can shatter worldviews and lead to untreated grief and negative posttraumatic outcomes (Smith et al., 2014). Smith et al. (2014), believe that posttraumatic symptoms complicate grief. Trauma responses will vary based on the type of trauma experienced (Chopko et al., 2017).

Reactions to stress include pre-traumatic, peritraumatic and posttraumatic (Marchand et al., 2015). Peritraumatic experiences consist of dissociation, physical and emotional symptoms, threat to a partner's life, exposure severity and exposure to death have been identified as risk factors for developing PTSD (Marchand et al., 2015). However, Marchand et al. (2015), stated that officers who receive support if exhibiting peritraumatic symptoms are less likely to develop PTSD. The need for immediate services following a traumatic event is crucial. Marchand et al., stated that posttraumatic symptoms that indicate PTSD rare enhanced by no periods of time off allotted to recover from a traumatic event, lack of organizational support and lack of social supports.

Symptoms

Lack of experience in the field, history of personal trauma and a history of mental illness in the family have proven to be significant risk factors that increase the development of PTSD (Marchand et al., 2015). Additionally, incident related injuries, depressive symptoms and negative life events have been identified as potential risk factors (Marchand et al., 2015). McCanlies et al. (2017), report that rates of PTSD and

depression are higher among first responders who have a previous history of trauma. Marchand et al. (2015), identifies acute stress disorder symptoms, depressive symptoms, dissociation, physical and emotional responses as additional risk factors that increase the likelihood of long-term psychological problems. Stanley et al. (2015), reports that there is an increased risk of suicidal thoughts and behaviors among lower ranked officers, fewer years in the career, participation in volunteer departments and a history of responding to a suicidal attempts or death.

Police officers have a versatile position and are responsible for responding to a plethora of calls. McCormack and Riley discuss different stages of trauma based on the content of the call. The first stage of trauma consists of anticipated trauma such as motor vehicle accidents, natural disasters, and combat exposure (McCormack & Riley, 2016). Simiola et al. (2015), stated exposure to trauma has been indicated as a risk factor for mental health issues, PTSD, depression, and substance abuse. Biggs et al. (2014) identify the correlation between exposure to natural disasters, and PTSD, anxiety, depression, and substance use. The second stage of trauma is described as isolated events that have the potential to trigger post-trauma responses such as domestic violence calls or threats with a firearm (McCormack & Riley, 2016).

McCormack and Riley (2016), report that desensitization will not occur no matter how many times an officer is exposed to trauma. Misconceptions that suggest officers adapt to their circumstances over time and not impacted by trauma are invalid. Officers are perceived as invincible and unaffected by exposure to trauma (McCormack & Riley, 2016). The third stage of trauma is described as chronic posttraumatic stress reactions

that can eventually develop into PTSD (McCormack & Riley, 2016). Smith et al. (2017), state that posttraumatic reactions and stress reactions occur when an officer is directly or indirectly exposed to a traumatic event. The last stage of trauma discussed by McCormack and Riley (2016), state that direct exposure from experience through dealing with distressed clients will put officers at risk of secondary traumatic stress or compassion fatigue.

Empathy

Exposure to violent environments and distressed clients has been reported to decrease an officer's ability to experience empathy for another's pain (Mercadillo et al., 2015). Empathy is a quality that is essential for professionals who work with people in a variety of situations (Inzunza, 2015). Understanding the difference between empathy and sympathy is crucial in the police context (Inzunza, 2015). Inzunza (2015), describes empathy as trying to understand others and sympathy is feeling bad for others. Showing empathy may result in more positive interactions between police and the community. Officers encounter problems if they are unable to understand people on an emotional and conscious level **(**Inzunza, 2015). These positive interactions may limit the amount of risk associated with irate individuals. However, while it is ideal to establish rapport, officers usually interact with individuals in stressful situations which makes building a trusting relationship difficult to achieve (Inzunza, 2015).

Empathy has been recognized as one of the five essential characteristics among officers and is experienced when a person establishes communication, poses self-other awareness of others, perspective talking and emotion regulation (Inzunza, 2015). It is

imperative that officers be empathetic and demonstrate empathy while on duty. Gender differences indicate that women are more sensitive than men when it comes to adverse situations and therefore influences the role of women in daily police practice (Mercadillo et al., 2015). There are noted difference between levels of empathy for women and men; thus, researchers believe that there are special codes and police norms that normalize gender tendencies to execute explicit actions (Mercadillo et al., 2015). Similar scores of empathetic expressions for males and women may be explained by learned strategies and dynamics of the police department that restrain expression of emotion (Mercadillo et al., 2015).

Compassion fatigue (physical and emotional exhaustion and an inability to feel empathy for others), secondary traumatic stress (development of PTSD symptoms) and burnout (emotional exhaustion) have been associated with exposure to trauma (Turgoose et al., 2017). Each pose a significant threat to an officer's health. Emotion appears to have a significant impact on an officer's ability to adapt following exposure to a stressor (Galatzer et al., 2013). Turgoose et al. (2017), acknowledges the correlation between compassion fatigue and a lack of empathy among law enforcement personnel. A lack of empathy can be problematic for officers when working with the public.

Self-other awareness is defined as the ability to identify with someone in a situation and identify boundaries between emotion and thoughts of self and others (Inzunza, 2015). Empathy can be useful when officers are trying to understand the individuals they encounter. Perspective talking is described as the ability to grasp how someone will react emotionally and cognitively (Inzunza, 2015). This skill allows

officers to have empathy for the individuals they provide support to during traumatic events. Emotion regulation is necessary for officers to respond to the ongoing demands of a traumatic experience (Inzunza, 2015). Increased emotion regulation may enable recovery from traumatic events (Smith et al., 2014).

Compassion fatigue, secondary traumatic stress and burnout make it more difficult for police to show empathy which impacts the experience of the victim (Turgoose et al., 2017). Research shows that victims who work with officers who show empathy are more likely to prosecute their cases and move forward in court (Turgoose et al., 2017). Officers who display empathy allow the victim to feel safe and protected, but it can be emotionally exhausting. The prevalence of compassion fatigue, secondary traumatic stress and burnout are becoming well recognized and require attention from professionals (Turgoose et al., 2017).

Police officers balance being firm and assertive while showing empathy for the individuals they encounter. Mercadillo et al., (2015) reports that compassion involves empathy, theory of mind, decision making and motor processes that are regulated by the brain. While empathy is perceived as a positive characteristic, it may curtail the expression of justice and aggressive actions manifested in policing (Mercadillo et al., 2015). According to this source, it is difficult for officers to be empathetic without feeling like they are not following the appropriate procedures.

The police department is a community of its own with its own culture. This "police culture" has been found to negatively influence brain function related to compassion (Mercadillo et al., 2015). It is suggested that the culture of the law

enforcement field prohibits officers from showing empathy. Police culture is further explored later in this literature review.

The law enforcement field has been referred to as "dirty work" due to the work required of public police officers (Lofstrand, Loftus & Loader, 2015). Officers endure the stress of traumatic events and the chaos of responding to calls within the community. The law enforcement field is described as a physically tainted profession because it is a job that directly involves; death and tasks that are performed under dangerous conditions (Lofstrand, Loftus & Loader, 2015). Officers are commonly required to touch people and be "hands on," but yet they are expected to deal with stigmatized populations in a fair manner while protecting the rest of the community (Lofstrand, Loftus & Loader, 2015). The community relies heavily on officers to protect and serve. At the same time society delegates dirty work to certain occupations and then stigmatizes the tasks performed (Lofstrand, Loftus & Loader, 2015). For example, police officers are expected to "protect and serve" yet face scrutiny from the public regarding use of force (Smith, 2018).

Over the last 30 years the law enforcement field has attracted a great deal of attention regarding the impact their occupation has on their physical and mental health (Steinkopf et al., 2015). Traumatic incidents and the nature of the profession can cause significant harm to an officer's well-being. Compassion fatigue, secondary traumatic stress and burnout can accumulate over time but the persistent exposure to trauma will increase risk for distress among officers (Turgoose et al., 2017). Exposure to traumatic events increases the risk of suicidal ideations, impairs their ability to cope and the development of psychological and physical problems (Steinkopf et al., 2015).

Job Performance

Physical and emotional reactions to trauma affect officer's overall well-being. More specifically their symptoms often impact job performance. There is a connection between high levels of stress and high aggression among officers (Schaible & Six, 2016). The fluctuation in their moods may impact how they engage with the public. Research has found that some officers use excessive force in a manner unnecessary for a situation (Ariel et al., 2016). Officers who report increased anger, which is related to the neuroticism dimension, reported more physical assaults in the field (Ellrich & Baier, 2016). Schaible and Six suggested (2016), that adverse effects have an impact on the quality of services provided to the public. Researchers recognize the impact of trauma on officers and the effects it has on officers and the communities they serve. Although there appears to be an evident need for services in the law enforcement field, officer's often go without treatment.

Police often encounter complex emotional situations and are unable to make informed decisions if they are too emotionally engaged (Inzunza, 2015). However, Galatzer et al. (2013), reports that positive emotions can aid in emotion regulation, accelerate recovery from cardiovascular activation caused by negative emotions and leads to positive meaning-making in negative circumstances. The controversy surrounding the display of emotions sends mixed signals to officers. It is often difficult for officers to express their emotions, let alone remain positive given the traumas they face.

Law enforcement are exposed to burning buildings, lootings, attacks with weapons, gunfire, bottles filled with urine and verbal threats to themselves and their

families (Galovski et al., 2016). These are unimaginable circumstances that would be traumatic for anyone involved. Yet officers are expected to remain cool, calm and collective in difficult situations (Schaible & Six, 2016). These dangerous situations produce many feelings and emotions among officers, but they are encouraged to suppress their negative feelings.

Strong emotions can be healthy, such as an officer taking pride in protecting the community like a sheep dog protecting the herd. However, dynamics of the job demand emotions that conflict with felt emotions and may lead to burnout or other adverse consequences (Schaible & Six, 2016). Schaible and Six (2016) indicate that conflicting demands lead to an increase in burnout rates, cynicism, and job dissatisfaction. According to the Emotional Labor Theory, when emotional demands of work contradict worker's emotions, they are likely to experience adverse side effects (Schaible & Six, 2016). This constant exposure to trauma generates high rates of comorbidity between PTSD and depression among officers (Galovski et al., 2016). Studies also report that constant exposure leads to decreased related brain structure and functioning (Levy-Gigi, Ritcher-Levin & Keri, 2014).

Traumatic stress has been linked to compromised mental health and functioning (Galovski et al., 2016). Officers who experience higher workloads, organizational restraints, and more incivility than their colleagues are more likely to experience negative reactions along with variables of mental, physical, and attitudinal strain (Fisher, Kerr & Cunningham, 2017). The development of symptoms following a traumatic event may not be apparent to officers. Research shows that disaster exposed officers who assisted

survivors are 2.98 times more likely to develop PTSD (Faust & Ven, 2014). Traumatic incidents involving victims increases the likelihood that PTSD symptoms will start to manifest. Faust and Ven also state that officers who develop PTSD experience higher rates of alcoholism, suicide, domestic violence, divorce, or mental and physical impairment due to lack of sleep (2014).

Faust and Ven (2014), state that first responders are at risk of negative effects and stress related symptoms following a disaster. In addition, officers with PTSD or experiencing symptoms are unable to detect when they are in imminent danger (Faust & Ven, 2014). Although symptom identification can be difficult for officers, the feelings they experience are undeniable. Faust and Ven report that following disasters, some officers are unequipped to manage the stress of the job and leave the field (2014). In the Hurricane Katrina disaster, out of 1,400 officers who responded 250 quit and at least two committed suicide (Faust & Ven, 2014). The law enforcement field involves officers to experience excruciating experiences.

