AN EXAMINATION OF POLICE STRESSORS AND ATTITUDES TOWARDS SEEKING PSYCHOLOGICAL HELP

by

Arthur Wlodyka

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Abstract

Police work is frequently cited as a high stress occupation in which officers are reluctant to access psychological services. A number of recent suicides by law enforcement officers have illuminated the need for an investigation into the psychological support of police officers.

The primary objectives of this study were to investigate police stress and officer attitudes towards mental health service providers, critical incident peer support programs, and psychoeducational training. Findings from the research of one hundred Lower Mainland area police officers revealed similar reported levels of stress to those found in other British Columbia law enforcement studies. Qualitative stress data further illuminated some of the unsparing trauma police officers are exposed to on a regular basis, as well as the profound impact on officers from external police conduct reviews.

In this study officers held more positive attitudes towards professional psychological help as compared to the normative sample of college students, teachers, and two samples of American police officers. Officers further supported ongoing psychoeducational training as well as the implementation of mandatory counselling within their organizations.

Implications and recommendations of these findings were discussed.

Preface

This thesis is an original intellectual product of the author, A. Wlodyka. All data was collected and analyzed by A. Wlodyka under the supervision of Dr. Colleen Haney. It was approved and covered under the University of British Columbia's Behavioural Research Ethics Board Certificate number H15-02173

Table of Contents

List of Tables

List of Figures

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Epigraph

"The badge no longer on my chest

I sleep now in eternal rest

My sword I pass to those behind

And pray they keep this thought in mind

I never dreamed it would be me

And with heavy heart and bended knee

I ask for all here from the past

Dear God, let my name be the last"

Excerpt from the "Monument" – George Hahn, LAPD, ret.

Chapter 1: Introduction

Background

Police work is a demanding profession and is frequently cited as a high stress occupation (Violanti & Aaron, 1994). Police officers are required to make split-second decisions, and deal with multiple complex problems on a daily basis. Officers face threats to their safety, an overexposure to human suffering, and are continually criticized in the media (Abdollahi, 2002; Burns, 2008; Violanti & Aaron, 1994). Apart from inherent stressors, police officers face numerous organizational stressors including excessive paper work, a lack of support from supervisors, and variable shift work (Violanti & Aaron, 1994). Outside of the work environment, police officers have been cited as having numerous difficulties in their family lives (Alexander & Walker 1996; Gilmartin 2002). A culmination of these factors leaves officers at risk of developing PTSD, job loss, or in extreme cases officer suicide (Gilmartin, 2002).

Despite holding a high stress job, police officers are typically reluctant to access psychological support. Officers are part of culture that emphasizes and promotes strength and emotional composure (Burns, 2014). Police officers are expected to be problem solvers and not "problem havers" (Berg, Hem, Lau, Ekeberg, 2012). Perceived stigma around accessing support, associated with a career limiting potential and with a loss of peer reputation, has also been frequently cited as a hindering factor (Burns, 2014). Despite a plethora of research on the harmful effects of police stress, there has been limited research on overcoming resistance to accessing psychological support. One possible approach is through the practice of mandatory yearly counseling and mental

health checks. This area has been traditionally studied in the context of rehabilitation for incarcerated persons, yet shows promising results for police (Carlan & Nored, 2008).

As a police officer, I have personally witnessed the devastating effects of these stress-related conditions if left un-treated. I have watched a close friend and a fellow police officer suffer from job-related PTSD that led to depression, drug and alcohol abuse, and finally the loss of his job. Recently, while attending the National Police Officers Memorial in Ottawa, I learned of another tragic story while speaking to a member of the RCMP. He had lost his best friend, a 25-year veteran of the Ontario Provincial Police, who committed suicide after suffering from PTSD. According to a recent CBC news article, a further 27 first responders took their lives in 2014. This is coupled with growing concerns around PTSD, as illustrated in a Globe and Mail article titled, "Hike in stress-disorder claims by Mounties raises questions for policy makers", published on August 8th, 2011 (Freeze, 2011). The article mentions that in the past very few members were diagnosed with PTSD, but that number has swelled to 1,711 in 2011.

Furthermore, the families of these officers are left struggling to deal with the dramatic changes their loved one has undergone. A 2011 case involved an RCMP major crimes investigator suffering from PTSD. His behavior changed so drastically that it culminated in the physical abuse of his wife, whom he threatened with a firearm in front of their two young children. Support in dealing with early warning signs was not in place. Standard police training appears focused on tactical and legal content, but seems to fall short in preparing officers for the ongoing psychological rigours of policing. Police support services do not appear to adequately address the ongoing needs of officers suffering from psychological injuries.

Chapter 2: Literature Review

Theory of Stress

Lazarus and Folkman (1984) provide a solid foundation to understanding stress based on the "Transactional Theory of Stress and Coping". Stress is seen as the result of a process in which a person is constantly appraising environmental cues, and assessing whether or not they have the internal resources to meet the specific needs of the situation. The process is broken down into two main stages, primary and secondary appraisal. During the primary stage, a person is noticing the cue in the environment and making a basic determination of whether there is a threat or not. If there is no threat, then there is no stress. If there is a perceived threat, then a secondary appraisal occurs. At this stage, a person appraises whether or not they have the internal resources to deal with the threat. If an individual believes they have the resources, then the situation can be seen as a challenge creating positive stress. On the other hand, if a person feels that they cannot meet the demand, than they become negatively stressed. This is an ongoing process and involves continual re-appraisal of the environmental cues. Numerous factors such as personality and emotional state, contribute to the process. Nonetheless, the side-effects of negative stress can be both physical and psychological health issues.

Police Stress. Duty- related stress has been commonly divided into operational and organizational stress since the 1970's (McCready & Thompson, 2006; Symonds, 1970; Violanti & Aaron, 1994). Operational stress has been further broken down into primary, secondary and routine stress. Primary stress comes from the personal danger experienced when responding to high-risk situation such as high speed pursuits, or confronting violent suspects (Mitchell & Everly, 1995). Secondary stress comes from an

overexposure to responding to human suffering. Police officers are often called to gruesome scenes involving fatal car accidents, homicides, or violent assaults. Some of these incidents, such as those involving exploited or victimized children, carry a special burden for officers (Brown, Fielding & Grover, 1999).

Secondary stress. Figley (1995) defines secondary stress as "the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other and the stress resulting from helping or wanting to help a traumatized or suffering person." Figley (1995) further describes this phenomena being as difficult to measure as the second hand smoke, but nonetheless real and consisting of severe effects. Despite a paucity of secondary stress research among law enforcement officers, a study conducted by Burns, Morley, Bradshaw and Domene (2008), investigated the experiences of 14 RCMP police officers within British Columbia. These officers were assigned to the Royal Canadian Mounted Police Integrative Child Exploitation Unit, and routinely investigating offences of sexual violence targeted at children. Findings indicated that although officers thought they would be prepared to deal with the severity of the work, most reported feeling overwhelmed and extremely distressed by the level of depravity and extensive caseload. Despite the challenging nature of the work, coping and resilience factors were noted especially in the area of support from peers on the team. Other issues identified included the importance of an understanding supervisor, as well as family and friends. Limitations of the study included being a small and limited sample, which was not designed to measure specific levels of stress or degrees of coping. Despite these

limitations, this study suggests that officers experience secondary traumatization from exposure to depraved acts of violence against children.

A majority of the research on secondary traumatization comes from therapists, mental health and social workers. A study conducted by Bride (2007) investigated the effects of secondary stress among 297 Master's level social workers in the United States. The researcher administered the Secondary Traumatic Stress Scale STSS (Bride, Robinson, Yegidis, & Figley, 2004). The STSS is a 17-item, self-report instrument designed to assess the frequency of intrusion, avoidance, and arousal symptoms associated with STS resulting from working with traumatized populations. Findings revealed that 89% of the respondents indicated working with traumatized persons, and 70% reported experiencing at least one secondary stress symptom in the past week. Further analysis of the data showed that 15.2 % met the criteria for PTSD based on their experiences in the past week, which is double the national average of 7.2 % (Kessler, 2000). While this study cannot be generalized to police officers, there are many consistencies among the traumatized individuals being dealt with in both professions. While studying coping with secondary stress among police officers, Conn and Butterfield (2013) pointed out that this research is still in its infancy and requiring further investigation.

Organizational stress. Another area of police stress has been categorized as organizational stress, such as shift work, overtime pressure, paperwork, inconsistent polices, and a lack of recognition (Tuckey, Winwood, & Dollard, 2012). These are seen as chronic and contributing to a negative work environment (Burns, 2014). Organizations are also often viewed as unsupportive after critical incidents. Many

police officers fear that their organization will not support them in the aftermath of deadly force encounters (Artwohl & Christensen, 1997). These stressors have often been cited as more damaging to officer psyches than operational stress (Tuckey, Winwood, & Dollard, 2012). Violanti and Aaron (1994) conducted a quantitative study among 110 police officers from a large department in New York to determine police stressors, levels of distress, and job attitudes. Officers were given three self-report measures including a 60 item police stress survey developed by Spielberg (1980), the 20 item epidemiological study depression test developed by Radloff (1977), and a 6 item job attitudes measure developed by Martelli and Martelli (1989). Findings concluded that organizational stressors had 6.3 times more effect on psychological distress than the inherent stressors such as danger and violence.

Personal stress. A third type of stress involves family, and not specifically experienced on duty, has also been discussed (Gilmartin, 2002). This type of stress comes from a documented history of interpersonal problems that police officers have in their relationships. Gilmartin (2002) explains this phenomenon in terms of the "hypervigilance" cycle. Officer's experience heightened autonomic system reactions at work, including elevated blood pressure, respiration, and body temperature. These reactions are necessary to effectively perform the duties of police work and respond to threats. This heightened awareness also allows the officer to feel a surge of energy and feel alive, alert, energetic, involved and humorous. The downside to this phenomenon occurs off duty. Police officers report feeling tired, detached, isolated and apathetic. As a result they disengage in their personal lives. They tend to want to zone out, and not deal with any decisions or conflict. This causes tension in personal relationships, as

'significant others' do not understand why their partners are not communicating, or actively participating in the relationship. This finding was further supported in a qualitative study among 8 spouses of British Columbia police officers. Thompson (2012) found that spouses reported a spillover effect from work to home life and described their spouses as never off duty, hypervigilant, and at times emotionally detached.