According to Wills and Schuldberg (2016), witnessing a crime or other traumatic events has a significant impact on an individual's personality. As noted above, exposure to trauma impacts officers on a physically and emotionally. Schaible and Six (2016), reported that officers begin to feel personally drained and complacent towards those they are expected to serve. These officers are expected to maintain a positive demeanor even after they have been exposed to the most indescribable tragedies (Schaible & Six, 2016). Individuals exposed to trauma display increases in neuroticism and especially anger, hostility and frustration, these individuals are also less likely to de-escalate during an

interpersonal conflict (Wills & Schuldberg, 2016). These personality changes inevitably start to impact officer's personal lives as well.

Faust and Ven (2014), stated that officers are faced with erratic and unpredictable high stress situations in the line of duty. Officers are placed in dangerous situations that often threaten their safety. Police abuse is associated with depression, anxiety, distress, and trauma symptoms (Oh, DeVydler & Hunt, 2017). Officers who develop these symptoms are at risk of developing a psychological disorder. Many mental health disorders are associated with PTSD as well as various health conditions (Boyraz et al., 2016). Trauma can cause emotional and physical symptoms. Boyraz et al. (2016), associates PTSD with pain symptoms and an overall lower quality of life.

Fearful police officers are not effective police officers, and the denial of their emotions only increases the probability of violent coping strategies being used (VandenBos, 2017). Officers who refuse treatment may believe they are being strong however their resistance causes turmoil in other life domains. Individuals who develop PTSD also commonly experience health issues, trouble at work and less productive at work (Simiola et al., 2015). Research has proven that trauma affects the individual and spreads into other aspects of their lives. As discussed above officers are personally impacted, their abilities at work suffer and their families are negatively affected.

Police officers are commonly one of the first responders to arrive to a critical incident (Watson & Andrews, 2017). Responding to traumatic events puts law enforcement personnel at risk. Most incidents consist of high public stress, threats of well-being to self and others and managing physical injuries and sometimes the deaths of

others (Watson & Andrews, 2017). Officers have higher rates of PTSD and depression then the rest of the general population (McCanlies et al., 2017). Faust and Vander Ven report that traumatic exposure may alter the way an officer performs on the job; putting themselves in danger or avoiding traumatic reminders (2014). The anticipated threat of the job impacts the decision-making process (McCormack & Riley, 2016).

Lofstand, Loftus and Loader (2015), identify that certain occupational environments can be littered with physical, social, and moral taint. The hazardous nature of the law enforcement environment puts officers at risk of other negative outcomes. On average officers from a large urban department have reported being exposed to 168 traumatic experiences throughout their career (Chopko et al., 2017). Officers from a smaller, mid-size agency reported 188 traumatic experiences (Chopko et al., 2017). These studies emphasize that the size of the department is irrelevant, and officers are still exposed to a significant amount of trauma. Studies show that at any given time nearly 30% of officers will experience PTSD symptoms or develop PTSD (Chopko et al., 2017).

Personal Relationships

Over the course of their career, officers face mental and physical effects due to the constant exposure to trauma (Papazoglou & Andersen, 2014). Papazoglou and Andersen (2014) indicate that mental health conditions such as PTSD and PSS are said to have a profound impact on their family's and personal relationships. There is an evident connection between discomfort in sharing personal feelings with family and the prevalence of traumatic stress symptoms (Chopko et al., 2017). Furthermore, studies suggest that officers who do not put a lot of effort into their personal relationships

experience higher levels of avoidance and hyperarousal of PTSD symptoms (Chopko et al., 2017).

Officers experience negative physical outcomes in addition to the social components endured due to the trauma exposure. Physically officers develop chronic disease, headaches, irritability, and interrupted sleep patterns (Papazoglou & Andersen, 2014). While these symptoms may be common for the first few weeks following a traumatic event, symptoms that linger for more than a month may be indicative of PTSD (Hartley, et al., 2013). Following a traumatic event, nearly 46% of officers reported moderate-severe trauma symptoms (Watson & Andrews, 2017). Other behaviors impacted by trauma include alcohol consumption, gambling, and unsafe sex (Papazoglou & Andersen, 2014). These behaviors are not only risky for the officer but typically cause tension between them and their families. Overall stress can impact an individual from functioning to their full potential (Papazoglou & Andersen, 2014).

Barriers to Treatment

Police officers may not see immediate effects of trauma but do require use of job resources, long term monitoring and access to support services to prevent issues from arising (Biggs et al., 2014). Papazoglou and Andersen (2014), suggested psychoeducation for mental and physical outcomes following critical incidents, helping officers understand that fear, anxiety and terror are normal human responses and are not signs of weakness in to decrease the stigma and stereotypes that exist and educate officers on the value of peer support officer's negative perceptions of mental health professionals, stemming from the police culture, negatively impacts the effectiveness of treatment (Steinkopf et al, 2015).

Steinkopf et al. (2015), also indicate that resistance to interventions stems from police culture and the stigma surrounding mental health problems. It appears that officer ambivalence to accessing resources may be fueled by common misconceptions and media that stigmatizes mental health issues.

Stigma. Police personnel exposed to traumatic events may develop psychological problems (Watson & Andrews, 2017). However, despite high rates of trauma officers are reluctant to seek help (Watson & Andrews, 2017). Stigma has been identified as a main reason behind officer's reluctance to treatment. In Goffman's words (2010), stigma is separated into three categories: abominations of the body, physical impairment or deformity, tribal stigmas such as race, gender and age and blemishes of character including mental illness or criminal conviction. Watson and Andrews (2017), report that there are two types of stigma: public stigma and self-stigma (stereotypes and labeling).

Society has placed stigma on individuals seeking mental health treatment due to their perceived mental illness. Equally individuals place the same stigma, label, on themselves when contemplating treatment and recognizing symptoms. Studies indicate that self stigma mediated the relationship between public stigma and attitudes surrounding seeking help (Karaffa & Koch, 2016). Police fear the negative perceptions of others making stigma a significant barrier to treatment (Watson & Andrews, 2017).

Obstacles such as a lack of knowledge about PTSD, treatment options and financial or time burdens have been reported as additional barriers to mental health treatment (Kim et al., 2018). Stigma has been identified as a large barrier to mental health treatment among officers (Faust & Ven, 2014). Most officers keep symptoms to

themselves because they do not want to be perceived as weak or mentally ill (Faust & Ven, 2014). Officers refrain from reporting their symptoms because they believe they could potentially face professional consequences. Faust and Ven (2014), state that those who need treatment the most are most concerned about the stigma.

Police culture. Steinkopf et al. (2015), state that police culture is founded on loyalty and unity created among officers by shared work experiences, hazards of the job and authority to use force. It has been indicated that due to the presence of police culture, officers resist seeking mental health treatment. Chaotic work environments result in officers feeling connected to one another through their traumatic experiences. However, police culture can place an officer at risk of adopting it as their primary identity and developing an "us versus them mentality" (Steinkopf et al., 2015). Steinkopf et al. (2015), suggest that when police culture is combined with secrecy and loyalty, the outcomes are undesirable. Over time the law enforcement organization has created a moral code that makes officers feel as though they cannot seek help. Police culture, stigma of mental illness and treatment and intervention delivery methods have created a barrier between the police and the services they need (Steinkopf et al., 2015).

Police officers are expected to manage their own symptoms, work the front lines, work long hours and endure increased emotional demand by the compassionate responses required by victims (Biggs et al., 2014). Occupational stress and police culture have been identified as the two reasons behind psychological distress (Steinkopf et al., 2015). An officer's relation to the critical incident determines the significance of the impact. Galovskil et al. (2016), explains that proximity is an individual's physical distance from

the traumatic event and is a strong and consistent predictor of negative mental health outcomes. Proximity can also be conceptualized as direct exposure to trauma, personal and emotional connectedness to the suffering, media exposure, life disruption and fear secondary to a traumatic event (Galovski et al., 2016).

Understanding root of police stress is imperative to police and public (Schabile & Six, 2016). The ability to identify risks to police officer's well-being may motivate discussions to determine how to enhance department policies. Officers expected to be "nicer than nice and tougher than tough" (Schabile & Six, 2016). Regardless of the contradictory expectations, officers must interact with the public in a way that gains their trust (Inzunza, 2015).

Officers are expected to provide the public with effective services, but it becomes difficult when they are faced with conflicting feelings. Due to police culture many officers do not feel comfortable expressing their feelings. Occupational culture is developed because of shared values and norms (Lofstrand, Loftus & Loader, 2015). Officers usually underreport their symptoms due to the police culture and their expectation for officers to provide more socially desirable responses in their psychological assessments (Marchand et al., 2015). Officers are fearful to express their true feelings.

Police culture has been described as a monolithic authority (McCormack & Riley, 2016). Police are expected to exhibit a high level of emotional control (McCormack & Riley, 2016). As a result, officer's feel as though they cannot express negative symptoms they are experiencing. McCormack and Riley (2016), state that there is a distinct

nonacceptance of emotional expression in the law enforcement field. It is that exact nature of police culture that hinders individuals from seeking social support, which is a key buffer against stress (McCormack & Riley, 2016).

Limited organizational support and untreated stress causes inevitable issues among officers. Quality of peer relationships and organizational support were directly correlated with stress among officers (Papazoglou & Andersen, 2014). The inability to seek social support puts officers at risk of experiencing psychological injury (McCormack & Riley, 2016). The bond among officers is an amazing support if utilized.

The law enforcement field relies highly on the collaboration among officers. Therefore, one consequence officers fear is that disclosure of symptoms may make other officers uncomfortable and feel like they cannot trust an officer with mental health symptoms (Faust & Ven, 2014). It is not uncommon for officers to feel incompetent if they experience posttraumatic symptoms (Chopko et al., 2017). In a similar study of veterans who were screened for a mental health disorder, 65% believed they would be seen as weak for seeking treatment, 51% said their leaders would blame them for their problems, 50% believed it would harm their career, 59% thought their colleagues would have less confidence in them, 63% thought leadership would treat them differently and 41% said they would be too embarrassed to self-report (Faust & Ven, 2014). Kim et al. (2018), agrees and states that officers feel that their jobs are threatened if they acknowledge their mental illness. Regardless of the reason, the percentage of officers who fail to seek treatment due to stigma is alarming.

Police work is demanding and although programs exist to help officers, many do not take advantage of the services offered (Papazoglou & Andersen, 2014). Police culture has been suggested as a reported barrier to officer treatment. There is a subculture among officers that consists of certain rules, lingo, set principles and ways to communicate (Andersen & Papazoglou, 2014). Officers feel obligated to act and express themselves in a certain way. Police culture fosters secrecy creating a barrier for officers to reach out when they are suffering (Papazoglou & Andersen, 2014). In this context, secrecy is defined as hiding personal information from loved ones and friends to prevent feeling discriminated against (Ray & Dollar, 2014). However, guarding painful emotions and withholding feelings can lead to additional negative reactions.

Impact of Suppression

Suppression of emotions can lead to physical illness, cognitive impairment, or burnout due to the physical and mental strain of "bottling it up." However, Papazoglou and Andersen (2014), stated that emotional suppression is encouraged at the start of an officer's career to prevent occupational burnout. Yet Schabile and Six (2016), reported that hiding negative emotions leads to burnout. Suppression of feelings result in a plethora of negative effects. Officers can experience peritraumatic dissociation. Peritraumatic dissociation causes officers to feel disconnected, altered perceptions of pain, tunnel vision which are said to help protect individuals from overwhelming distress (McCanlies et al., 2017). It has been suggested that the presence of peritraumatic dissociation increases the chances of developing PTSD and depression (McCanlies et al.,

2017). Despite the negative effects, officer's feel obligated to model how to manage painful emotions when working with victims (Risan, Milne & Binder, 2016).

Officers engage in deep and surface acting while on duty. Deep acting embraces organizational expectations by placing themselves in an altered state (Schabile & Six, 2016). Officers who engage in deep acting experience strong emotions during a traumatic event but suppress them due to perceived consequences of the police culture. Police culture impacts officer's ability from seeking help because they are afraid of negative job consequences (Papazoglou & Andersen, 2014). Surface acting involves engaging in actions that support organizational expectations but do not make effort to experience the feelings accompanied with it (Schabile & Six, 2016). This type of acting also prevents officers from experiencing their true feelings in a healthy manner. Officers feel required to display specific emotions (Schabile & Six, 2016).

Officers are responsible for multiple roles and duties throughout the day. In addition to witnessing and encountering trauma, officers may be tasked with interviewing victims of trauma. Research suggests that it is a difficult task to interview distressed survivors while trying to keep them calm and prevent re-traumatization (Risan, Milne & Binder, 2016). Officers are expected to be conscious of their emotions and reactions. In addition to being conscious of their own emotions, it is important to become aware of an interviewee's capacity to cope (Risan et al., 2016). Furthermore, officers must understand how to regulate distress by responding to interviewees emotional needs (Risan et al., 2016). To appropriately manage victim stress, Risan et al., Binder (2016), suggest officers follow a 3-step model that consists of; becoming aware of interviewees capacity

to cope with distress by attending to non-verbal cues, communicating acceptance and modeling how to cope with painful emotions and regulating distress by responding to emotional needs (helping them feel safe and promote the positive). It is easy to understand how officers feel responsible to carry the burden of more than just their personal feelings and experiences.

Emotional dissonance refers to emotional exhaustion, depersonalization and questions pertaining to one's sense of personal accomplishment (Schabile & Six, 2016). Inevitably the suppression of feelings can also lead to compassion fatigue, secondary traumatic stress and burnout and require awareness from the law enforcement field (Turgose et al., 2017). Suppression of felt emotions can result in burnout, physical illness, and cognitive impairment (Schabile & Six, 2016). Research suggests that officers have a lower life expectancy than the rest of the population by 21 years (Steinkopf et al.,2015). Furthermore, research suggests suppression of emotions is associated with the activation of parasympathetic nervous system and a host of psychological and physiology symptoms (Schabile & Six, 2016). Ultimately, increased suppressed emotions lead to individual's wanting to quit their jobs (Schabile & Six, 2016).

According to the General Strain Theory, work-related strain has been linked to an increase the officer's likelihood of experiencing violence (Ellrich & Baier, 2016). Violence geared towards officers is an additional risk of the job. A combination of work stress and police culture increases an officer's risk of serious psychological and physical problems (Steinkopf et al., 2015). Job resources were shown to address emotions and promote positivity among employees (Biggs et al., 2014). However, Fisher, Kerr and

Cunningham (2017), argued that while job control and social supports are common resources, they are highly controlled by supervisors and not the employees. Limited access to support increases psychological stress of officers (Chopko et al., 2017).

Dark Humor

Without appropriate resources, officers may cope with their symptoms inappropriately. Individuals who work with human trauma often handle the stress of the job with humor (Craun & Bourke, 2015). Craun and Bourke (2015) also identified that lighthearted humor is associated with secondary traumatic stress and gallows humor has the inverse relationship. Craun and Bourke (2015) explained that gallows humor is "dark humor" and refers to the physically threatening or emotionally disturbing situations. Humor is often utilized as a coping skill for those who investigate or report on trauma (Craun & Bourke, 2015). Officers are exposed to many events where they are required to investigate or report trauma.

Professionals who use humor believe it creates a bond between them and their colleagues and helps reduce the stress of the job (Craun & Bourke, 2015). As discussed above, this bond is known in the law enforcement field as police culture. However, Craun and Bourke (2015) indicated that the use of humor is not always beneficial. Some even suggest that gallows humor is a sign that individuals are not coping well with secondary traumatic stress (Craun & Bourke, 2015). Officers react to trauma differently and their symptoms are not always identical.

Studies found that lighthearted humor was associated with lower secondary traumatic stress scores and gallows humor was related to higher secondary traumatic

stress scores (Craun & Bourke, 2015). Craun and Bourke (2015), found that humor at the expense of the victim was a red flag and indicated higher secondary traumatic stress. In the law enforcement field officers deal with perpetrators and victims. In the past humor and jokes about the victim have been perceived as insensitivity but research shows that this type of humor may indicate that interventions are necessary to mitigate secondary traumatic stress (Craun & Bourke, 2015).

Higher secondary traumatic stress rates are associated with distrust of the world, overprotectiveness of loved ones and lower job satisfaction (Craun & Bourke, 2015). Distrust of the world may impact an officer's receptiveness to receive treatment from a mental health provider. Supportive supervisors and supportive co-workers have been found to lower secondary traumatic stress scores (Craun & Bourke, 2015). A direct correlation was found between supervisory procedural justice and management of anger and frustration. However, changes in work engagement, supervisor support, and colleague support showed an increase in supportiveness of the work environment (Biggs et al., 2014). As noted above, strong support systems were identified as a protective factor against mental health diagnoses among officers.

Despite the risk factors and negative outcomes for officers, there are resources available to treat their symptoms. Law enforcement agencies commonly have policies in place to ensure support for employees who have experienced a traumatic event (Biggs et al., 2014). Many department policies require administration to refer officers to an outpatient mental health provider if warranted. The primary goal of psychological

treatment is to restore officers to an adequate level of functioning, so they may perform their jobs effectively and safely (Steinkopf et al., 2015).

Coping Skills

Understanding risk factors that increase an officers' risk of developing PTSD will help prevent psychological symptoms and reduce the negative consequences associated (McCanlies et al., 2017). Understanding the risk factors may also help departments develop trainings and other preventative measures. McCanlies et al. (2017), states that peritraumatic dissociation occurs when an individual's ability to cope with trauma is overwhelmed. Coping is defined as an individual's cognitive and behavioral ability to manage internal and external stressors (Craig et al., 2017). When dealing with traumatic exposure, there are healthy coping skills and unhealthy coping skills.

Healthy coping skills allow individuals to face stress with positive options (Heffer & Willoughby, 2017). Examples of healthy coping skills include getting support and advice from other people, finding comfort in religious beliefs, and accepting the reality of the situation (Craig et al., 2017). Marchand et al. (2015), states it is inconclusive whether problem focused coping or emotion focused coping is more effective for officers. Regardless, when individuals can increase their use of healthy coping skills, they increase their ability to manage their illness and reduce the impact of symptoms (Craig et al., 2017).

Unhealthy coping skills are described as maladaptive coping and involves emotion suppression (Chopko et al., 2017). It is common for officers to isolate and withdrawal from activities that do not pertain to the law enforcement field. This

withdrawal makes it hard for mental health professionals on the "outside" to help. Solidarity may help officers cope with internal stressors of the job however it also encourages isolation from the rest of society (Papazoglou & Andersen, 2014). Silence is not recommended as a viable coping skill (Craun & Bourke, 2015) Steinkopf et al. (2015) explain that officers want to remain loyal and therefore are reluctant to "break the code" which reinforces their silence.

Isolation is viewed as an unhealthy coping skill and may be another indicator of the development of a mental illness. Symptoms of psychological conditions may lead to maladaptive coping skills like alcohol abuse and withdraw from social supports such as family members and peers (Faust & Ven, 2014). Officer's wives reported that their husbands hid their thoughts and feelings as a method of coping (Chopko, Palmieri & Adams, 2017). However, this form of coping is counterproductive and commonly impacts officer's personal relationships such as limiting communication with their spouses (Chopko, Palmieri & Adams, 2017). Given potential risks to their well-being, officers would benefit from resources to help them appropriately cope and prevent emotional distress (Turgose et al., 2017).

The law enforcement population are exposed to trauma more frequently and to a wide variety (Chopko et al., 2017). Due to the trauma exposure it is imperative that officers possess the ability to cope with their symptoms. Many officers utilize emotional detachment to cope with the chronic exposure to trauma (Chopko et al., 2017). Emotional detachment may be helpful to some officers but there is a plethora of healthier coping options available. Healthy coping skills and the ability to problem solve have shown to

increase rates of posttraumatic growth (Chopko et al., 2017). Officers have access to a variety of coping skills but must possess the desire to utilize them when necessary.

The way individuals cope has a greater impact on how they adjust than the traumatic event itself (Boyraz et al., 2016). Officers engage in avoidance and approach coping. Avoidance coping consists of trying to avoid feelings of distress and can include substance use or behavioral disengagement (Boyraz et al., 2016). Studies show avoidance coping has been responsible for several health conditions even after controlling for PTSD (Boyraz et al., 2016). Avoidance coping may lead to a dual diagnosis of PTSD and substance abuse disorders.

Avoidance coping interferes with an individual's ability to process the trauma and hinders natural recovery (Boyraz et al., 2016). This type of coping does not allow officers to appropriately process their trauma. Negative posttraumatic outcomes occur because posttraumatic symptoms drive avoidance which hinders an individual from fully processing the traumatic event (Smith et al., 2014). Individuals with PTSD who utilize avoidance coping experience temporary relief but then are overwhelmed by more persistent distress (Boyraz et al., 2016).

Approach coping is a construct that requires the use of emotional processing and expression in response to a stressful situation and focuses on the individual's ability to deal with the stressor and feelings associated (Boyraz et al., 2016). Self-distraction strategies may help individuals process their traumatic experiences without being overwhelmed by their trauma related emotions/feelings (Boyraz et al., 2016). Although there is literature that verifies the ineffectiveness of avoidance coping, officers may use a

combination of skills to help them obtain balance. Research suggests that to adjust to a traumatic experience, individuals must be flexible and sometimes may have to use opposing coping strategies (Boyraz et al., 2016). Similarly, stress response theory suggests that intrusion and avoidance are necessary to help process trauma (Boyraz et al., 2016). Officers must discover effective strategies that address their individualized symptoms. Effective coping skills are needed to help protect trauma exposed individuals from health conditions (Boyraz et al., 2016).

The literature supports the need to provide services for police officers. Providing training to officers from the beginning of their career may help decrease stigma to receiving mental health treatment (Papazoglou & Andersen, 2014). Integrating resiliency programs into cadet trainings may increase positive outcomes and decrease stigma to receiving treatment (Papazoglou Andersen, 2014). This approach is preventative instead of reactive. Furthermore, police trainers should educate new officers on the mental and physical strains of the job, traumatic exposure, help seeking behaviors and how to combat the stigma of mental health (Papazoglou & Andersen, 2014). Information provided from seasoned officers may help get the attention of newer officers and encourage them to take their advice.

Early Detection of Symptoms

Chopko et al. (2015) believe that the influence of traumatic incidents on PTSD symptoms may be stronger on officers from smaller departments. Size of the department may be something for administrators to consider when examining the impact of trauma on their officers. Events that occur infrequently were rated higher by officers regarding

severity to the ones commonly experienced (Chopko et al., 2017). According to Chopko et al., studies indicate that nontraumatic work stress was a stronger indicator of psychological distress including PTSD (2015). Additional questionnaires that have been used to identify symptoms are WRIs, work-related injuries, questionnaire, the Maslach Burnout Inventory (MBI) and the Impact of Event Scale-Revised-Greek version (Katsovouni et al., 2016). Departments can gather a great deal of information from their officers with the use of these instruments.

Despite the instruments discussed above, Faust and Ven argue that literature on police stress lacks information on what departments do to screen for vulnerability to PTSD prior to an officer's exposure to the field (2014). Due to the reluctance to self-report, it is safe to say that the officers who need treatment never receive services. Displaying hesitance to receive services also prevents officers from reporting their symptoms. However, research has shown that it is imperative for officers to receive treatment in a timely manner following a traumatic event (Faust & Ven, 2014).