Impact of stress. Negative outcomes of police stress include poor physical and mental health issues, including depression, substance abuse, PTSD and, in extreme cases, suicide (Abdollahi, 2002; Chae & Boyle, 2013; Violanti, 2004; Violanti, 2009). A recent Canadian study involving two large police departments in British Columbia and Alberta (N=1,071) revealed that 29% of the sample met the clinical criteria of PTSD (Kitt, 2016). Other American law enforcement studies have reported PTSD rates between 12% and 35%, compared to PTSD estimates of 6.8 % among the civilian population (Kates, 2008; Kessler, 2006). Elevated rates of PTSD among police are a concern, as Violanti (2004) found that PTSD was associated with increased likelihood of suicidal ideation among law enforcement officers. Violanti (2009) further reported that suicide rates in the United States among police officers were four times higher than that of firefighters. In Canada, a newly created non-profit organization called Tema Conter Trust has begun tracking suicides among first responders. Tema Conter Trust estimates that 140 first responder suicides have occurred since 2014 (Savoia, 2016). In 2016, 19 police suicides have been reported, which is the highest number since data tracking began in 2014. Suicide prevalence rates compared to civilian populations have not yet been accurately reported, and this research continues to be in its infancy.

Psychological Services for Police

Given the nature of police work, counseling and mental health services would appear to be a suitable support mechanism for police officers. Counseling is widely regarded as an effective treatment for stress related issues (Wampold, 2010). Glass and Smith (1977) conducted an in depth meta-analysis involving 400 controlled evaluations of psychotherapy research and reported that 75% of participants showed improvements in anxiety reduction, self-esteem, adjustment, and work or school performance following counseling. Psychotherapy has since become widely accepted, with new research focusing more on individual treatments rather than the institution as a whole (Wampold, 2010).

For a long time policing has been associated with a reluctance to access psychological services. In a Scottish study of 409 police spouses, only 6% of respondents reported that their spouse ever spoke to a mental health professional despite feeling that their existing coping methods were ineffective (Alexander & Walker (1996). Culture, stigma, and fear of loss of reputation have often been cited as reasons why officers do not pursue counseling (Burns, 2014). While barriers to accessing help are well known, minimal research has studied overall attitudes towards seeking help. Karaffa (2012) conducted one of the few known studies examining police attitudes towards seeking professional psychological help in a sample of a 158 sworn police officers in Texas, United States. The author administered the attitudes towards seeking professional psychological help shortened form ATSPPH-SF (Fischer & Farina, 1995). Karaffa (2012) reported that officers held a neutral but more negative view of seeking psychological help then the normative sample of college students. Consistent with the

normative sample and other studies using ATSPPH-SF, the author reported that females had a more positive outlook on seeking help (Elhai, Shweinle & Anderson, 2008; Fischer & Farina, 1995; Karaffa, 2012).

More recent Canadian evidence suggests that police officers may be more open to seeking psychological support. Conn and Butterfield (2013) conducted a qualitative study involving 10 police officers from 6 different jurisdictions in British Columbia using the enhanced critical incident technique. A surprising finding concluded that 80% of her sample expressed a desire to access mental health resources including counseling or education. Limitations of the study included being a small sample from a small geographical area in British Columbia. This study may provide further evidence of a desire among police officers to talk about their problems and access mental health support services.

Critical incident debriefs. The most common services available to police officers are critical incident stress debriefs (CISD), peer support programs, employee family and assistance (EFAP) and recently psychoeducational programs such as the Road to Mental Readiness R2MR (CACP, 2015). CISD protocols were developed by Jeffrey Mitchell in 1970's in an effort to aid recovery for first responders after large-scale events or traumatic incidents. CISDs involved a trained facilitator leading a psychoeducational workshop for a group of emergency workers who had been exposed to a traumatic incident, in the hopes of reducing psychological distress. Mitchell (2004) has identified three key objectives including mitigating the effects of the trauma, normalizing the human response to the incident, and identifying participants who could benefit from further intervention. CISDs are typically held two to fourteen days after the incident

and designed to facilitate the cognitive and emotional processing of the traumatic incident (Mitchell, 2004). They are considered one of several phases of critical incident stress management (Everly & Mitchell, 2000).

To date, findings regarding the effectiveness of CISDs have been inconsistent. Although typically reported by participants as helpful, research outcomes have been mixed. Worse yet, evidence has been found suggesting they may even be harmful for participants (Addis & Stephens, 2008). CISD research has also been wrought with methodological problems. Randomized control trials are difficult, given the perception of potentially withholding treatment from a group of affected individuals (Carlier, Van Uchelen, Lamberts & Gersons, 1998). Further discrepancies exist over terminology and standardized procedures. (Malcolm, Seaton, Perera, Sheehan & Van Hesselt, 2005). Despite these challenges, several older studies have been conducted involving first responders and law enforcement.

Bohl (1991) examined police officers in Southern California using the State-Trait Anxiety Inventory, the Beck Depression Inventory, and the Novaco Provocation Scale. All officers had experienced a critical incident 3 months prior to the assessment. Also, 40 underwent a brief psychological intervention as per departmental policy. The intervention was based on the Mitchell Model, involving a 90-minute debrief occurring 24 hours after the event. During the debrief, participants were asked to describe the event and how they felt during the incident. The counselor then explained some of the common stress reactions and normalized the responses for the participants. A second group of 31 officers did not receive any intervention, again, due to department policy. Bohl found that the officers who participated in the brief intervention showed a

statistically significant decrease in their rates of stress symptoms (e.g., depression, flashbacks, and anger). Bohl's research was later replicated among a group of firefighters, 30 of whom received a debrief following a critical incident, and 35 who did not. Bohl found that those who did not receive a debrief were more anxious, depressed and angry (Bohl, 1995).

Other studies have used symptoms of PTSD as a means of comparison between individuals who have been debriefed compared to those who have not. Researchers in Amsterdam conducted a qualitative interview study involving 105 police officers; 46 who had experienced a CISD, and 59 who had not (Carlier, Voerman & Gersons, 1998). The participants were chosen from a group of 200 police officers that had responded to a catastrophic plane crash in 1992, in which 43 lives were lost. Of those officers, due to operational requirements, only 45% received the debriefing. Researchers then recruited 105 participants, 59 of whom had not been debriefed, reflecting the original ration of debriefed vs. non-debriefed officers. The examiners conducted structured interviews with the participants at intervals of 8 months, and 18 months after the incident. Interviews were focused on symptoms of PTSD. Researchers found no clinically significant differences between the debriefed and non-debriefed group at either interval.

This finding was replicated in another study among 157 police officers following an unspecified critical incident involving 82 officers who did not receive debriefing, compared to 75 who had (Carlier, Voerman & Gersons, 2000). Again, researchers did not find any difference in PTSD symptomology between the two groups. Despite this finding, 98% of the debriefed group reported being satisfied with the CISD.

CISD did not appear to reduce PTSD symptoms in several studies, and greater concern creates a study in which a CISD appeared to exacerbate symptoms. Addis and Stephens (2008) conducted a quantitative study among 74 New Zealand Police officers who had either been debriefed or not after witnessing the on duty murder of a fellow police officer. Officers were given several measures 5 years after the incident, including the impact of event scale, the general well being scale, and a physical health scale. One of the surprising findings included that those who had been debriefed scored significantly higher on PTSD symptomology. This raises this question of whether or not CISDs do improve mental health outcomes.

The authors did suggest caution before implying that those who were debriefed were more likely to develop PTSD. The authors suggested those who were initially affected may have chosen to seek out a debrief. Nonetheless, even after using a regression analysis, the debriefed group was found to be no better off than the group who did not receive a debrief. Consistent with previous studies, those who attended the debrief did report it as being helpful.

Everly and Mitchell (2000), however, argued that many of the studies discounting CISD were of unsound research methodology, lacked trained people, or were used as a stand alone measure of crisis response, such as a debrief only. Everly and Mitchell (2000) contend that the model must only be used only in conjunction with a full spectrum of other services and for specific populations such as emergency responders. These notions were supported in a CISD literature review conducted by Malcolm et al., (2005) which maintained that CISD does maintain promise as part of a full spectrum of critical incident services. Yet this research is now over ten years old, and participant

satisfaction alone should not be enough in itself to support CISD's continued use. Further standardized research needs to be done to better understand the effects of using CISD intervention in response to a critical incident.

Peer support. Another support mechanism for police officers comes from the peer support model. Peer support programs (PSP) were developed in the 1980's in Los Angeles (Toch, 2002). This model has been identified as being consistent with elements of the police subculture, including the common belief that only law enforcement officers can understand the unique experiences of other officers. Police officers are also concerned with the credibility of providers and their level of experience relevant to policing (Finn & Tomz, 1998). Bloodgood (2005) found that law enforcement officers were distrustful of mental health providers outside of law enforcement, and 84% of her sample of 256 US law enforcement officers indicated that they would be more likely to engage in mental health services if providers had experience in policing.

Peer support programs serve two major functions. First, peer supporters can provide an outlet for officers to discuss work-related or personal concerns if they are distrustful of outsiders (Finn & Tomz, 1998). Second, peer supporters can act as referral agents to connect officers in need with qualified mental health professionals. If rapport is established, the officer may be more likely to seek professional help upon receiving a referral from a sworn peer supporter. Furthermore, peer supporters have the benefit of being readily available, easily accessible and less costly than mental health professionals.

One of the challenges in evaluating peer support programs is that limited research exists on peer based programs. One of the hallmarks of the program is anonymity and

confidentiality. Very few records are kept on peer based interactions and referrals in order to protect the officer. This makes gathering information and data very challenging. A qualitative study among 19 police officers in metropolitan policing in the United Kingdom did, however, identify the importance of talking to co-workers (Evans, Pistrang & Billings, 2013). Officers described taking comfort in knowing that they were not alone, and also being able to use humour with co-workers that others may not understand.

Burns (2014) further conducted a qualitative analysis of the experience of 20 Lower Mainland RCMP officers and their experiences on what helped or hindered access to psychological services. Burns (2014) found that 5 officers from her sample had experience with the RCMP peer support providers known as a member employee assistance program (MEAP). Descriptors such as "trusted, respected, helpful, efficient and confidential" were used by the respondents. One participant described the appreciation for a dedicated MEAP member who attended the residence of a distraught colleague. Limitations of MEAP were described as a lack of advertising and awareness among many members, and occasional poor selection of MEAP participants. These concerns appeared to be more geared at the RCMP for not making members aware of this program, or poor selection of its facilitators. There were no direct criticisms of the model itself. Participants further mentioned their dismay that the MEAP program had recently been phased out in favour of a 24/7 helpline. Participants explained that they would be reluctant to contact someone over the phone and "have no idea who you were talking to" (Burns, 2014). Given the mistrust towards outsiders prevalent in police subculture, and a prevailing fear of stigma and career implications, officers are likely to

be reluctant to reach out to someone they do not know. Officers are likely to be even more fearful of how information is collected and if it is reported back to their employer. Given criticism of the RCMP for a lack of education on the MEAP program, these concerns are likely to be exacerbated with the helpline. To date, no research has been conducted on the efficacy and utilization of the new RCMP helpline.

Outside of policing, peer support programs have been growing in popularity. Persons who experienced mental illness are increasingly being used to support others in navigating the mental health system. The Canadian Mental Health Commission piloted a study called "Making the Case for Peer Support" in 2010 (O'Hagan, Cyr, Mckee & Priest, 2010). As part of this study, 600 individuals from across Canada took part in focus groups and interviews. Key findings included reductions in hospitalizations for mental health problems, reductions in symptom distress, improvements in social support, and improvements in quality of life.

Peer support programs are also being used among military veterans. In an attempt to monitor the effectiveness of such programs, researchers sent out surveys to 38 sites across the United States who conducted "vet to vet" peer support initiatives (Barber, Rosenheck, Armstrong & Resnick, 2008). Surveys included questions on demographics, satisfaction of service, attitudes towards recovery, and engagement in meaningful activities. Researchers received 1,847 surveys in response, but not all were usable due to missing data. Satisfaction with peer support was typically high, and those with higher satisfaction levels tended to have more positive attitudes towards recovery and were more engaged with meaningful activities. An interesting finding was that payment to peer facilitators was associated with more positive recovery attitudes, and

engagement attitudes, but no difference in user satisfaction. The researchers hypothesized that paying peer supporters may attract more skilled facilitators. This is a significant finding given that the majority of peer support positions are voluntary.

Employee assistance programs. Due to concerns about confidentiality or counseling skills, some police officers express a preference to work with mental health providers who have professional training (Finn & Tomz, 1997). That is, officers may be reluctant to discuss topics such as inability to perform the aggressive functions of the job, fears of getting injured or killed, or marital and family problems with other officers. Employee Assistance Programs (EAPs) provide professional short-term counseling for employees and their families for personal problems, based on the premise that these problems can affect performance in the workplace (Goldstein, 1995). According to Goldstein (1995) offering EAP services leads to more productive and dedicated employees. EAP programs are believed to have originated in the 1940's and 50's with alcohol abuse support groups. One of the earliest known law enforcement stress programs originated in Boston in the 1950's as an alcohol treatment group and then expanded in the early 1970's to include other personal problems (Goldstein, 1995). These programs have expanded and now cover a range of personal problems.

Although no research has been done on the effectiveness of EAP programs in law enforcement, Csiernik and Csiernik (2012) recently conducted a survey of 142 EAP programs in Canada. Researchers sent out surveys by regular mail and email to 200 organizations across Canada, including two of the three territories. The organizations were primarily unionized and consisted of an almost equal number of private and public sector organizations. Of the 200 surveys sent out, 142 were completed and returned. The

questions included inquiries about demographics, referral routes, utilization, addressing who was eligible to receive assistance, and for what length of time. The instrument also contained a 15-item list of program options. Csiernik and Csiernik (2012) cited challenges in evaluating the programs, and noted 20 different methods of calculating utilization statistics. The researchers also noted that over 60% of programs lacked any sort of governing body. A further 90% of programs involved contracting to an external professional provider, 33.8 % (48) offered services provided by an internal professional, most commonly a social worker, and 14.2 % used volunteer peer support providers. A final 57% of participants incorporated a cap of 6 sessions for their employees. The researchers suggest that this practice continues despite no evidence that organizations without a cap incur any sort of abuse. Finally, the researchers suggest that the study provides evidence that further examination is required, as well as efforts to standardize and operationalize the field.

Psychoeducation. More recent approaches to combat stress in law enforcement have included a preventive psychoeducational component. Rees and Smith (2008) argue that the absence of training to educate officers about the physiological, emotional, and vicarious effects of their work keeps them in a state of social isolation when attempting to cope with traumatic stress. Rather than waiting till officers are suffering adverse reactions to stress from organizational, operational, and personal life stress, a focus has begun to shift towards prevention. Officers need to be aware of their own reactions, and available resources in order to later access appropriate psychological support. “Road to mental readiness” R2MR was designed by the Canadian Forces, and has recently been adopted by several police agencies in Canada (CACP, 2015). The road to mental

readiness training program was designed to reduce stigma and increase resilience in police officers. R2MR focuses on teaching officers to recognize stress reactions within themselves and identify appropriate coping mechanisms to best return to duty. R2MR teaches officers that there is a normal range of reactions to stress, and identifying where they fall along a spectrum is essential to identifying the appropriate response. As these programs have only recently come into effect, almost no empirical research exists. Despite the lack of research, early feedback from officers who have taken the course has been positive. Given that workplace costs due to mental health problems in Canada are estimated in the billions, an emphasis on preventative support and further research seems warranted (Kim, Jacobs, Ohinmaa, Schopflocher, & Dewa, 2008).

Mandatory Counselling. Mandatory counseling and mental health check-ins have also been proposed as a solution to allowing officers to access psychological support while overcoming stigma (Carlan & Nored, 2008). Mandated counseling allows officers to "save face" rather than appearing weak by asking for help. Traditional research in the area of mandated counseling has come from court ordered rehabilitation. Sex offenders, domestic batterers, and substance abusers often receive court-ordered counseling. Findings in this area have been mixed. A meta-analysis among domestic violence intervention programs did not find conclusive support for reduced recidivism (Babcock, Green & Robie, 2004). Despite a lack of support for these practices, it is important to note that the goals of these interventions are entirely different. In these examples the primary goal is the likelihood of re-offending. This goal differs from the one in policing, in which positive mental health would be the primary goal.

Another field that has generated some research on mandatory counseling comes from the counseling field itself. In some regions such as the United Kingdom, counseling students are required to participate in counseling as part of their training (Chaturvedi, 2013). Research proving the effectiveness of this practice has also been mixed. The self-reported value of this practice was evident, but other measures provided inconsistent findings. Some of the findings around the efficacy of personal growth could be applicable to policing, while student goals based on understanding the counseling experience is less so.

Despite some research in the area of mandatory counseling from other fields, little has been done involving police officers. Carlan and Nored (2008) conducted a quantitative study of self-reported stress among 1,114 officers from 21 municipal police departments in Alabama. Officers were asked to self-report stress and counseling use, which was correlated with departments who supported counseling. Carlan and Nored (2008) found that officers from departments that promoted counseling had lower levels of reported stress. Tanigoshi, Kontos and Remley (2008) also conducted a study involving 51 officers from Southern Louisiana. The officers receiving wellness counseling demonstrated significantly higher wellness scores, whereas the corresponding scores of officers in the control group remained static (Tanigoshi, Kontos & Remley, 2008). Further research is needed to examine the effectiveness of various counseling initiatives including mandated sessions.

Chapter 3: Hypotheses

Purpose of the Study

Police work is a demanding profession and is frequently cited as a high stress occupation (Violanti & Aaron, 1994). Yet previous studies have focused on organizational stressors and safety risks associated with the job, often overlooking the effects of secondary traumatization. A review of the literature has also suggested that law enforcement officers maintain a negative attitude toward mental health treatment and are resistant to seeking help (Burns, 2014). Some evidence has suggested that attitudes toward seeking mental health treatment among the law enforcement community may be improving (Conn, 2013), but few studies have empirically studied this. Additionally, psychological support programs both preventatively such as the R2MR psychoeducational training program, and peer support programs have increased in popularity, although little empirical research has been conducted to study how attitudes among police could interfere with program utilization. Therefore, the primary objectives of this study were to gain additional information about the stressors identified in this population, while also investigating the attitudes of officers towards mental health service providers, psychoeducational training, mandatory counseling, and the degree to which law enforcement officers preferred to seek mental health support from professional mental health providers versus peer supporters for a variety of issues.

Hypotheses:

Question 1: What are the stressors identified in this police population?

Hypothesis 1: It is expected that officers will report organizational stressors (e.g. staff shortages, lack of resources, and dealing with supervisors) as measured on the PSQ-ORG (McCreary & Thompson, 2006) as more stressful than operational stressors (e.g. paperwork, balancing personal time, shift work) as measured on the PSQ-OP (McCreary & Thompson, 2006).

Hypothesis 2: It is expected that officers with moderate experience (5 – 9 years of service) will report the highest levels of stress as measured by the PSQ-ORG (McCreary & Thompson, 2006), the PSQ-OP (McCreary & Thompson, 2006).

Question 2: What attitudes do police officers hold towards seeking mental health services as measured by the Attitudes Towards Seeking Professional Psychological Help Short Form (Fischer & Farina, 1995)?

Hypothesis 3: It is expected that officers will hold a neutral attitude towards accessing psychological services as measured on the ATSPPH-SF (Fischer & Farina, 1995).

Hypothesis 4: It is expected that senior officers (officers with more than 15 years of service) will hold more negative attitudes towards mental health support as measured by the ATSPPH-SF (Fischer & Farina, 1995).

Question 3: In which situations would officers prefer to access peer support versus a mental health professional and vice versa?

Hypothesis 5 : Law enforcement officers will express a preference for a peer supporter on items as measured on the PSPM (Karaffa, 2012) if the situation involves issues that are unique to the profession (e.g. critical incident stress, post-shooting trauma, or organizational stressors).

Hypothesis 6 : Law enforcement officers will express a preference for a professional mental health provider on the PSPM (Karaffa, 2012) if the situation involves general personal or interpersonal issues (such as family problems, physiological complaints, depressive symptoms, or substance abuse issues).

Question 4: Which organizational measures would law enforcement officers support to improve access to psychological services (such as psychoeducational training, or mandatory counselling, etc.)?

Hypothesis 7: Law enforcement officers will indicate that they agree psychoeducational preparedness training is important, and officers will indicate that they agree with its implementation within their organization as measured on question 25 and 26 of the PSPM (Karaffa, 2012).

Hypothesis 8: Law enforcement officers will indicate that they agree that mandatory counseling reduces stigma, and will indicate that they agree with its implementation within their organization as measured on question 27 and 28 of PSPM (Karaffa, 2012).

Chapter 4: Methods

Research Design:

Recent research on police stress and coping has involved both the qualitative and quantitative approach. A quantitative approach was selected as this approach allowed the researcher to reach a wider range of participants, use standardized questions and responses, while providing a high degree of anonymity. Aside from providing greater anonymity, the survey method also allows for ease of coding information. The closed-ended questions with pre-categorized proposed answers greatly reduce the potential of interviewer's misinterpretation of responses.