Many police officers experience symptoms related to coronary disease, sleep issues, mood swings, difficulty concentrating, substance abuse and various other psychological symptoms related to trauma and go undiagnosed (Sijaric-Voloder & Capin, 2008). Therefore, Faust and Ven (2014), recommended additional training to help officers detect PTSD symptoms and encourage peer support. The idea is that if officers are more knowledgeable of their symptoms, they may be able to realize that they need help. Furthermore, officers should be made aware of policies and procedures regarding trauma response (Faust & Ven, 2014). Additional strategies to minimize adverse effects

consist of educating officers and their families on signs and symptoms of PTSD and providing hotlines, resources, and information to the employee assistance program (Faust & Ven, 2014). Families are often impacted by an officer's trauma and their input can be helpful when it comes to symptom recognition.

Some departments may mandate debriefings, psychological testing, and fitness for duty testing (Faust & Ven, 2014). Mandating services may be the only way to increase compliance with resources following a traumatic event. CISD, Critical Incident Stress Debriefing, when implemented has shown a reduction in the number of officers who leave the department following a traumatic shooting (Faust & Ven, 2014). However, Marchand et al., argues that psychological debriefing was found to be ineffective or increase PTSD symptoms (2015). Regardless, any department can take advantage of requesting CISD trained individuals to provide services for their officers. Research suggests that police departments need to take a more active role in identifying stress risk (Faust & Ven, 2014). Initiating CISD resources may be an active first step in identifying stress risk among officers.

McCormack and Riley (2016) identify the significance of cognitive appraisal, personality structure and social supports on stress and coping following a traumatic event. Officers are encouraged to hold their departments accountable to provide appropriate and adequate services. Police departments have a responsibility to provide training and support to officers to protect their psychological well-being. McCormack and Riley identified resiliency training and posttraumatic facilitation training as necessary supports (2016).

Stressors of the law enforcement field exist beyond the traumas of the job. Organizational stressors may include lack of support (McCormack & Riley, 2016). Therefore, a great deal of consideration should be given to officers and the trauma they experience. It is imperative that organizations recognize the value of nurturing psychological well-being throughout a high-risk service career such as policing. As well as prioritize changes to policy for necessary psychosocial, psychiatric, and psychological support that is free of mental health stigma for maintaining not only the mental well-being of their personnel but contributing to the well-being in policing families (McCormack & Riley, 2016).

Protective Factors

Prior field experience and adequate training are shown to be protective factors against PTSD (Marchand et al., 2015). The more protective factors that are present among officers the less likely they are to be significantly impacted by traumas of the job. However, studies fail to identify any protective factors that impacted the intensity of the symptoms (Marchand et al., 2015). Researchers suggest that officers who are training to face stressful situations can be more resilient and capable of managing a variety of dangerous experiences (Marchand et al., 2015).

As noted above, there are a plethora of intervention strategies officers can utilize to address officer trauma. For example, departments could foster resilience by providing training on coping skills, problem-solving, relaxation and breathing strategies (Marchand et al., 2015). Studies show that resilience is a powerful protective factor in buffering the impact of traumatic stress on the development of PTSD (Lee et al., 2014). However,

Skeffington et al., argues that the integration of a four-hour resiliency training intervention did not prove to be effective in preventing PTSD (2016). In addition to in house resources and trainings, outpatient treatment can also be helpful. A five-week, cognitive behavioral therapy centered sessions are suggested to minimize the impact of trauma two weeks after the traumatic incident (Marchand et al., 2015). Furthermore, cognitive processing therapy has been identified as a therapy model to change trauma related cognitions and ultimately facilitate change in PTSD symptoms (Schumm et al., 2015).

Posttraumatic growth. Regardless of the treatment options, it is important to increase the presence of protective factors to help officers with their psychological responses to trauma (Chopko et al., 2017). Posttraumatic growth refers to the positive changes that occur because of the trauma moving forward in life (Chopko et al., 2017). Posttraumatic growth may help minimize the impact of trauma on officers. Sattler, Boyd and Kirsch (2014), indicate that the utilization of mental health resources helps promote posttraumatic growth. Trauma exposure, direct or indirect, plays a significant role in the development of posttraumatic growth (Chopko et al., 2017). Researchers like Chopko et al. (2017), have explored how to increase posttraumatic growth among officers and departments.

Chopko et al. (2017), found that the only predictor of posttraumatic growth in the field among officers in the was being involved in an on-duty shooting. Therapy may be required to achieve posttraumatic growth and increase better health outcomes (Chopko et al., 2017). However, as discussed above the officer's preference and willingness to

engage in treatment should be taken into consideration. Trauma related to threats on self are more closely related to PTG and most associated with PTSD symptoms (Chopko et al., 2017). Furthermore, Chopko et al. also reported that frequency or witnessing harm to others was not directly associated with posttraumatic growth (2017). The type of trauma can impact the development of PTG (Chopko et al., 2017).

Self-efficacy. In addition to empathy, self-efficacy has also been identified as a crucial characteristic to help officers manage trauma symptoms. Benight and Bandura (2003) define self-efficacy as an individual's ability to manage their own functioning regarding events that occur in their lives. Often interventions are necessary to foster self-efficacy to allow individuals to make meaning of the grief and process the traumatic event (Smith et al., 2014). Self-efficacy is believed to regulate functioning through cognitive, affective, decisional, and motivational processes and impact whether a person has self-enhancing thoughts or self-debilitating ones (Benight & Bandura, 2003).

Self-efficacy can be developed through mastery experiences, vicarious learning, reappraising affective and physiological reactivity and verbal encouragement (Smith et al., 2014). Departments can host trainings that encompass each of these learning components. Self-efficacy can play a critical role in stress reactions and the ability to cope when faced with threatening situations (Benight & Bandura, 2003). Interventions that increase self-efficacy and address posttraumatic stress symptoms may reduce long term negative mental health outcomes (Smith et al., 2014).

Available Resources

Due to police stress, steps have been taken to intervene and provide services to help maintain the level of functioning for officers (Steinkopf et al., 2015). The purpose of the resources is to act as a buffer between occupational stressors and potential health problems (Steinkopf et al., 2015). Departments have offered indirect and direct interventions as viable treatment options. Indirect interventions include trainings on mental health education and awareness, identification of signs and symptoms and coping skill development (Steinkopf et al., 2015).

Steinkopf et al. (2015), define direct interventions as; individual therapy, exercise programs, critical incident stress debriefings and peer support programs. However, it has been reported that scheduling appointments and making time for treatment is problematic for officers due to their shiftwork schedules and heavy workload (Kim at el., 2018). Regardless of potential barriers, Turgose et al. (2017), suggests that officers would benefit from additional supports when dealing with victims and other challenges of the criminal justice system. Despite the plethora of interventions suggested, Steinkopf et al. (2015) believe that no intervention strategy will result in a psychological, physiological or behavioral outcome for officers. It is important to note that although there are resources that exist, their existence does not guarantee that officers will engage in treatment.

Law enforcement officers have identified dynamics of their departments as additional reasons they go without treatment. Officers find that the behaviors of police management fail to address the psychological well-being of their officers (McCormack &

Riley, 2016). McCormack and Riley (2016) suggested that failure to recognize officer's emotional struggles leaves them feeling like the department does not value their mental health. As noted above, organizational support has been identified as a protective factor against occupational stress and trauma. Officer's feelings of depreciation may lead to "moral injury" which causes officers to feel deceived by their authoritative figures (McCormack & Riley, 2016).

Organizations that lack positive support and validation make officers feel betrayed (McCormack & Riley, 2016). Officers are less likely to share their emotions if they do not feel supported in their work environment. Many officers felt that their psychological frailty made them a nuisance to the department (McCormack & Riley, 2016). Personal stigma of symptoms decreases an officer's likelihood of seeking assistance. McCormack and Riley (2016), state officers learned to shut down on the job to prevent and demonstration of weakness.

Police officers who shut down and refrain from sharing their symptoms are further traumatizing themselves. Officers who have a difficult time expressing their emotions are at risk of developing posttraumatic reactions (Marchand et al., 2015). Law enforcement personnel have learned to handle trauma and stress of the job in their own unique ways. However, studies show utilizing avoidance-based strategies to cope, like shutting down, leads to greater psychological symptoms (Marchand et al., 2015).

Officers who were discharged medically due to PTSD directly linked their diagnosis to a lack of organizational support (McCormack & Riley, 2016). In hindsight police officers were able to identify many red flags, symptoms, and risk factors they

experienced during active duty. Following discharge, officers were able to recognize the "domino" effect of chronic exposure, lack of support and invalidation of their psychological distress (McCormack & Riley, 2016). Although officers gained the ability to show insight into their career experiences, they still experienced the negative effects long afterwards. Due to police trauma, officers felt shamed and perceived themselves as failures, they felt they could not integrate back into civilian life without support, they felt betrayed, started to disconnect and become reclusive (McCormack & Riley, 2016).

There is an evident need to provide law enforcement personnel with mental health services. Martin, Tran and Buser (2017), emphasized the importance of targeting depressive and PTSD symptoms to reduce suicidality. However, despite the clear need for mental health treatment among law enforcement personnel, research shows that most interventions have been inconsistent (Steinkopf et al., 2015). Boffa et al. (2018), argues that anxiety sensitivity specific interventions are shown to reduce PTSD symptoms and suicidality. Cognitive anxiety sensitivity concerns account for the link between PTSD and suicide (Stanley et al., 2017). Many officers were able to recognize the impact the law enforcement field had on their physical and mental well-being. Officers who wanted to make changes in their lives attributed that desire to change to their adverse experiences, invalidation by the organization and lack of support for integrating post-policing (McCormack & Riley, 2016).

Researchers agree there is a great deal of reluctance displayed by officers to seek mental health services. It is exhausting for officers to maintain a positive outlook on the job when most of their calls cause negative feelings (Schabile & Six, 2016). Despite

potential negative outcomes, officers are expected to manage their strong emotions while providing the public with adequate services. Trainings may help officers develop the ability to handle stressful situations with empathy (Inzunza et al., 2015). Inzunza et al. (2015), also suggest that trainings may provide officers the ability to see situations objectively, failure to do so may cause bad judgements when in contact with citizens and a development of stress.

Recommended Treatment Options

Mental health resources may be needed to address distress (Galovski et al., 2016). Motivational interviewing is an intervention delivery style that has proven to increase the alliance between the mental health profession and treatment resistant populations (Steinkopf et al., 2015). The relationship between officers and the mental health professional is crucial to the therapeutic relationship. Motivational interviewing has proven to be effective for common police problems; substance use, depression, marital discord and health-related behaviors (Steinkopf et al., 2015). Addressing these common problems may help an officer recover from the exposure to trauma.

Motivational interviewing. Motivational interviewing treatment goals include increasing engagement and efficacy of the treatment and improving officer functioning (Steinkopf et al., 2015). Motivational interviewing techniques are inexpensive, easy to implement and may be more effective because peers are more capable of overcoming stigma associated with emotional difficulties (Steinkopf et al., 2015). Overcoming stigma may help increase officer's receptiveness to treatment. Despite the negativity experienced by officers who attempted to be open and honest, many were glad that they did seek

assistance (McCormack & Riley, 2016). Steinkopf et al. (2015), report that motivational interviewing techniques can be taught to increase officer's ability to help fellow officers.

Although researchers agree that interventions to address officer trauma is necessary, research is limited on effective strategies to assist trauma exposed officers. In addition to motivational interviewing, mindfulness has been identified as another potential treatment option. A basic definition of mindfulness is moment by moment awareness (Germer, 2004). Mindfulness is a skill used to teach individuals to be less reactive and focus more on relating to all experiences to reduce overall suffering and increase well-being (Germer, 2004).

Mindfulness. Mindfulness is described as a personal resource used to prevent job stressors from resulting in personal and job-related strain outcomes (Fisher, Kerr & Cunningham, 2017). Fisher et al. (2017), explain that mindfulness is helpful in high stress jobs especially ones that challenge interpersonal relationships. One of the main benefits of mindfulness is to increase resiliency in the face of challenges (Fisher et al., 2017). Mindfulness allows individuals to develop insight into psychological functioning to respond proficiently to new situations (Germer, 2004). As discussed above, officers face many challenges while on duty and are impacted significantly. Given the severity of the impact trauma has on officers, researchers have explored methods to minimize the effects. According to Fisher et al., (2017), mindfulness has been connected to the reduction of certain adverse mental health symptoms as well as physical disturbances.

Treatment is recommended to address the mental and physical impact of trauma. Fisher et al. (2017), identify mindfulness as an intervention that promotes physical and

mental well-being. Mindfulness is also connected to positive reactions and reducing negative reactions to work-related experiences (Fisher et al. 2017). Although there is limited research on effective interventions for officers, Fisher et al. (2017), suggest that mindfulness has been beneficial to officers willing to participate in treatment.

Validation. Ensuring resources like therapy, peer support, supervision and debriefings have been suggested to minimize the impact of traumatic experiences on officers (Turgoose et al., 2017). However, due to stigma and other barriers discussed above officers are ambivalent about taking advantage of services offered. Researchers suggest that greater recognition would help normalize the reactions experienced by officers, giving them the courage to speak about their symptoms and challenges they face (Turgoose et al., 2017). Officers have reported caring a great deal about how their peers perceive them.

Validation of feelings may help officers feel less judged and more supported. Self-help strategies could potentially be beneficial but should not completely replace organizational supports such as peer support and supervision (Turgoose et al., 2017). It is helpful when officers can utilize healthy coping strategies to help them manage their symptoms. Some studies indicate a positive relationship between approach coping and positive health outcomes and others show no relationship Boyraz et al., 2016). Officers may require education to help them identify signs and symptoms. Turgoose et al., report that training interventions on empathy are useful and increase officer knowledge (2017).

Peer support. Peer support has been identified as a protective factor and helpful resource following a traumatic event. Watson & Andrews (2017) describe a trauma risk

management team (TRiM) that was developed to be utilized following a traumatic event. TRiM is a peer support group that aims to decrease stigma, provide peer support, and encourage help seeking (Watson & Andrews, 2017). Officers have reported that peer acceptance is very important to them. Studies suggest that officers believe seeking help is a sign of cowardliness and admission of incompetence (Watson & Andrews, 2017). Police officers behave in a way that they believe will be approved by their fellow officers. Additionally, masculine values have been identified to discourage expression of emotions and internal solidarity characterizes police culture, creating the "us and them" mentality which ultimately increases stigma to receive assistance (Watson & Andrews, 2017).

While many officers do not seek assistance, there are resources available. Following a survey in NJ, nearly 71% of officers were aware of employee assistant programs, EAP, but only 22% had ever utilized them (Watson & Andrews, 2017). The trauma risk management team has been suggested as an effective treatment method for officers. TRiM relies on nonmedical volunteers to be practitioners, have a basic understanding of trauma psychology, and trained to conduct risk assessments and identify officers at risk of symptoms (Watson & Andrews, 2017). Those identified at risk are monitored and followed up on, if symptoms worsen or persist officers are referred to a mental health provider (Watson & Andrews, 2017).

The key goal of TRiM is to change organizational culture within police departments (Watson &Andrews, 2017). As noted above, the culture of the law enforcement field has been identified as a barrier that hinders treatment. Additional

barriers for seeking treatment was fear that it may harm their career and their colleagues may have less confidence in them (Watson & Andrews, 2017). It is evident that officers are concerned with the perception their colleagues have of them. The trauma risk management team fosters relationships among officers and their peers verses mental health professionals who have "not experienced the same things they have experienced" (Watson & Andrews, 2017).

Watson and Andrews reported the trauma risk management team has not been predicted to lower psychological distress however, the team does aim to increase acceptance and early intervention through detection efforts, followed by linkage to services (2017). Officers who engaged may have an easier time expressing their symptoms and seeking treatment. Participants reported being happy about seeking help or had little concerns about seeking help (Watson & Andrews, 2017). It appears that officers began to feel more comfortable with symptom management. Change within police organizations needs to be decreasing negative stigma associated with mental health needs and seeking treatment (Watson & Andrews, 2017).

Policies that reduce stigma may help increase police effectiveness (Morabito & Socia, 2015). Facilitating change within police departments may be the first step to increasing officer receptiveness to treatment. TRiM is suggested as an appropriate intervention to address stigma in the law enforcement field (Watson & Andrews, 2017). In addition to addressing stigma among police personnel, fewer barriers were also reported when officers are exposed to TRiM forces (Watson & Andrews, 2017). The

trauma risk management team model can be mimicked in other departments to address officer symptoms.

There is little research on how departments screen for PTSD or how they provide post-trauma training and support (Faust & Ven, 2014). Departments have utilized standardized instruments to measure the impact of traumatic incidents. Critical Incident History Questionnaire (CIHQ) is used to measure frequency and severity of traumatic incidents experienced by officers (Chopko et al., 2017). This standardized tool allows departments to understand the impact the trauma exposure has had on an officer. The CIHQ is utilized along with additional tools to assess alcohol use, suicidal ideations, overall health, sleep, depression, and PTSD (Chopko et al., 2017).

Treatment Methods

There are a variety of services available to officers who experience trauma. Treatment options can include department resources, available trainings, medication management, outpatient treatment and inpatient treatment. While many treatment methods exist, it is important to discuss options with the individual seeking treatment. Research suggests that preferred participation, individuals chooses treatment method, in mental health treatment will lead to better outcomes (Simiola et al., 2015). Simiola et al., also reports that almost 60% of individuals who received preferred treatment showed improvement (2015). However, Chopko et al. argue that reference for treatment does not necessarily motivate an individual to engage in mental health treatment (2017). Furthermore, individuals with PTSD vary with their willingness to address their traumatic

symptoms (Chopko et al., 2017). This may be especially important to keep in mind with officers when contemplating treatment.

Being aware of an officer's willingness to engage in various types of treatment may help providers when they are offering and discussing treatment options (Simiola et al., 2015). To be more specific, if an officer is not interested in taking medication, suggesting psychotropic medications will not be beneficial. In general, it is estimated that individuals chose therapy over medication because of the potential side effects and stigma associated with taking psychotropic medications (Simiola et al., 2015). Specially, individuals diagnosed with PTSD preferred psychotherapy over medication (Simiola et al., 2015).

Police officers who sustained trauma related injuries were more likely to prefer psychotherapy (Simiola et al., 2015). A small portion of individuals denied being interested in any type of treatment at all (Simiola et al., 2015). Lack of interest in treatment is common among officers. Those with PTSD interested in treatment often request the participation of their partner or family in treatment as well (Simiola et al., 2015). Personal preferences may vary thus it is crucial to have a wide variety of treatment options available for officers.

Increase Access to Information

Additional mandatory trainings that focus on trauma, mental health, and available resources prior to entering the field may help officers in many ways. Barriers to resilience that result from police culture can also be discussed in police trainings (Papazoglou & Andersen, 2014). Education on mental and physical effects of the job are missing from

cadet training (Papazoglou & Andersen, 2014). New officers should be informed of potential harm and side effects they could experience. As discussed above, officers in training may be more receptive to seasoned officers who have years of experience in the field. Research further suggests that student centered training will increase acceptance and cohesion among the group (Papazoglou & Andersen, 2014).

Studies have recommended several strategies to help address trauma among officers. First, the literature suggests that resiliency training be incorporated into every academic police training (Papazoglou & Andersen, 2014). Research shows that resiliency has been considered a protective factor against stress (Jeong et al., 2015). The second recommendation is that trainings be mandatory and all officers practice resiliency exercises (Papazoglou & Andersen, 2014). Third, advertise for resiliency trainings to be something that enhances job performance and less focused on mental health, stigma or weakness (Papazoglou & Andersen, 2014). Employing these steps may help increase officer receptiveness to treatment.

Educating officers on potential risks and initiating a conversation about their well-being is imperative. Program enrollment and early education may help officers seek treatment later in their careers and recognize their own mental and physical health symptoms (Papazoglou &Andersen, 2014). Training recommendations for educators include psychotherapy, relaxation techniques, mind-body connection (yoga and dance) and journaling (Papazoglou &Andersen, 2014). It is essential that officers who train new officers are aware of effective coping techniques and resources available. This dynamic

between officers and trainees will foster trust and close communication (Papazoglou & Andersen, 2014).

The Diagnostic and Statistical Manual of Mental Disorders fifth addition recognized risk among first responders and the development of PTSD (Carmassi et al., 2017). Law enforcement officers have a diverse role in the community and often wear many hats. One of their primary responsibilities requires their assistance in emergency situations. Emergency responders bear the negative consequence of their work in the form of posttraumatic stress symptoms (Oginska-Bulik, 2015). Researchers in one study explored the impact on officers following two years after a traumatic event. Many reported taking frequent days off, difficulty sleeping, higher rates of burnout, lower quality of life and weight gain (Wild et al., 2016). Statistics like this confirm the impact trauma has on officers and the long-lasting effects that continue to disrupt their lives. Continuing to explore our understanding of positive factors and how they are associated with fewer PTSD symptoms and can inform and guide treatment modalities for PTSD to better serve police officers (McCanlies et al, 2014).

As noted above, researchers agree that police officers experience trauma due to the nature of their work (Chopko & Schwartz, 2013). The literature highlights key points that identify types of trauma, define police culture, and suggest ways to address barriers to treatment (Smith et al., 2015). Steinkopf et al. (2015), agree on the various types of traumas and occupational stressors that officers encounter each day. As a result of trauma, physical and mental health symptoms may manifest in a variety of ways. Despite

the literature that supports the benefits to treatment, Simiola et al. (2015), acknowledges that officer resistance to treatment exists and is a valid social problem.

As the researcher I collaborated with social workers to explore officer ambivalence and identify perceived barriers to mental health treatment. The research identifies the need to address officer trauma but does not explain what departments can do to ensure the implementation of standard interventions. I believe most officers are influenced by aspects of their departments not to seek treatment. Increasing acceptance of disclosure and symptom acknowledgement may help break down the barriers to treatment and overall facilitate change among the law enforcement field.

Summary

Social workers are obligated to abide by the principles and ethics discussed in the NASW Code of Ethics. One of the leading principles is to identify social problems and assist those in need (NASW Code of Ethics, 2017). As a researcher, it is important to address these social problems and explore potential solutions to bridge the gap in services. Throughout the literature review external stressors, internal stressors, signs and symptoms of trauma, effects of trauma, the presence of police culture, barriers to treatment, and treatment recommendations for addressing officer trauma were discussed. Reviewing the information found in the literature review will not shield officers from the trauma they experience. However, the research may allow me to facilitate positive change among departments by providing law enforcement personnel and social workers with adequate information to make changes. Police departments may be able to use the information to enhance their cadet trainings, minimize occupational stressors, provide

more on the job training, and increase access to services for officers identified as at risk. Social workers may be better able to use the finding found in this study to advocate for officer's needs.

The research above was conducted by researchers who have studied the law enforcement field. However, CISM-trained social workers have witnessed the impact of trauma on officers and therefore will be a vital asset to this research project. The purpose of the research project was to explore social workers' perceptions of the impact trauma has on officers. I envision that this research may be helpful within the following fields: criminal justice, medical and psychology fields.

This next section will review my research design and the data collected. Research variables will be further explored. The methodology will be examined, procedures will be discussed, and the sample population will be identified.

Section 2: Research Design and Data Collection

The impact of daily professional tasks performed by police officers can be physically and mentally daunting. In many cases, not receiving treatment can be detrimental to an officer's health. Untreated trauma in adulthood can cause physical and emotional hardships (Center for Nonviolence and Social Justice, 2014). This qualitative study was developed to explore social workers' perceptions of the impact trauma has on police officers. In this section I discuss the research design, methods for obtaining data and the ethical procedures followed to ensure quality.