Measures:

Police Stress Questionnaires. McCreary and Thompson (2006) developed and validated two reliable and valid measures of police stress – Police Stress Questionnaire–Operational (PSQ-Op) and Police Stress Questionnaire-Organizational (PSQ-Org) that measure corresponding stressors from both categories of police occupational stress. Both of these measures include 20 item using a 7 point scale from 1 (no stress at all) to 7 (a lot of stress). These measures have been used in several recent studies, and have been psychometrically validated. Cronbach's alpha reliability was found to be .90 for PSQ-Op and .89 for PSQ-Org on a similar sample of police officers (McCreary & Thompson, 2006).

One main disadvantages of the PSQ-OP is that only one question is devoted to traumatic events. Question #6 simply asks the participant to rate their level of stress to "traumatic events (e.g. MVA, domestics, death, injury)." This means that primary and

secondary traumatization is grouped together. I think this a significant limitation as these two experiences may vary widely for many participants. Some officers may be comfortable with the possibility of being assaulted or injured while apprehending violent suspects, but ill prepared to deal with the emotional toll of witnessing horrific abuse. In my personal experience, I have survived being violently attacked with a weapon, but recall much more vividly the hardship of a father, whose son died in his arms after being shot in front of him.

In order to address this issue, the PSQ-OP was modified to include both an item on personal safety written as "experiencing critical incidents with threat to personal safety or that of another," and an item on vicarious trauma, written as "repeat exposure to human suffering (i.e. child sex assault victims, NOK's after a tragedy, etc.)." The modified version will be known as the PSQ-OP-R. Qualitative questions were also added asking the participants to describe a police call that sticks with them and why.

Based on anecdotal experience the PSQ – ORG was also modified to include two new items. One of the items added included the perceived pressure around career advancement, written as "pressure to get promoted and advance within the organization." A second item was added based on criticisms with British Columbia's independent investigations office who are a civilian oversight committee tasked with investigating police officers if serious injury or death occurs to a person while involved with the police. The modified version will be known as the PSQ-ORG-R. A qualitative question was also added asking if the officer was subject to an investigative review process and to describe their experience.

Attitudes toward seeking professional psychological help. Attitudes towards accessing psychological help were measured using Fischer and Farina's (1995) Attitudes Toward Seeking Professional Psychological Help Short Form (ATSPPH-SF). The ATSPPH-SF is the only psychometrically valid measure in use to examine attitudes towards seeking mental health services (Elhai, Shweinle & Anderson, 2008). The measure was revised from the 29-item Fischer and Turner (1970) Attitudes Toward Seeking Professional Psychological Help (ATSPPH) scale which has been found to accurately distinguish those who have sought mental health treatment from those who have not (Fischer & Turner, 1970). This scale made up items 1-10 on the research survey (Appendix F). Participants were asked to respond according to the degree in which they agreed with each statement on a 4-point Likert-type scale. Some items were reversed scored.

For purposes of this study, scale attributes were modified slightly from the ATSPPH-SF and the direction of presentation was reversed for clarity. That is, the attribute "agree" was modified to "strongly agree", "partly agree" was modified to "agree", "partly disagree" was modified to "disagree", and "disagree" was modified to "strongly disagree." The option "strongly disagree" was presented to the far left and "strongly agree" was presented to the far right. Because of its brevity, the ATSPPH-SF is better suited for this research population. The term "psychologist" was also changed to "professional mental health provider," as to include other mental health professionals such as a registered counsellor or psychiatrist. The ATSPPH-SF correlates highly with the original ATSPPH ($r = .87$), and it has also demonstrated strong psychometric properties (Fischer & Farina 1995; Elhai, Shweinle & Anderson, 2008). For example, the

internal consistency of the ATSPPH-SF using Cronbach‘s alpha was .84 and 1-month test-retest reliability was .80 for the normative sample (Fisher & Farina, 1995).

Service Provider preference. In order to build on the ATSPPH-SF and determine what type of service officers prefer, a short 14 item preference questionnaire was designed for this study and adopted from a measure devised by Karaffa (2012). This survey included statements relating to common work-related, interpersonal, and personal issues that law enforcement officers could experience in the course of their careers, as reflected in the literature. Items referred to marriage and family issues, physical symptoms of stress, substance abuse, depression, organizational stress, task-oriented concerns, post-traumatic and critical incident stress, and suicide.

The goal of this component was to assess officers‘ preference for a peer supporter versus a mental health professional for various issues. Consequently, officers were asked to respond according to the degree in which they would prefer to contact a professional mental health provider or a peer supporter in each hypothetical situation. Items were scored 0 to 3 on a 4-point scale. Higher scores reflected a greater preference for a professional provider (0 = strongly prefer peer, 1 = prefer peer, 2 = prefer professional, 3 = strongly prefer professional). For analysis, these items were divided into two scales. The first scale included 7 items that specified issues impacting one‘s job performance and the second scale included 7 items that specified issues impacting one‘s personal life.

Participants were also asked to rate the degree to which they would support psychoeducational training, and mandated counseling as part of a continuum of psychological support. Additionally, participants were also asked to provide a brief response for five open-ended questions, including suggestions for improving mental

health service utilization within their departments. They were also given an opportunity to explain their preferences for a peer supporter or a professional mental health provider. Responses will be analyzed and grouped into predominant themes to aid in interpretation.

A demographic questionnaire was also included gathering information on age, gender, ethnicity, current relationship status, education, rank, years of service and current assignment.

Procedure

The study involved three medium sized police departments in the Lower Mainland. An email was sent to the three police chiefs of these agencies explaining the goals of the study, potential risks and benefits, the level of confidentiality, and that participation is completely voluntary. The email also contained a link to the electronic version of the research survey, and a request that if the agency consented, to forward to its membership. After completing the research survey a debriefing statement was presented, which included contact information to reach the researcher or supervisor with any questions, or to request a copy of the findings.

Data Analysis

Research was conducted using secure online software Qualtrics, and analyzed with SPSS. Descriptive statistics including means and standard deviations were reported for all measures. Analysis of variance (ANOVA's) was used to determine the significance of differences between groups among reported operational and organizational stressors, as well as within their reported attitudes towards seeking

psychological help. Independent Sample T-Tests were used to compare the study findings with other research. Pearson's product-moment coefficient correlational analysis was used to explore the relationships between organizational and occupational stress. It was further used to examine the relationship between attitudes towards seeking professional psychological help with various demographic factors. Descriptive analysis identified the most frequently mentioned stressors, which was further subcategorized by length of service groups. Frequencies were reported for a variety of questions asking officers about the extent to which they agreed or disagreed with various statements around psychological services. Qualitative data was analyzed and reported by themes.

Ethics

Completing the survey could have resulted in the triggering of unprocessed traumatic events. Among the materials sent to participants was a list of mental health service providers. This list was presented again electronically at the end of the survey. Anonymity is a major contributing factor of the research design. Police culture does not promote openly discussing personal issues such as stress or coping. Officers may fear the loss of reputation or worry about career implications if identifying information was made available to management from the police agencies. Confidentiality was strictly maintained and only the researcher and supervisor had access to the data in a secure location at the university of British Columbia.

Chapter 5: Results

Demographics

One hundred-twenty online responses were received using the Qualtrics software. Twenty responses were incomplete, and did not include any completed measures. These twenty responses were deleted. Of the remaining one hundred responses, five included only the completion of the first two stress measures. The other ninety-five respondents completed all measures. Ages were collected by groupings to avoid any potential of identifying specific participants. The age of the officers ranged from twenty-four years of age to over fifty-five. The largest group consisted of twenty-five respondents in the forty-four to forty-eight age group. Respondents were primarily male at 72%, with 28% of the sample being female. A majority of the officers reported being married or common law at 81%, followed by 19% being single. Policing experience ranged from one year of service to over thirty years of service. The most common range of experience was fifteen to nineteen years of service and comprised 33% of the sample. Forty-five respondents reported working in the general duties patrol section, while the other fifty-five identified as working in a non-patrol position. Seventy-five officers reported a rank of constable, detective or corporal, while twenty-five were ranked sergeant or higher. More specific information on assignments and ranks was not collected to protect confidentiality (see Table 1).

Table 1
Demographics

Variables		N	Percent
Gender	Male	72	72.0
	Female	28	28.0
Age	24 - 28	6	6.0
	29 - 33	16	16.0
	34 - 38	19	19.0
	39 - 43	19	19.0
	44 - 48	25	25.0
	49 and over	15	15.0
Relationship	Single	19	19.0
	Common Law/ Married	81	81.0
Education	High School/ Some post-secondary	46	46.0
	Bachelor's Degree	39	39.0
	Graduate School or higher	15	15.0
Service Ranges	1-4 years	13	13.0
	5-9 years	15	15.0
	10-14 years	33	33.0
	15-19 years	15	15.0
	20 or more years	24	24.0
Assignment	Patrol	45	45.0
	Other	55	55.0
Rank	Constable / Detective or Corporal	75	75.0
	Sergeant or Above	25	25.0

Police Stress

Research Question 1: What are the stressors identified in this police population? Stress was measured using the modified PSQ-OP (Mccreary & Thompson, 2006) and the modified PSQ-ORG (Mccreary & Thompson, 2006). Both of these measures included 22 items using a 7-point scale from 1 (no stress at all) to 7 (a lot of stress). Internal consistency was measured with cronbach alpha and found to be 0.93 for the PSQ-ORG-R and 0.92 for the PSQ-ORG-R.

Hypothesis 1: It is expected that officers will report organizational stressors (e.g. staff shortages, lack of resources, and dealing with supervisors) as measured on the PSQ-ORG (McCreary & Thompson, 2006) as more stressful than operational stressors (e.g. paperwork, balancing personal time, shift work) as measured on the PSQ-OP (McCreary & Thompson, 2006). Minimal overall difference was found between the reported organizational stressors as reported on the PSQ-ORG-R ($M = 3.42$, $SD = 1.11$) compared to operational stressors on the PSQ-OP-R ($M = 3.36$, $SD = 1.10$), and it was not statistically significant (see Table 2).

Males and females also reported similar stressors, with males reporting organizational stressors ($M= 3.45$, $SD= 1.13$) and operational stressors ($M=3.36$, $SD= 1.14$), compared to females who reported organizational stressors ($M=3.34$, $SD=1.10$), and operational stressors ($M=3.36$, $SD= 1.10$). A paired correlation test revealed that the PSQ-ORG-R and the PSQ-OP-R were strongly correlated, $r(98) = .69$, $p < 0.05$.