Methodology

To appropriately address the purpose of this research study, I facilitated a focus group with social workers. Focus groups are a data collection method in which the data are collected in a semi-structured interview process (Cohn & Crabtree, 2006). The key feature of focus groups is the interaction among participants to explore their opinions and beliefs (Then, Rankin, & Ali, 2014). Focus groups are convenient when exploring new areas of research, exploring a topic that does not lend itself to observational techniques like attitudes and beliefs and when you want to collect a set group of observations in a short time span (Cohn &Crabtree, 2006). According to Then et al. (2014), focus groups are comprised of three main components: a data collection method, interaction as a source of data and the active role of the researcher in facilitating a discussion for data collection.

A focus group is the most appropriate method to collect data since I am trying to explore the beliefs of social workers. Stringer (2013) promoted the use of focus groups,

mainly because the data collection process is not bound by an interpretive framework that allows participant thought free from a researcher or theoretical paradigms. Focus groups are defined as a gathering of selected people who participate in a planned discussion about a specific topic in an environment that is nonthreatening (Devault, 2018). Focus groups explore how people feel, perceive, or view a certain topic (Wilson, 2016). Evident themes were generated through data analysis. The data collected uncovered findings that provided the foundation to the development and implementation of actions to increase officer access to resources and alleviate the impact of trauma.

Participants

For this study, I requested participation from social workers from the following counties on the lower shore of Maryland: Wicomico, Worcester, and Somerset. To be eligible to participate, the social workers had to be trained in CISM debriefings and possess a valid social work license in the state of Maryland. Furthermore, they had to reside in and have conducted a CISM debriefing in Wicomico, Worcester, or Somerset county. The participants included social workers who directly or indirectly had interactions with police officers through CISM debriefings. There was no other demographic information required to participate.

I began my recruitment process by sending a letter to the CISM coordinator for the lower shore of Maryland briefly explaining the purpose of the study, how it is pertinent to the social work field, how I believe it may benefit police officers and request permission to send an email to all CISM certified members. Wicomico, Worcester, and Somerset are rural counties that consist of approximately 60 CISM-trained social workers

and 250 police officers. Among the 60 CISM-trained social workers, nine volunteered to participate. To keep their identity confidential, each participant's feedback was coded as an assigned number. The social workers are identified by number throughout the data: Social Worker 1, Social Worker 2, Social Worker 3, Social Worker 4 and so forth.

Procedure

Once I received permission from the CISM coordinator, I requested a list of emails for all CISM-trained social workers on the lower shore. I drafted an email with a synopsis of the study and requested responses from social workers interested in participating. After a list of interested participants was generated, I sent an invitation with a meeting place and time where the focus group would be conducted. I was seeking participation from 10 CISM-trained social workers from the Eastern Shore of Maryland. In the case that I received more than 10 social workers, I would have operated on a first come, first serve basis, and accept the volunteers who submit their consents first. The Eastern Shore of Maryland is rural and includes three counties. Due to the size of the area being researched, 10 social workers would be an appropriate sample size. According to Wilson (2016), focus groups are more successful when comprised of 6-10 homogenous individuals who are willing to have a flexible conversation that lasts up to one to two hours.

Participatory Action Research

This study was a participatory action research project. Participatory action research is common because it stresses the use of academic research to promote change among policy and practice (Banks, Herrington, & Carter, 2017). According to Banks et

al. 2017), participatory research includes individuals who have an interest in the topic being explored. I utilized purposive sampling strategy, specifically homogenous sampling. I chose homogenous sampling because each of my participants are being selected based on their educational background and occupation. To be identified as a social worker in the state of Maryland, the individual must possess a degree in social work. As noted above, professionals from any discipline can become trained in critical incident stress management debriefing. During the recruitment process, I asked the CISM coordinator to only provide names of CISM trainers who are licensed social workers. This ensured that each participant selected would share the same educational background and occupation.

Instrumentation

I needed certain materials to successfully complete this research project. First, I drafted a letter to send to the CISM coordinator. Once permission was received from the CISM coordinator, a similar letter was sent via email to the CISM-trained social workers within the three lower counties of Maryland. All letters and emails were submitted to the IRB for review prior to their distribution. Packets explaining informed consent and respondent rights were compiled and given to each social worker prior to the start of the focus group. According to the NASW (2017) Code of Ethics, informed consent is required and ensures equal treatment of all participants. The internet was used to access my email account to secure social work participants.

Then et al. (2014), reported that focus groups are used widely in health care research to better understand attitudes, beliefs, and perceptions about a specific health

concern. Therefore, I provided each social worker with paper and pencils to document their thoughts and opinions to share during the open discussion. Due to the number of participants and risk of more than one person talking at a time, a recorder was used to record all communication from the focus group. Recording the information helped ensure that I did not miss any crucial feedback from any of the social workers. The dialogue captured on the recorder was used during the next step in this research project. There was no existing data used for this action research project. Important opinions, key themes, discussion points, and other insights were emphasized and discussed in further detail among the participants.

Data Analysis

Once the information was gathered from the social workers in the focus group, the data were analyzed. Data analysis refers to exploring the content or meaning of the data (DeVillis, 2017). I discovered whether the analyzed data supported or challenged my presuppositions and addressed the research question. Regarding qualitative research, the most important part of data analysis is to be true to the participants and showcase their voices (Sutton & Austin, 2015). All dialogue shared by the social workers in the focus group was used to generate research recommendations. The audio recordings taken from the focus group should be transcribed verbatim (Sutton & Austin, 2015). I spent several days listening to the audio to transcribe the feedback accurately. Sutton and Austin (2015) recommended tagging each voice because multiple voices may complicate the transcribing process. Each social worker's voice was identified as Social Worker 1,

Social Worker 2, Social Worker 3, and so forth to simplify the coding process and to further develop the findings of the project.

Data analysis is necessary following the conclusion of a qualitative study, but it is a time-consuming task (Watkins, 2017). Watkins (2017), proposed the use of the rigorous and accelerated data reduction (RaDaR) technique,a team-based approach to coding and analyzing qualitative data. Watkins explained that prior to utilizing the RADaR technique, the data or audio recording must be transcribed and reviewed meticulously. The RADaR technique should be used to help the researcher revisit the researcher question and become one with the data prior to the development of data codes (Watkins, 2017). Watkins explained that the idea behind the RADaR technique is that researchers can focus on the content of the data and less on the transcript number, participant responses, notes, code and theme.

There are five steps researchers must follow to utilize the RADaR technique (Watkins, 2017). The first step requires researchers to ensure that all transcripts are formatted similarly (Watkins, 2017). Watkins (2017), recommended placing details about the focus group (time, date, location) on the top of the page or in a header. The Wicomico County Health Department could not accommodate the date and time of the focus group. It was held at the Wicomico County public library. The date and time were provided to participants in the initial email explaining the study and requesting volunteers. The second step includes entering all the data from the transcripts into a table with multiple rows and columns and labeling it phase one (Watkins, 2017). Phase 2 will emerge during

Step 3 when researchers condense the data even further to eliminate text that is not relevant to the research question (Watkins, 2017).

Step 4 consists of condensing the data even more into additional rows and columns (Watkins, 2017). Watkins (2017) reported that this technique will help the researcher identify commonalities among the data and acknowledge the relevance of quotes in relation to the study. This step will assist in the recognition of themes and developing patterns to better understand the research question. The final step requires the researcher to create an additional phase within the same table to prepare the language for the project deliverables (Watkins, 2017).

There are several advantages of using data analysis. For this research, 10 social workers were asked to participate. Nine social workers volunteered and were able to participate. Watkins (2017), explained that due to the simplicity of the RADaR technique, the analyst will copy, cut, paste and highlight the data manually. This action research study is an ideal size to utilize the RADaR technique. The RADaR technique is most effective when the researcher is aiming to develop a project deliverable (Watkins, 2017). The goal of this action research project is to generate a dissemination of findings to present to local police departments.

Ensuring the data is analyzed quickly was important because it allowed me to present results that may be used to positively impact police officers sooner. Data analysis is cost effective and helps the researcher move rapidly through the qualitative data (Watkins, 2017). I conducted this action research project without a budget or available funds to supplement the research. Convenience and feasibility were imperative. The

information found in the data was not altered and the inclusion of citations will guarantee precision. It was imperative to minimize the risk of bias and use of nonacademic information.

There has been a great deal of research regarding how to eliminate non-attitude reporting to enhance the quality of research results (Krosnick et al., 2002). Researchers can choose to adjust the data or ignore the problem (Groves et al., 2009). Researchers who decide to adjust the data have a variety of techniques available to help them clean their data. Imputations refer to the researcher's decision to place an estimated response into an item's data field to compensate for missing data (Groves et al., 2009). Like all data cleaning techniques, imputations have advantages and disadvantages. According to Groves et al., the benefit of imputation is that the method is known, and researchers can use all the data. However, researchers also dispute that imputed data is the equivalent of "made up" data (2009). Through the analysis, the data were cleaned to confirm the absence of false data and to ensure accurate and high-quality data.

Role of the Researcher

The role of the researcher is imperative because the interaction between the individuals involved in the study mediates the outcomes of the research (Karagiozis, 2018). As a CISM-trained social worker I have experience working with police officers. Based on my professional experiences, I have my own set of presuppositions that I believe prevent officers from receiving mental health treatment. I believe many officers are in denial of their symptoms, fearful of repercussion from their departments and lack general knowledge about mental health issues. However, although I discuss in detail the

rationale for my presuppositions, for the purpose of this research project my role was to be the researcher and not a social worker.

My assumptions were developed through my personal encounters with police officers. Nevertheless, there is literature that supports my presuppositions and validates my beliefs. Compartmentalization is a technique used that allows individuals to block negative memories however, for police officers this blocking may cause overconfidence or denial (Thomas, Ditzfeld & Showers, 2013). Denial is defined as a defense mechanism that prevents unpleasant internal and external realities from entering the conscious (Miller-Keane, 2003). It is common for anyone to suppress their emotions following a traumatic event to block out their feelings. This is particularly true with police officers. Even when officers leave the job, some experience denial that continues to prevent them from utilizing the appropriate services (Warren, 2015). I believe denial was a pertinent theme because it is derived from literature and is supported by the historical resistance to treatment in the law enforcement field.

According to Edwards (2006), police officers do not report their feelings to other officers due to the fear of revenge or being "black balled." Furthermore, many officers fear that their jobs as officers are at risk and they may face termination if the disclose their emotions (Warren, 2015). The initial denial followed by fear of discussing their symptoms haunt many officers, preventing them from seeking services. Warren (2015) believes that officers fear professional repercussion if their signs and symptoms are exposed. In addition to fear, it is believed that a lack of awareness and education significantly impacts an officer's ability to engage in treatment. This assumption was

made from the literature, but I am aware that this theme may not be addressed in the focus group.

According to Warren (2015), officers do not acknowledge that they have compassion fatigue or lost their ability to empathize with others. Although symptoms may be apparent to social workers, Warren (2015), suggests that officers are less knowledgeable about how to recognize emotional and behavioral changes. Awareness refers to the conscious ability to differentiate and identify sensory stimuli (Miller-Keane, 2003). Furthermore, as a clinician in the field I believe increasing officer knowledge on mental health issues may naturally increase their sense of awareness as well and ability to identify symptoms. Hanafi, Bahora, Demir & Compton (2008), suggest that if officers increased their knowledge on mental health issues, they would be less concerned with stereotypes and develop more empathy.

The preexisting information derived from the literature and my personal experiences was not shared with the social workers during the focus group. However, it was important for me to be aware of my preconceptions, so they did not impact the accuracy of the data being collected. The social workers selected for the focus group have experienced their own encounters with police officers and possessed very different perceptions of the identified problem. Their impartial participation was crucial to the study.