Table 2
Total Operational and Organizational Stress Means

		Mean	N	Std. Deviation
Pair 1	Operational Stress	3.36	100	1.10
	Organizational Stress	3.42	100	1.11

The top 5 reported organizational stressors are reported as follows, staff shortages (M=4.59, SD=1.87), Feeling like you always have to prove yourself to the organization (M=4.17, SD=1.82), bureaucratic red tape (M=4.15, SD=1.78), Too much computer work (M=3.97, SD=1.69), and external investigations (M=3.96, SD=2.15). See table 3. The top 5 reported operational stressors are reported as follows, fatigue (M=4.36, SD=1.72), paperwork (M=4.33, SD=1.56), occupation related health issues (M=4.02, SD=1.94), repeat exposure to human suffering (M=3.85, SD=1.78), negative comments from the public or media (M=3.81, SD=1.66). See table 4.

Table 3
Top 5 Organizational Stressors

Question	Mean	SD
Staff shortages	4.59	1.87
Feeling like you always have to prove yourself to the organization	4.17	1.82
Bureaucratic red tape	4.15	1.78
Too much computer work	3.97	1.69
External Investigations (Independent Investigations Office - IIO)	3.96	2.15

Table 4
Top 5 Operational Stressors

Question	Mean	SD
Fatigue (e.g. shift work, over-time)	4.36	1.72
Paperwork	4.33	1.56
Occupation related health issues (i.e. back pain)	4.02	1.94
Repeat exposure to human suffering (i.e. child sex assault victims, SIDS death, delivering NOK's after a tragedy)	3.85	1.78
Negative comments from the public or media	3.81	1.66

Hypothesis 2: It is expected that officers with moderate experience (5 – 9 years of service) will report the highest levels of stress as measured by the PSQ-ORG (McCreary & Thompson, 2006), and the PSQ-OP (McCreary & Thompson, 2006). There were no statistically significant differences on reported stress between the various categories of service (see Tables 5,6).

On the PSQ-OP-R, the reported means for the various service categories are as follows, 1 – 4 years (M=3.40, SD=1.08), 5 – 9 years (M = 3.57, SD = 1.00), 10 – 14 years (M=3.25, SD =1.11), 15 – 19 years (M=3.01, SD = 0.94), 20 or more years (M = 3.58, SD = 1.25). See Figure 2.

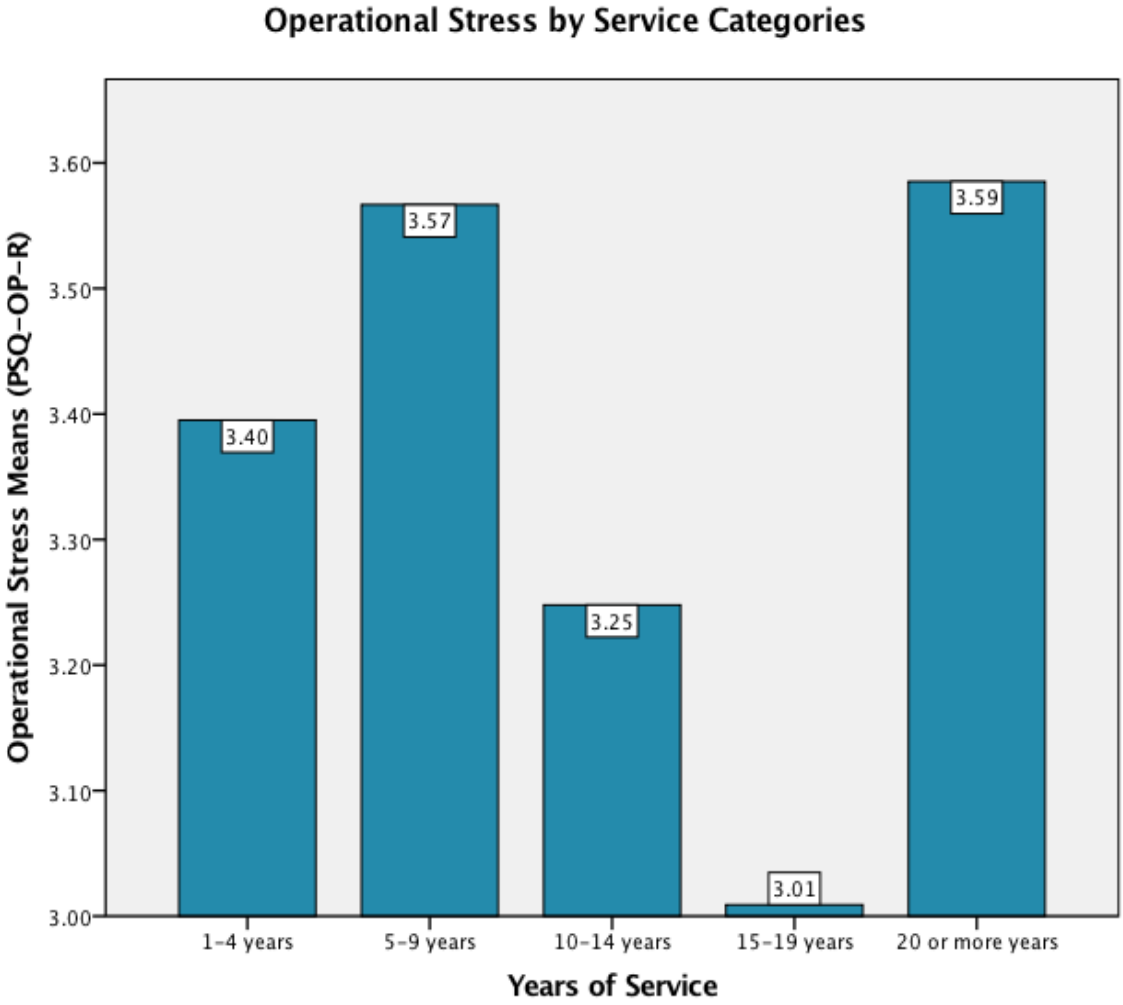

Figure 1. Bar chart illustrating mean scores for Operational Stress as compared by different levels of service using a scale of .10 between 3 and 3.6.

On the PSQ-ORG-R, the reported means for the various service categories are as follows, 1 – 4 years (M=3.42, SD=1.24), 5 – 9 years (M = 3.53, SD = 1.15), 10 – 14 years (M=3.36, SD =0.98), 15 – 19 years (M=3.10, SD = 0.93), 20 or more years (M = 3.64, SD = 1.32). See figure 3.

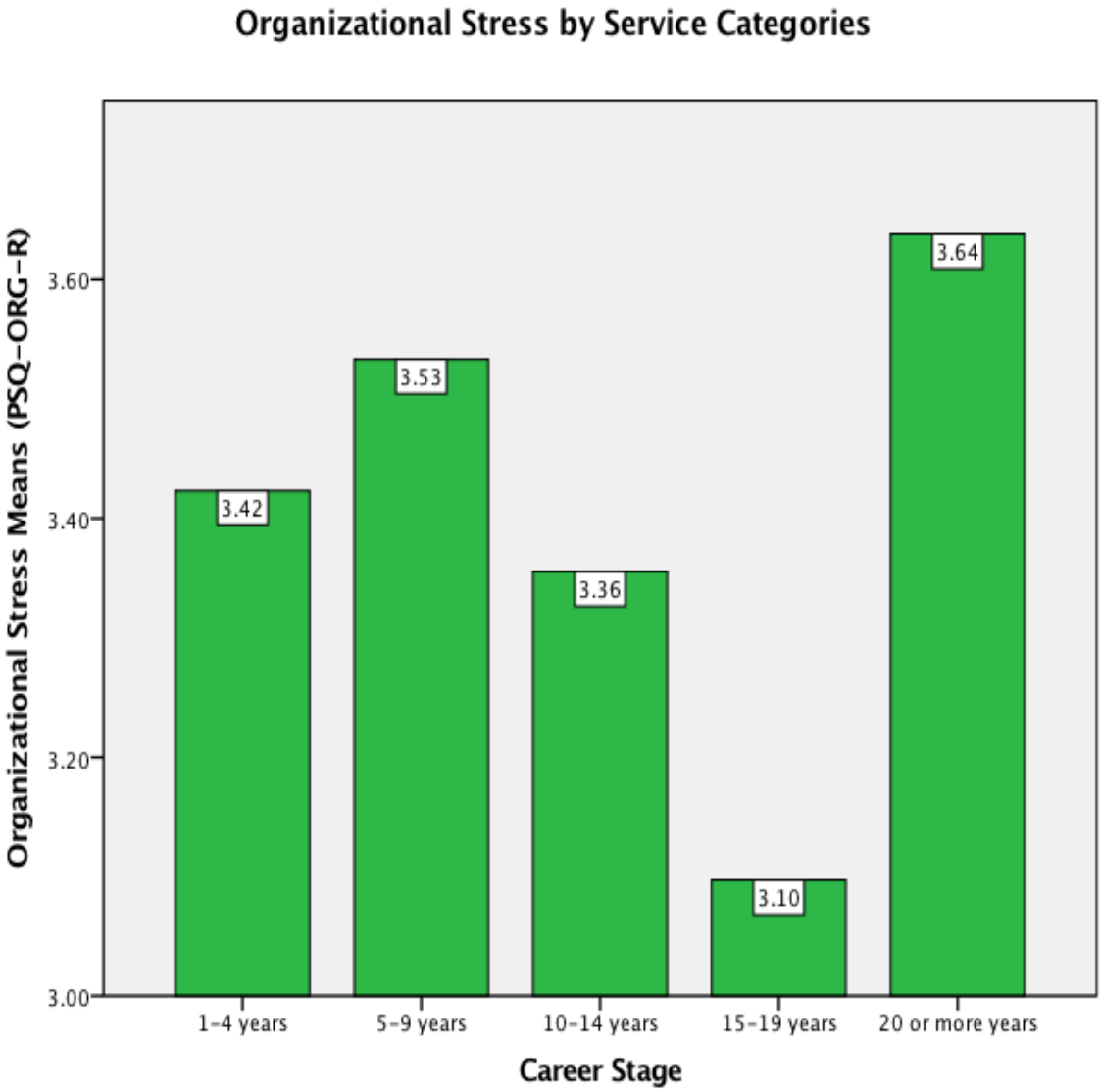

Figure 2. Bar chart illustrating mean scores for Organizational Stress as compared by different levels of servicce using a mean scale of .20 between 3 and 3.6

On the PSQ-OP-R, the top reported operational stressors identified for the various service categories are as follows (see Table 5), paperwork for 1-4 years (M=4.46, SD=1.27), paperwork for 5-9 years (M=4.93, SD=1.62), paperwork for 10 – 14 years (M=4.36, SD=1.41), fatigue for 15 – 19 years (M=3.93, SD=1.83) and fatigue for 20+

years (M=4.88, SD=1.71). As reported on the PSQ-ORG-R, the top organizational stressor was identified as staff shortages among all service categories with means as follows, 1 – 4 years (M=4.85, SD=1.63), 5 – 9 years (M = 4.39, SD = 1.94), 10 – 14 years (M=4.39, SD =1.94), 15 – 19 years (M=4.33, SD = 1.56), 20 or more years (M = 4.67, SD = 2.08).

Table 5
Operational Stress by Service Categories

	1-4 years (M)	5-9 years (M)	10-14 years (M)	15-19 years (M)	20 + years (M)
PSQ-OP - Shift Work	3.46	3.40	3.12	**3.53**	3.08
PSQ-OP -Working alone at night	**3.15**	2.60	2.24	2.20	1.96
PSQ-OP -Over time demands	2.54	**3.60**	2.85	2.93	3.33
PSQ-OP-Risk of being injured on the job	3.23	**3.53**	2.42	2.80	2.63
PSQ-OP-Work related activities on days off (e.g. court, community events, etc.)	3.00	**3.60**	2.97	2.80	3.21
PSQ-OP-Experiencing critical incidents with threat to personal safety or that of another	**4.31**	3.73	3.42	3.20	3.83
PSQ-OP -Repeat exposure to human suffering (i.e. child sex assault victims, SIDS death, delivering NOK's after a tragedy)	3.62	3.73	3.88	3.20	**4.42**
PSQ-OP -Unable to fix the situation (i.e. responding the same domestic, seeing children repeatedly at risk)	3.62	3.60	3.55	3.27	**3.71**

	1-4 years (M)	5-9 years (M)	10-14 years (M)	15-19 years (M)	20 + years (M)
PSQ-OP -Managing your social life outside of work	2.54	**3.40**	3.36	2.27	3.25
PSQ-OP -Not enough time available for friends and family	3.23	**3.93**	3.52	2.60	3.50
PSQ-OP –Paperwork	4.46	**4.93**	4.36	3.80	4.17
PSQ-OP -Eating healthy at work	3.62	**4.47**	3.03	3.53	3.33
PSQ-OP -Finding time to stay in good physical condition	3.69	**4.47**	3.33	3.73	3.83
PSQ-OP -Fatigue (e.g. shift work, over-time)	4.15	4.53	4.18	3.93	**4.88**
PSQ-OP -Occupation related health issues (i.e. back pain)	3.92	3.87	3.76	3.53	**4.83**
PSQ-OP -Lack of understanding from family and friends about your work	**3.08**	2.60	2.97	2.47	2.83
PSQ-OP -Making new friends or maintaining friendships with people outside of work	**3.31**	2.80	2.94	2.20	2.96
PSQ-OP -Upholding a "higher image" in public	3.15	3.20	3.03	3.13	**3.71**
PSQ-OP -Negative comments from the public or media	3.77	3.40	3.64	3.40	**4.58**
PSQ-OP -Limitations to your social life (e.g. who your friends are, where you socialize)	2.77	2.67	2.73	2.33	**3.17**

	1-4 years (M)	5-9 years (M)	10-14 years (M)	15-19 years (M)	20 + years (M)
PSQ-OP -Feeling like you are always on the job	3.23	3.67	3.21	3.13	**4.46**
PSQ-OP -Friends / Family feel the effects of stigma associated with your job	2.85	2.73	2.94	2.20	**3.21**

* Items in bold indicate that it is the highest reported mean among the various service categories.

Table 6
Organizational Stress by Service Category

	1-4 years (M)	5-9 years (M)	10-14 years (M)	15-19 years (M)	20 + years (M)
PSQ-ORG-Experiencing harassment or bullying from co-workers or supervisors	1.92	**2.67**	2.58	2.00	2.58
PSQ-ORG.-The feeling that different rules apply to different people (e.g. favoritism)	3.62	3.27	4.09	3.73	**4.21**
PSQ-ORG.-Feeling like you always have to prove yourself to the organization	4.23	3.87	4.21	4.07	**4.33**
PSQ-ORG.-Pressure to get promoted and advance within the organization	2.69	2.93	**3.24**	3.07	2.67
	1-4	5-9	10-14	15-19	20 +

	years (M)	years (M)	years (M)	years (M)	years (M)
PSQ-ORG.-Excessive administrative duties	3.62	3.67	3.82	3.80	**4.04**
PSQ-ORG.-Constant changes in policy / legislation	3.62	3.60	3.73	3.33	**4.08**
PSQ-ORG.-Staff shortages	4.85	**4.93**	4.39	4.33	4.67
PSQ-ORG.-Bureaucratic red tape	4.00	4.07	3.97	3.93	**4.67**
PSQ-ORG.-Too much computer work	4.46	**4.47**	3.73	3.53	4.00
PSQ-ORG.-Lack of training on new equipment	**3.46**	2.73	2.45	2.67	2.17
PSQ-ORG.-Perceived pressure to volunteer free time	**2.69**	2.47	2.18	1.87	2.50
PSQ-ORG.-Dealing with supervisors	2.46	2.93	3.18	2.60	**3.71**
PSQ-ORG.-Inconsistent leadership style	3.00	4.27	3.85	3.53	**4.46**
PSQ-ORG.-Lack of resources	3.54	4.07	3.61	3.47	**4.54**
PSQ-ORG.-Unequal sharing of work responsibilities	3.38	**4.13**	3.03	3.33	3.63
PSQ-ORG.-If you are sick or injured your co-workers seem to look down on you	2.77	**3.33**	2.48	2.40	2.50
PSQ-ORG.-Leaders over-emphasize the negatives (supervisor evaluations, public complaints, etc.)	2.54	2.73	3.00	3.07	**3.88**

	1-4 years (M)	5-9 years (M)	10-14 years (M)	15-19 years (M)	20 + years (M)
PSQ-ORG.-Internal Investigations (Professional Standards)	3.69	3.67	3.18	2.20	**4.04**
PSQ-ORG.-External Investigations (Independent Investigations Office - IIO)	**4.62**	3.93	3.79	3.47	4.17
* PSQ-ORG.-Dealing with the court system	3.85	**4.33***	3.73	2.47*	3.88
PSQ-ORG.-The need to be accountable for doing your job	**3.54**	3.47	3.39	2.87	3.50
PSQ-ORG.-Inadequate equipment	**2.77**	2.20	2.18	2.40	1.83

* $P < 0.05$. Items in bold indicate that it is the highest reported mean among the various service categories.

Additionally, two qualitative questions were asked to further explore specific areas of both operational and organizational stress. Qualitative data were analyzed and grouped into categories. An independent investigator provided a category check and amendments were discussed until consensus was reached.

Question 1: "When you think back on your service, what call(s) sticks with you? (Can be big or small). Please describe it." 92 responses were received for this question, in which 188 police calls or events were described. Specific calls will not be reported to protect anonymity and confidentiality. Response categories included traumatic calls involving infants/children (N=46), very serious or fatal motor vehicle accidents (N=45), critical incidents involving threat to safety (40), traumatic scenes such as gruesome

deaths (N=24), next of kin notifications (N=19), other events such as cruelty to animals or organizational stressors (N=18), watching a person die in front of them (N=7), and witnessing general trauma (N=6). See Table 7.

Question 1 – Part 2: "Why do you think that call(s) sticks with you over others". 85 responses were received to this question. Response categories included intense sadness (N=20), personally relating (N=19), helplessness (N=12), shock/outside of normal experience (N=10), fear including personal safety or of "doing the right thing" (N=8), guilt (N=4), lacking support (N=3), all other (N=21). See table 8.

Table 7

"When you think back on your service, what call(s) sticks with you? (Can be big or small). Please describe it."

Type of Call / Event	N	%	
Witnessing trauma involving Infant/Child	46	24.47%	Police officers described responding to horrific calls involving abuse, neglect, murders and tragic accidents involving children or infants
Very Serious/Fatal MVI	45	23.94%	Serious or fatal accidents were described, including dealing with witnesses and distraught family members at the scene
Critical Incident involving threat to safety i.e. Police shooting	40	21.28%	Officers described a number of incidents in which they were attacked, and sometimes seriously injured. They also described having to make difficult decisions around the use of force to protect themselves, colleagues or members of the public
Other	18	9.57%	Officers described a number of other calls that caused stress including cruelty to animals, or some that identified organizational stressors rather than specific calls as sticking with them
Watching a person die (suicide or other)	7	3.72%	A number of officers described calls in which they were forced to watch people die in front of them from suicide, homicide, or fatal motor vehicle accidents
Witnessing general trauma	6	3.19%	Some officers stated that it was not any specific calls, but rather an accumulation of traumatic calls and that every officer had a "breaking point" because police officers were not "robots"

Table 8

Why do you think that call(s) sticks with you over others?

Why	N	%	
Intense Sadness	20	23.53%	Many officers identified feeling profound sadness, especially when young lives were taken
Personally relating/connecting	19	22.35%	Officers often cited similarities to victims within their own families, such as young children, or relating a victim to a "grandmother"
Helplessness/Loss of control	12	14.12%	Officers were distressed because they felt powerless to help a victim who died, or watched a person be re-victimized through the criminal justice system
Shocking/Outside of normal human experience	10	11.76%	Many felt that these calls remained with them because they were so far outside the range of normal human experience
Fear	8	9.41%	Fear was sometimes described in terms of safety, but also in feeling unsure of what to do and making the "right" decision
Guilt	4	4.71%	Some officers described feeling guilty that they could not do more to save a victim
Lack of support	3	3.53%	Some officers felt they didn’t receive adequate support after the call from the organization/management, or the call took place prior to the establishment of critical incident / peer support teams
Other	21	24.71%	A variety of explanations were given, including some officers who described that they remembered the "fun calls", or another officer reported feeling "proud" of the work they did in a difficult situation

Question 2: “Have you ever been the subject of an external review processes? (i.e. OPCC - Office of the Police Complaint Commissioner, or the IIO – Independent Investigations Office) If so, please describe your experience and its effect on you.” Forty-six responses were received for this question. Categories of experience with process were categorized as perceived unfair process (N=18), lack of support (N=6), and fear of unknown outcome (N=2). See Table 9. Effects of the experience were categorized as causing significant stress/anxiety (N=21), anger/frustration/demoralization (N=13), or having minimal effect (N=9). See Table 10.

Table 9
“Have you ever been the subject of an external review processes? (i.e. OPCC - Office of the Police Complaint Commissioner, or the IIO – Independent Investigations Office) If so, please describe your experience and it's effect on you.”

Effect Category	N	%	
Anxiety/Significant Stress	21	45.65%	"The experience was one of the most stressful situations I've had to deal with."
			"Even though this was a minor incident, it caused me great stress-worry, anxiousness, lack of sleep."
Frustration/Demoralization	13	28.26%	"Completely took away my excitement and motivation in my career. Destroyed my confidence".
			“They made me feel like they were trying to catch me in a lie, which was extremely frustrating. It made me leery of doing my job for a while.”