I am aware that countertransference exists, but by acknowledging it I hope to prevent biases. Countertransference refers to the emotional state of the analyst to the client's influence (King & O'Brien, 2011). I did not want to interfere with the social

workers' ability to engage freely with one another during the focus group. I wanted to completely extract my beliefs from the research so that I may gain an understanding of their perceptions related to barriers that exist. Once their perceptions were documented I was able to use their data to either affirm or deny my initial presuppositions.

The study was qualitative, and the data will be obtained through a focus group discussion. The social workers volunteering for this study are CISM-trained and have worked firsthand with police officers. Utilizing a focus group as their platform to share information will allow me to collect their responses to use as data. The data will be analyzed to identify themes regarding officer trauma and the opinion they have on seeking mental health treatment. The project was conducted ethically and followed all NASW Code of Ethics guidelines.

Ethical Considerations

According to the American Psychological Association's (2016) Ethical Principles of Psychologists and Code of Conduct, it is imperative that researchers take necessary precautions to ensure the safety and protection of all research participants. Prior to the start of the focus group, I asked all social workers to protect the identity of police officers who may have contributed to the information they provide. Furthermore, each participant signed a contract agreeing not to disclose personal details about officers and to keep their identifying information confidential. As discussed above, participation from each social worker was voluntary and their identity will remain anonymous. This ensured that the participant information was confidential as well throughout the project process. Each social worker who agreed to participate was informed that their involvement was

voluntary and that they had the right to refrain from participating. Social workers utilized the focus group to share their perceptions of barriers that prevent officers from gaining access to mental health treatment.

I received permission to contact CISM-trained social workers from the CISM coordinator prior to the start of the focus group. The information I collected from the social workers was kept electronically on my computer. My computer requires a password to login, and I am the only person who has access to my personal laptop. At the end of the project I intend to share the results with police departments in Wicomico, Worcester and Somerset County, Maryland. In addition to law enforcement, each social worker will have access to the finalized project upon request. Once my research is published, the information will be deleted.

Summary

This section discussed the qualitative methods that were used to explore the perception of social workers regarding officer trauma during CISM debriefings. Following the conclusion of data collection, I aimed to answer the research question discussed above. I feel confident that the information collected will help successfully address the research question and help explain the relationship between the law enforcement profession and the mental health field. The population, sampling methodology and the right to informed consent was presented.

I would like to utilize the results of the action research project to increase access to mental health resources for officers. In addition to myself as a researcher, the social workers who participated in the focus groups may also act like agents of change in the

community and advocate for an increase in access to services. A successful study may help alleviate stress among law enforcement personnel and ensure utilization of mental health treatment.

Section 3: Presentation of the Findings

The purpose of this action research project was to explore the following question: What are social workers' perceptions of the impact trauma has on police officers? To do this, I asked social workers to reflect on their personal encounters with police officers during times they facilitated CISM debriefings. I wanted to focus on their thoughts regarding officer's responses to trauma and their reactions when mental health resources were recommended. The need to explore the detrimental effects on first responders has become increasingly popular among researchers.

To collect my data, I facilitated a focus group. I had nine social workers offer to participate in the study. The focus group took place on Tuesday, February 4th, 2020 from 5-7 p.m. The focus group was held at the Wicomico County library because the Wicomico County Health Department was unable to accommodate the evening hours of the group. All nine social workers responded to my invitation and disclosure agreement via email with "I consent." The focus group was informal and allowed the social workers to speak in an open forum style. I prepared follow-up questions to prompt additional comments or feedback when the social workers became silent. The audio was recorded by a voice recorder I purchased so I could transcribe the data verbatim.

Data Analysis Techniques

As discussed in Section 2, I used the RADaR technique to code and analyze my qualitive data. RADaR is a team-based approach to coding and analyzing qualitative data (Watkins, 2017). Prior to implementing the RADaR technique, I transcribed the data and examined it several times with my research question in mind. The rationale for

implementing RADaR is to focus on the content of the data collected verses the responses from each participant.

I created a spreadsheet in Microsoft Excel to ensure the data were formatted and documented consistently. I placed the details of the focus group including time, date, and location on the top of the page. I then entered all the data from the transcript into a table, creating multiple rows and columns, labeling it Phase 1. I reviewed the data collected and attempted to identify common themes and words used multiple times by each social worker. I was able to condense the data even further to eliminate text that was not relevant to the research question.

I repeated this step to create additional rows and columns on the sheet to identify similarities among the data. I was also able to recognize the importance of certain quotes that emerged from the data in relation to the study. It was in this step where I was able to start identifying the themes to better understand the research question. I continued to examine the data and finalized the sheet that best represented the project deliverables.

Findings

The data collected for this project was initiated by the research question. Follow-up questions (see Appendix B) were used to prompt additional thoughts and perspectives. There were seven follow-up questions that were open ended in nature. Each question specifically asked for details regarding officer responses during the various phases of CISM.

When the research question was presented, the social workers shared their experiences with CISM and the nature of their roles as CISM-trained clinicians in the

community. This allowed me to better understand the context of their insight and experiences in the field. Although the social workers are all CISM-trained, they had different professional roles which made their responses unique.

After examining the data collected from the focus group, these primary themes emerged: stigma, training, denial, maladaptive coping skills and fear. These themes were developed from the data and can be used to address the research question: What are social workers' perceptions of the impact trauma has on police officers? Mental illness-related stigma creates barriers to treatment and quality care (Knaak, Mantler, & Szeto, 2017). All nine social workers in the focus group discussed stigma surrounding mental health and how they believe it hinders officers from seeking mental health treatment.

Stigma

It is noteworthy to mention that five of the nine social workers shared examples of officers only willing to seek treatment through the "back door." Social worker 1 reported that a police officer completed an intake and claimed he was having marital issues. However, through the progression of their therapeutic relationship, it was evident that the officer was only using his marriage as a cover up for his deeply rooted mental health issues. The officer disclosed that it was easier to tell others he was in therapy for his marriage than to disclose the truth about his own mental health symptoms. Social Worker 1reported that the officer was too ashamed to share his personal battle with his mental health.

Social Worker 4 stated that, in her experiences, officers are often resistant to local treatment options but will travel out of the area for services. An officer approached her

after a CISM debriefing and asked for resources outside of their county. He was willing to travel one hour away for mental health services because he did not want anyone to find out he was in treatment. All nine of the social workers agreed that officers were receptive to services if their engagement in treatment was discreet because they cared about how they may be perceived by others.

Officers' secretive approach to treatment coincides with social cognitive theory. The belief that they can manage their functioning when dealing with events that have negatively impacted their lives. This concept is relevant because stigma is one of the common themes identified in the focus group. As discussed above, police officers have not been able to manage symptoms effectively on their own. The presence of stigma is an underlying barrier that prevents officers from pursuing treatment.

Training opportunities

The lack of time and resources allocated to educate officers about mental health while in the academy was another prevalent theme discussed in the focus group. Social Worker 9 commented that she believes officers are trained "military style" and programmed to be "tough." This style of training prohibits the display of emotions and recognition of mental health symptoms. According to Social Worker 5, the negative effects of stigma would decrease if police officers had more education on mental health. Increasing their exposure in the academy will create a foundation of understanding that is necessary for the duration of their careers.

Social Worker 6 reported that some officers are taking advantage of training opportunities available. Several of the officers they know have completed the CISM

training and became certified to facilitate debriefings. Social Worker 4 reported that the officers who are CISM trained were more receptive to mental health treatment. In Social Worker 4 and Social Worker 5's opinion, officers with CISM experience are more empathetic to individuals' feelings. These experiences have allowed officers to see the value in treatment and understand how imperative it can be to a person's overall well-being.

Although some police officers have taken advantage of CISM trainings, Social Worker 3 believes that they need to be exposed while in the academy. All nine social workers stated that introducing mental health at the beginning of officer careers will enhance their interactions with mentally ill individuals. Even more so, they believe officers will be able to better identify and address their own mental health symptoms. The social workers in the focus group unanimously agreed that a lack of training and education is detrimental to police officers and their ability to acknowledge their own mental health needs.

Denial

Among the nine social workers in the focus group, all agreed that stigma and a lack of training are evident barriers that promote denial among officers. Social Worker 8 shared that an officer told her, "I am supposed to be able to handle this; I should not be affected by it." This comment is a prime example of how social cognitive theory relates to police officer trauma. Officers have a fixed belief that they can manage their own symptoms regardless of the trauma they encounter. This unrealistic expectation of

themselves leads to denial when they are faced with mental health symptoms that they cannot control.

Social Worker 2 shared a similar comment from an officer who stated, "I chose this job, and this is what I have to deal with." Social Worker 5 agreed and replied, "Their lack of training normalizes their responses because they do not know any better." From the social workers' perspectives, police officers minimize the impact of the traumas they endure. As a result, they ignore the normal physical and emotional reactions caused by the abnormal situations.

All nine social workers had a unique experience and perspective to contribute to the group. Although some of the interactions were different, seven out of nine social workers reported that officers were dismissive and negative during the CISM debriefing process. Social Worker 6 stated that officers ignored her and refused to make eye contact. Social Worker 9 reported that officers during her CISM completely shut down and claimed the debriefing "wouldn't help anyway." The common word used to describe officer's attitudes by all nine social workers was "rude." Social workers reported that even though they were requested to conduct a CISM, officers resented them for talking about the incident and denied needing their support.

Social Worker 1 stated that police officers tend to believe that, "they are brass balled and bullet proof, they can take on anything and it doesn't bother them." She formulated this opinion after 17 years in the social work field; the last six years dedicated to working with officers and first responders during CISM debriefings. Eight out of nine of the social workers believe that officers are unfamiliar with risk factors and symptoms.

Social Worker 7 believes it is easier for officers to be in denial because they are not educated enough to accept it. All nine social workers perceived denial as a prevalent barrier when working with officers during debriefings.

Maladaptive coping skills

Instead of acknowledging mental health symptoms, all nine social workers agreed that officers utilize unhealthy coping skills to manage their feelings. The teaching phase of CISM debriefings consists of discussing healthy ways to manage symptoms so that the individual can return to homeostasis. Five of the nine social workers specifically reported that police officers they interacted with displayed maladaptive coping skills. Through the debriefings, Social Worker 3 learned that officers were engaging in risk-tasking behaviors and utilizing coping skills that were detrimental to their physical and mental health. Social Worker 9 shared that an officer she worked with was being promiscuous, self-medicating with alcohol and being verbally aggressive towards his family members. Additionally, Social Workers 6 and 8 reported that several officers they engaged with were at risk of losing their jobs due to erratic moods and reckless behavior.

Social Worker 8 elaborated on her encounter with the reckless police officer. She stated the officer was able to recognize his mental health symptoms after his superior threatened to terminate him. Social Worker 8 described the officer's behavior as impulsive; his judgement was impaired, and he was engaging in sexual relationships that started to interfere with his position in the department. After a pattern of poor choices, the officer was addressed by another supervisor on the shift who voiced concerns about his behavior. It was at that point he realized the severity of his symptoms and was motivated

to seek treatment. The officer shared this personal testimony during the CISM debriefing with Social Worker 8. Social Worker 8 stated the other participating officers reported feeling at ease when they realized they were not alone in how they felt. Social Worker 8 believed the other officers in the CISM were less fearful of negative reactions from their peers once the presenting officer validated their feelings by sharing his experiences.

Fear

The fear of unemployment influenced the officer above to seek treatment for his symptoms. In addition to being fearful of termination, officers are fearful of how they will be viewed by others. It was disclosed in the focus group by Social Worker 1, that police officers do not divulge their symptoms or feel comfortable seeking treatment because they are afraid of being judged. Social Worker 5 agreed and stated in their experiences, officers are fearful of how their partners will perceive them, and they are fearful that a mental health diagnosis may jeopardize their standing within the department. Social Workers 1 and 5 perceived that fear caused police officers to internalize their symptoms, which later manifested into negative physical symptoms and maladaptive coping skills.