Effect Category	N	%	
Minimal effect	9	19.57%	"I received a lot of support from the department and the union, was kept in the loop for the entire process, and was never made to feel as if I had made a significant mistake."

Table 10
Categories of Concerns About Oversight Process

Why Category	N	%	
Perceived unfair	18	39.13%	“What makes this more frustrating is that although we are held to a higher standard, a person can make an outright lie about your (police officer's) involvement with no legal repercussions.”
			“The investigations are far too long and there is never feedback when the investigation determines you are not at fault or have not committed any default.”
Lack of support	6	13.04%	"Was the department interested in its own self interest and was I going to be sacrificed. No clear indication of support and discussion. "
Fear of unknown outcome	2	4.35%	"Very blind and frightening process."

Attitudes Towards Seeking Professional Psychological Help Short Form

Research question 2: What attitudes do police officers hold towards seeking mental health services as measured by the Attitudes Towards Seeking Professional Psychological Help Short Form (Fischer & Farina, 1995)? The 10 items on the ATSPPH-SF were scored 0 to 3, where a higher score indicated a more favorable attitude toward seeking mental health treatment. Therefore, scores on this scale could range from 0 to 30.

Hypothesis 3: It is expected that officers will hold a neutral attitude towards accessing psychological services as measured on the ATSPPH-SF (Fischer & Farina, 1995). An overall mean score of 21.40 (SD = 4.56) was computed for the Fischer and Farina (1995) ATSPPH-SF scale. This score was compared to the normative group of college students established in the Fischer and Farina (1995) study using a one-sample t-test. The mean ATSPPH-SF score of the law enforcement sample (M = 21.4, SD = 4.56) was significantly higher than the control group (M = 17.45, SD = 5.97), t (6.03), $p < 0.0001$, indicating a more positive attitude toward seeking professional psychological help by the police officers.

Hypothesis 4: It is expected that senior officers (officers with more than 15 years of service) will hold more negative attitudes towards mental health support as measured by the ATSPPH-SF (Fischer & Farina, 1995). On the ATSPPH-SF, the reported means for the various service categories are as follows, 1 – 4 years (M=22.18, SD=5.25), 5 – 9 years (M = 22.93, SD = 3.79), 10 – 14 years (M=21.39, SD =3.97), 15 – 19 years

(M=20.47, SD = 0.94), 20 or more years (M = 20.67, SD = 1.25). See Table 11 and Figure 3.

Table 11
Total Attitudes Towards Seeking Professional Psychological Help by Service Ranges

	N	Mean	Std. Deviation
1-4 years	11	22.18	5.25
5-9 years	14	22.93	3.79
10-14 years	31	21.39	3.97
15-19 years	15	20.47	5.49
20 or more years	24	20.67	4.79
Total	95	21.38	4.56

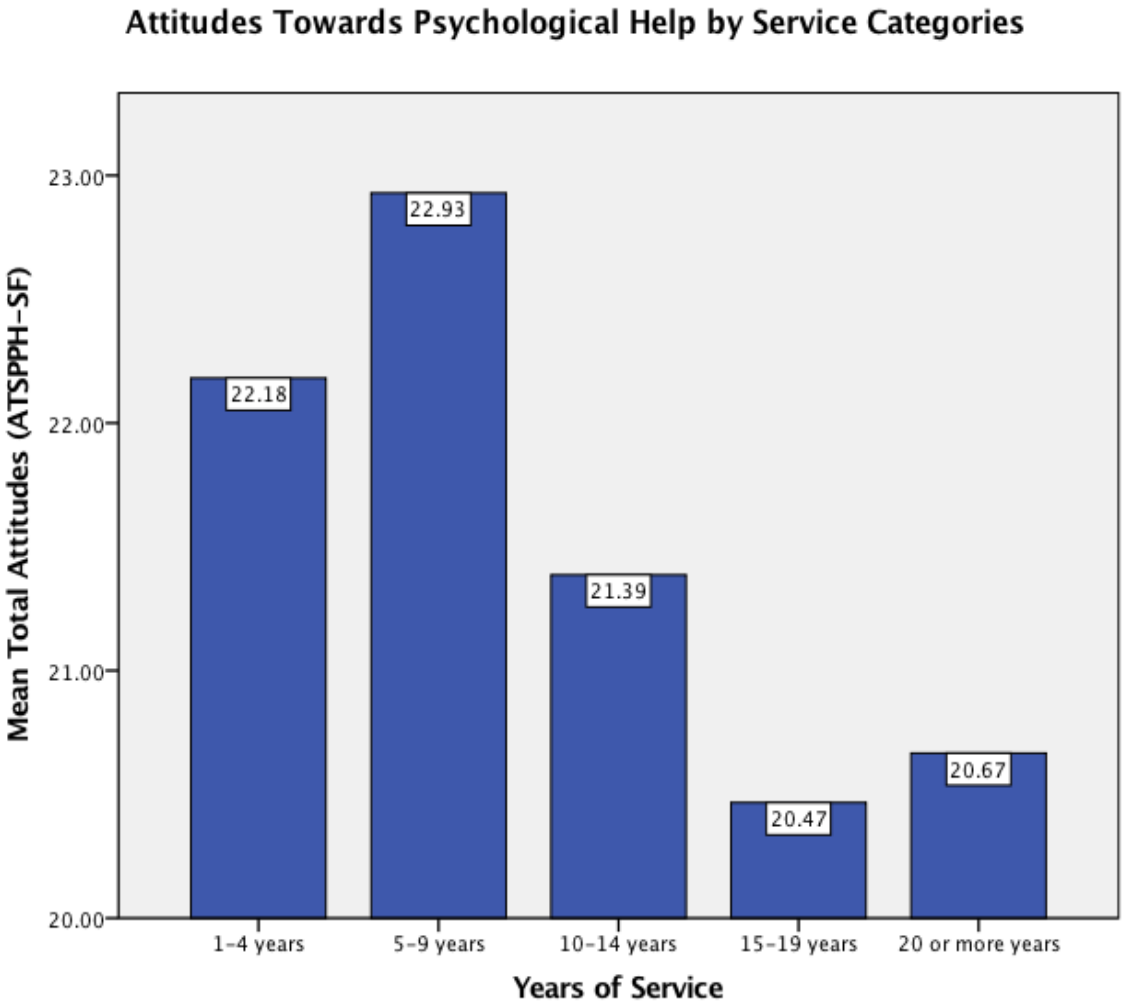

Figure 3. Bar chart illustrating Attitudes towards Seeking Psychological Help as compared by different levels of service.

Independent sample T-Tests were also conducted to compare demographic variables of gender, education, age, rank, assignment and relationship status. Statistically significant results were found for gender, relationship status and age (See table 12). The mean ATSPPH-SF score obtained by females (M=23.00, SD=4.52) was significantly higher than the score obtained by males (M=20.76, SD=4.45), $t(2.18), p < 0.032$. The mean ATSPPH-SF score obtained by single officers (M=23.45, SD=4.49)

was significantly higher than the score obtained by officers who were married or common law (M=20.85, SD=4.43), *t(*2.22), $p < 0.03$. The mean ATSPPH-SF score obtained by officers of different age categories are as follows, 24 to 28 (M=24, SD=5.41), 29 to 33 (M=21.73, SD=3.35), 34 to 38 (M=22.84, SD=4.06), 39 to 43 (M=22.58, SD=4.74), 44 to 48 (M= 19.50, SD=4.84), 49 & over (M= 19.86, SD=4.42). A paired correlation test revealed that age was found to be negatively correlated with attitudes towards seeking psychological help, r(95) = - .24, p(.02) < .05.

Table 12
Total Attitudes Towards Seeking Professional Psychological Help by Age, Gender and Marital Status

Variables		N	Mean	Std. Deviation
Ages	24 - 28	4	24	5.41
	29 - 33	15	21.73	3.35
	34 - 38	19	22.84	4.06
	39 - 43	19	22.58	4.74
	44 - 48	24	19.5	4.84
	49+	14	19.86	4.42
Gender	Male	69	20.77	4.45
	Female	26	23	4.52
Relationship Status	Married/Common Law	78	20.85	4.52
	Single	6	23.56	4.49
	Total	95	21.38	4.56

Research question 3: In which situations would officers prefer to access peer support versus a mental health professional? Service provider preferences between a peer supporter and mental health professional for a variety of work and personal issues were measured using the 14-item preference survey, which was scored 0 to 3 on a 4-point scale. Higher scores reflected a greater preference for a professional mental health provider (0 = strongly prefer peer, 1 = prefer peer, 2 = prefer professional, 3 = strongly prefer professional). Officers were asked to select their first preference and were limited in that they did not have an option of choosing both a peer and a professional.

Hypothesis 5: Law enforcement officers will express a preference for a peer supporter on items as measured on the PSPM (Karaffa, 2012) if the situation involves issues that are unique to the profession (e.g. critical incident stress, post-shooting trauma, or organizational stressors). Of the 7 items related to workplace stress, police officers preferred or strongly preferred Critical Incident Stress Management Peer Supporter on only one item "If I were dealing with stress related to the court system or a particular case in which I was involved" (Prefer CISM/Strongly Prefer CISM (N=60, 63.2%). See table 13.

Table 13
Service Provider Preference for Items Related to Workplace Stress

Workplace Items	Strongly Prefer CISM N / %	Prefer CISM N / %	Prefer Professional N / %	Strongly Prefer Professional N / %
Career Hopelessness	2 (2.1%)	22 (23.2%)	39 (41.1%)	32 (33.7%)
Organizational Issues	5 (5.3%)	36 (37.9%)	38 (40%)	16 (16.8%)
Emotional dysregulation at work	2 (2.1%)	15 (15.8%)	48 (50.5%)	30 (31.6%)
Drinking alcohol affecting work	0	6 (6.3%)	39 (41.1%)	50 (52.6%)
Critical Incident Stress	17 (17.9%)	26 (27.4%)	31 (32.6%)	21 (22.1%)
Frustration with Court System	11 (11.6%)	49 (51.6%)	24 (25.3%)	11 (11.6%)
Experiencing PTSD symptoms	2 (2.1%)	8 (8.4%)	41 (43.2%)	44 (46.3%)

Hypothesis 6: Law enforcement officers will express a preference for a professional mental health provider on the PSPM (Karaffa, 2012) if the situation involves general personal or interpersonal issues (such as family problems, physiological complaints, depressive symptoms, or substance abuse issues). Law enforcement officers preferred a professional mental health provider for all 7 items presented affecting personal lives. See table 14.