All nine social workers agreed that officers are afraid to talk about how they feel, and their reasons vary. Social Worker 4 reported,

> "A lot of them have said that they do not feel like it's natural to be able to talk to somebody that they don't know, they don't feel comfortable with that. They said that um, they learn to compartmentalize everything and then they just but then they also realize that each little piece builds on the

> next thing but they don't do anything about it because they don't, their fear is that, you know, they're going to be reported to their agency, their guns are going to be taken and they're going to be looked down upon. They're not stable, so on and so on."

Although police officers have access to their EAP and in-house resources, many are fearful to utilize them due to the affiliation with the department. Social Worker 2 shared that an officer she worked with during a CISM was encouraged to talk to the police department psychologist. However, the officer later discovered that any officer who utilized the psychologist was forced to undergo a fitness for duty evaluation. Social Worker 7 agreed and emphasized that police officers are fearful of admitting they need help due to the negative impact it poses to their position and reputation.

All nine social workers agreed that officers were reluctant to share their emotions with mental health professionals hired through the department due to feeling fearful of what would happen as a result. Social Worker 3 stated that although officers were fearful of how their peers would perceive them, there was a strong bond detected between the officers participating in the CISM. Social Worker 5 agreed and shared that officers seemed to feel more comfortable talking with one another then engaging with her during the CISM. According to Social Worker 7, an officer reported feeling more comfortable with his peers because they do not have the authority to remove his weapon. Although officers felt more secure sharing their feelings with their peers, Social Worker 1 believes that officers minimize the severity of their symptoms because of underlying stigma.

Findings Compared to Preconceived Notions

Prior to the facilitation of the focus group, I envisioned that three themes would emerge: denial, fear and lack of knowledge on mental health among police officers. Based on my professional experiences, I identified denial as a factor that impedes officers from seeking treatment following a traumatic event. I theorized that officers are in denial of their symptoms because they are afraid of repercussions from the department.

According to the data shared in the focus group, all nine social workers perceived denial as a barrier to treatment. The nine social workers confirmed that officers are in fact in denial because they normalize their symptoms as "part of the job." Throughout the focus group, social worker two emphasized how police officers attribute their negative responses to trauma as something they are expected to manage while in the field. Social Worker 4 believes this mindset creates an environment that is not conducive for officers to be transparent about their symptoms and seek treatment.

The presence of denial among officers contributes to the presence of fear. My rationale for selecting fear as a barrier was due to my personal interactions with officers as a CISM-trained social worker. I had several police officers tell me that they were afraid to seek treatment because they did not want to be judged by their peers. They were also fearful of being terminated and being viewed as weak. These fears prolonged their denial as they consistently told themselves they were fine and could manage their symptoms on their own.

This preconceived notion was validated by the data shared in the focus group. According to the Social Worker 8, police officers felt that their jobs were in jeopardy if

they disclosed their feelings to their wrong people. As discussed by Social Worker 7, officers did not always recognize their feelings as mental health symptoms, but they were still weary to share how they felt with anyone employed through the department. According to social worker two, police officers did not trust that their EAP programs were completely confidential. Therefore, officers believed they would be penalized for utilizing the resources. Through the experiences and perceptions of all nine social workers, it was determined that for many officers it was difficult enough to acknowledge they needed help, let alone understand the importance of seeking support and being overwhelmed with the fear of speaking up.

Additionally, I proposed that officer fear and denial was influenced by their lack of knowledge on mental health. As a clinician in the field, I believed increasing officer knowledge on mental health issues may naturally increase their sense of awareness and ability to identify symptoms. The focus group supported this notion. According to the social worker nine, officers portrayed a military style atmosphere that made them feel obligated to deal with obstacles on their own because it was "part of the job." Social Worker 5 also reported that officers felt inadequate when it came to discuss their own needs because of the lack of exposure they have to mental health. All nine social workers recommended implementing a mandatory mental health training during the academy to acclimate officers to behavioral health.

Social Worker 4 verified that officers are in fact fearful of losing their jobs which ultimately causes them to deny and ignore their symptoms. Social workers' perceptions did not highlight the lack of knowledge regarding mental health symptoms but more so

the lack of training and education opportunities that are provided to officers. Based on the information provided by the social workers; fear, denial, learning opportunities, stigma and maladaptive coping skills were the common themes that evolved from the focus group.

Section 4: Application to Professional Practice and Implications for Social Change

The purpose of this action research project was to explore social workers' perceptions of the impact trauma has on police officers. This action research project relied on feedback from social workers who have facilitated CISM debriefings for officers following a traumatic incident. According to the data collected from the social workers, they believe officers are influenced by stigma, a lack of training, denial, and fear. The findings will be used to educate local departments and facilitate change within police culture. The potential changes may influence officers to feel comfortable acknowledging and receiving treatment for their mental health symptoms.

Application to Professional Ethics in Social Work Practice

This research project coincides with several professional ethics in the field of social work. The research question aimed to explore the perceptions of social workers who have provided CISM debriefings to officers. The feedback will be used to suggest changes within the department to enhance the quality of life for police officers. Advocating for the mental health of officers applies to the ethical principal that social workers' primary goal is to help people in need and address social problems.

According to the NASW Code of Ethics, social workers are expected to utilize their knowledge, values, and skills to assist people in need and address social problems (2017). Police officers endure traumatic experiences but are ambivalent to seeking treatment. Social workers' perceptions uncovered barriers that proved to be detrimental to officer health. These barriers included stigma, fear, denial, lack of training, and

maladaptive coping skills. I will use the social worker's recommendations provided during the focus group to address each barrier to advocate for the needs of police officers.

In addition to addressing social issues, this project also emphasizes the value of relationships. According to the NASW (2017) Code of Ethics, social workers understand that the relationships individuals share with one another are vehicles for change. It is essential that officers develop a trusting bond with their partners and supervisors. It is even more crucial that among these relationships, they feel safe disclosing their emotions and allow themselves to be vulnerable. The research supports the need for officers to feel accepted and supported by their colleagues, as well as the therapeutic value of being able to share difficult emotions with others who have experienced similar situations.

It would be ideal to encourage all police officers to receive mental health treatment, the reality is that some will still refuse. The voluntary nature of treatment introduces the ethical standard of respecting an individual's right to self-determination. The right to self-determination requires social workers to assist individuals with their goals while respecting their decisions if they do not pose a threat to themselves or others (NASW, 2017). Adhering to this ethical standard allows me to support the decision of each officer regardless of his/her choice to engage in services. I can respect their right to self-determination while remaining supportive and providing resources if they change their mind.

I hope my conversation with the department is viewed as an opportunity to integrate mental health training into the academy. Training in the academy will be the foundation officers need to process their feelings and contemplate treatment after

traumatic days in the field. I hope the conversations also lead to a greater presence of mental health resources within the department. In addition to EAP resources, community resources should be available for officers to inquire about treatment if necessary. Conversations regarding treatment introduces another ethical standard that applies to this proposal, confidentiality. The NASW (2017) Code of Ethics defines confidentiality as respecting an individual's right to privacy, protecting the information they share and prohibiting the sharing of private information without consent. It is imperative that police officers understand confidentiality and their right to keep their personal information private. Understanding confidentiality may help overcome the barriers of stigma, fear, and denial.

Recommendation for Social Work Practice

The data I obtained will be shared with local police departments. My goal is to educate police officers about the perceived barriers and present suggestions that will best address their needs. Furthermore, I will share the data with CISM-trained social workers so they too can work towards overcoming barriers for officers. Revising the structure of the police academy is the first recommendation to increase exposure to mental health matters. After the academy, officers should be mandated to participate in trainings like CISM and mental health first aid. Social workers are required to receive continuing education units every year. Officers should be required to attend a certain number of mental health related trainings as well to ensure they are receiving the most up-to-date information and effective intervention strategies.

In addition to increasing training opportunities, officers should have access to external resources. Although EAP information is offered, a list of alternate mental health resources should be readily available if officers desire to receive support outside of the department. The list of providers should be in a common area that is easily accessible to officers including the lounge, the locker room and on the department's website. Access to external providers is crucial to ensure a supportive environment. Officers need to know they have a choice when it comes to their mental health treatment. It is equally important that supervisors convey a nonjudgmental culture that is safe for officers to disclose how they feel. If the supervisors can model acceptance and promote treatment it will change the culture of the department, increasing officers' comfort levels to seek treatment.

Implication for Social Change

Social workers will continue to advocate for police officers and recommend necessary changes to enhance their physical and mental well-being. I hope conversations with the department lead to the implementation of mental health trainings for all officers. According to the perceptions of all nine social workers, the academy should dedicate an entire week to the topic of mental health to prepare officers for the field. This recommendation is supported by all nine of the social workers and their belief that more training opportunities will enhance officer's abilities to acknowledge their own mental health needs.

Additional trainings like CISM and mental health first aid will be supplemental and further enhance officer's skill set. Quarterly trainings should be scheduled to target common diagnoses, treatment options, and recommended interventions. These training

opportunities will normalize police officer's experiences and expose them to available resources in the area. Social Worker 1 supported the idea of normalizing officer feelings. In her opinion, officers felt more relaxed when their feelings were validated and normalized by their peers. Mandatory trainings would ensure all police officers are exposed to mental health to develop a foundation that will assist in their own recovery.

Incorporating mental health into the day-to-day functions of police work may not only increase awareness but it also may help decrease stigma as well. It is essential for management to emphasize the importance of mental health and set the precedence for their fellow officers that it is okay to seek treatment. According to Social Worker 3, the bond between officers is special and comparable to the brotherhood identified in the military. Taking advantage of this bond may provide an opportunity for departments to implement a peer program where officers can utilize one another for debriefings. Social Worker 9 shared that officers were often reluctant to share their thoughts with "outsiders." However, if "one of their own" facilitated the debriefing, they may be less resistant and more likely to benefit from the process. Minimizing stigma will be a huge contributing factor when police officers consider pursuing treatment for their own mental health needs. When I disclose my findings, I will offer lists of local resources to any department willing to accept them.

Summary

There is an evident need to address the mental health of police officers. Due to a variety of barriers uncovered in the focus group, officers allow their mental health symptoms to worsen and avoid seeking treatment. The decompensation of symptoms

impacts police officers at an individual level but is also detrimental to their partners, families, and the community they serve. It is time to ensure that our officers are mentally and physically well because they dedicate their lives to ensuring the safety of ours each day.

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Appendix A: Focus Group Guidelines

Focus Group Guidelines

- Prior to the start of the group, the disclosure form will be reviewed and any questions or concerns you may have will be addressed
- Expect the focus group to last at least one hour and up to two hours
- Water and snacks will be provided for your convenience
- Identifying information will not be necessary when giving examples or sharing professional encounters
- Everyone is expected to respect the privacy of the group and keep all information that is disclosed confidential
- Remember that we are all mandated reporters and obligated to report any abuse disclosed
- Minimize side bar conversations so everyone can hear and stay focused on the purpose of the group
- Respect one another and give each other an opportunity to share their experiences
- Everyone has the right to ask questions for clarity
- Everyone is encouraged to speak openly and freely without consequence
- If a topic gets too difficult emotionally, please feel free to take a break and step outside
- Resources will be provided for those who need additional support about the group

Appendix B: Additional Focus Group Questions

Focus Group Questions

Primary research question: What are social workers' perceptions of the impact trauma has on police officers?

Follow up questions:

In the thought phase of the critical stress management debriefings, what have you noticed about police officer's initial thoughts regarding the traumatic event at hand?

In the reaction phase of the critical stress management debriefings, what have police officers identified as the worst part of the incident for them?

Have you noticed any themes in the parts they identify as the worst?

Were there any parts they wished they could erase?

In the symptom phase of the critical stress management debriefings, what are some physical or behavioral changes police officers reported?

How did they say the event has impacted their life?

When mental health resources were offered, how did police officers respond?