Table 14
Service Provider Preference for Items Affecting Personal Life

Personal Items	Strongly Prefer CISM N / %	Prefer CISM N / %	Prefer Professional N / %	Strongly Prefer Professional N / %
Relationship Issue / break-up	2 (2.1%)	5 (5.3%)	50 (52.6%)	38 (40%)
Difficulty sleeping	1 (1.1%)	4 (4.2%)	63 (66.3%)	27 (28.4%)
Drinking alcohol affecting personal life	0	9 (9.5%)	44 (46.3%)	42 (44.2%)
Work interfering with family	3 (3.2%)	26 (27.4%)	48 (50.5%)	18 (18.9%)
Thoughts of suicide / self-harm	0	6 (6.3%)	39 (41.1%)	50 (52.6%)
Depression	1 (1.1%)	5 (5.3%)	61 (64.2%)	28 (29.5%)
Emotional dysregulation towards family	0	1 (1.1%)	56 (58.9%)	38 (40%)

Additionally, two questions asked officers to select all that apply in relation to service provider preferences for mental health issues. A third question was asked in relation to choosing a mental health professional.

Question 29: Officers were asked for what reason they would prefer a peer support officer based on a selection of 5 items. The top reason provided was “a good

place to start" (N=54, 57%). Of the 21 responses to other, 13 (62%) out of 21 identified that they would not seek out a CISM member. One explanation provided was that "CISM members are inadequately trained in mental health issues." See table 16

Table 15
Reasons to See a Critical Incident Stress Peer Supporter

Reason	N	%
Good place to start	54	56.84%
Trust a fellow officer	47	49.47%
They understand the issues	47	49.47%
Other	21	22.11%
Worried about stigma of seeing a professional	3	3.16%

Question 30: Officers were asked to select from 4 options, for what reasons they would contact a professional mental health provider? The reason selected by the highest number of officers was "more qualified to deal with the issue" (N=79, 83.16%). The two other responses specified, "all of the above", and as a "last resort". See table 16.

Table 16
Reasons to See a Mental Health Professional

Reason	N	%
More qualified to deal with issue	79	83.16%
Confidentiality	74	78%
Independent opinion separate from the work environment	64	67.37%
Other	2	2.11%

Question 80: "If you were to seek out a mental health professional, which of the following would you prefer." The top selection was for a mental health professional familiar with law enforcement issues but not directly tied to the organization (N= 64, 67.3%). See table 17.

Table 17
Preference for a Mental Health Professional

Option	N	%
Familiar with law enforcement issues but no ties to your organization	64	67.37%
Expertise in policing issues and works closely with your organization	22	23.16%
No law enforcement focus but is an expert in stress/trauma and coping	9	9.47%

Critical Incidents:

Officers were asked to report which item was most important after a critical incident based on a selection of 5 items. "In your opinion, in terms of a department related initiative, what do you find most helpful after a critical incident?" The top reported item was "CISM team support" (N=60, 63.16%). See table 18.

Table 18
Most Important Department Initiative After a Critical Incident

Reason	N	%
CISM team support	60	63.16%
Support from management	49	51.58%
Critical Incident Group Debrief with a Psychologist	47	49.47%
Individual referral to a psychologist	40	42.11%
Other	9	9.47%

Training and mandatory counselling

Research question 4: Which organizational measures would law enforcement officers support to improve access to psychological services (such as psychoeducational training, or mandatory counselling, etc.)?

Hypothesis 7: Law enforcement officers will indicate that they agree psychoeducational preparedness training is important, and officers will indicate that they agree with its implementation within their organization as measured on question 25 and 26 of the PSPM (Karaffa, 2012). 87 (91.58%) of officers either agree or strongly agree that psychological preparedness training is helpful, and 87 (91.58%) also supported psychological preparedness training within their organization. See Table 19.

Table 19
Perception of Psychological Preparedness Training

Item	Strongly Disagree N	Disagree N	Agree N	Strongly Agree N	Total
I believe psychological preparedness training is helpful.	1 (1.05%)	7 (7.37%)	57 (60 %)	30 (31.58%)	95
I would support psychological preparedness training within my policing organization.	1 (1.05%)	7 (7.37%)	56 (58.95%)	31 (32.63%)	95

Hypothesis 8: Law enforcement officers will indicate that they agree that mandatory counseling reduces stigma, and will indicate that they agree with its implementation within their organization as measured on question 27 and 28 of PSPM (Karaffa, 2012). Seventy-two (75.79%) officers reported that they agreed or strongly agreed that a mandatory counseling session every two years would remove the stigma of accessing psychological support. 83 (87.37%) officers agreed or strongly agreed that they would support a mandatory counseling session every two years within their organization. See Table 20.

Table 20
Perception of Mandatory Counselling

	Strongly Disagree N	Disagree N	Agree N	Strongly Agree N	Total
A mandatory counselling session every 2 years would remove the stigma of accessing psychological support.	6 (6.32%)	17 (17.89%)	43 (45.26%)	29 (30.53%)	95
I would support a mandatory counselling session every 2 years within my policing organization.	7 (7.37%)	5 (5.26%)	44 (46.32%)	39 (41.05%)	95

Improving Mental Health Service Utilization:

Officers were further asked to select all that apply from several options that may improve mental health service utilization. "In your opinion, what conditions might improve mental health service utilization within your department?" Officers most frequently selected mandatory counseling (N=62, 65.26%). Of the 8 officers who provided responses to other, responses varied from, "the department does a good job," to the "department needs a whole new approach to mental health." Suggestions further included, "a committed management team that looks at mental health rather than just operational requirements." Another officer stated, "being able to see a counselor of our choice, not just a psychologist." See table 21.

Table 21
Improving Mental Health Service Utilization

Option	N	%
Mandatory Counselling	62	65.26%
Greater awareness of Resources	47	49.47%
Better access to a Mental Health professional	43	45.26%
Less stigma within the organization	41	43.16%
More training	24	25.26%
Other	8	8.42%

Officers were then asked if "there was anything else you would like to say on the subject of police stress and accessing support." Seventeen officers responded to this question. Responses were categorized as follows: improved access to a mental health professional (N=5), removing stigma (N=4), lack of trust in CISM (N=2), other (N=6). See table 22.

Table 22
Other Suggestions on Police Stress and Psychological Support

Suggestions	N	%	
Access to Mental Health professional	5	29.41%	"It is imperative that those reaching out for help have access to GOOD mental health professionals." "Realizing today that I need some professional help and knowing that it will not be arranged for several weeks is frustrating."
Stigma	4	23.53%	"If mandatory check-ins were required, we may find that seeking professional help becomes the norm and open conversations about our mental health will become routine." "It's all well and good to say we are removing the stigma but many senior managers still do not support this."
Trust in CISM team members	2	11.76%	"I worry on how trustworthy CISM will be with information told to them."
Other	6	35.29%	"If you don't think this job affects you, you need to be more self aware." "It is more than frustrating when you have something occur at work that triggers some sort of stress reaction that you put a claim in for it and you know before you even submit it that worksafe will deny it. They have no clue and for the most part, feels like they are there to just say no in the first instance."

Chapter 6: Discussion

The purpose of this study was to gain information about operational and organizational stressors identified in the police population that involved three medium sized departments in the Lower Mainland of British Columbia. Simultaneously, the goal also included investigating the attitudes of officers towards mental health service providers, psychoeducational training, mandatory counseling, and the degree to which law enforcement officers preferred to seek mental health support from peer supporters or professional mental health providers for a variety of issues. Officers reported similar levels of stress to those found in other British Columbia law enforcement studies, while qualitative stress data illuminated some of the horrific trauma police officers are exposed to on a regular basis. Other qualitative data showed that many officers experienced significant amounts of stress while being subjected to conduct reviews being performed by the Office of the Police Complaints Commission or the Independent Investigations Office. Contrary to much of the police research literature, officers held more positive attitudes towards seeking psychological help than the normative sample of college students, teachers, and a sample of American police officers (Fischer & Farina, 1995; Linseman, 2016; Karaffa, 2012). Officers in this study also supported mandatory counselling within their organizations and ongoing psychoeducational training.

Police Stress

Stress was measured using the modified PSQ-OP (Mccreary & Thompson, 2006) and the modified PSQ-ORG (Mccreary & Thompson, 2006). Both of these measures included 22 items using a 7-point scale from 1 (no stress at all) to 7 (a lot of stress). Findings on these measures suggest this police population reported low-moderate levels

of overall stress as presented on the PSQ-ORG-R (M=3.42, SD=1.11) and the PSQ-OP-R (M=3.36, SD=1.10). Males and females in this study reported similar levels of stress, with no significant difference. Findings were consistent with a recent local study involving 92 police officers from a large city in British Columbia. That study reported similar organizational (M=3.65, SD = 0.18) and operational stressors (M=3.31, SD= 1.23) using the PSQ-ORG and the PSQ-OP (Della-Rossa, 2014).

Hypothesis 1: It was hypothesized that organizational stressors would be reported as more taxing than operational stressors. Violanti and Aaron (1994) suggested that organizational stressors contribute to 6.3 times that of operational stressors. In this sample, there were minimal differences. Organizational stress in this sample was also found to be significantly lower than the normative sample of 47 Ontario Police officers (M=3.80, SD=3.92), $t(2.04)$, $p(.0.04) < 0.05$ (McCreary & Thompson, 2006).

Minimal differences were found between operational stress in this study (M=3.36, SD=1.10) as compared to the normative sample of 47 OPP officers (M=3.47, SD=0.92). It is important to note that the dichotomy between organizational and operational stress is not always clear, as other authors have already suggested (Brown, Fielding & Grover, 1999). For example, paperwork (M=4.33, SD=1.56) was identified as the second most stressful operational stressor. Paperwork could also be seen as an organizational constraint much in the same way as computer work is classified as an organizational stressor. Perhaps it would make more sense to delineate stressors more in terms of the daily hassles and frustrations associated with internal and external policies and administration, and categorize the human elements, such as dealing with trauma, as a separate category.

Nonetheless, organizational stressors were a significant source of police stress in this sample. Staff shortages were identified as the top organizational stressor (M=4.59 SD=1.87) and the top overall police stressor among both males and females, and all service categories. This result mirrors similar studies of British Columbia police officers, Ontario police officers, as well as Canadian border service guards (Della-Rossi, 2014; McCreary & Thompson, 2006; Prasad, 2012). This is also consistent with other international policing studies including a sample of 699 Scottish police officers (Biggam, Power, Macdonald, Carcary, & Moodie, 1997). Staff shortages can contribute to higher caseloads, longer duty hours and canceled holiday leaves in order to fulfill operational requirements. These can have spillover effects outside the workplace, as officers need to scramble to make adjustments in their personal lives..

Other organizational stressors such as feeling like you always have to prove yourself to the organization (M=4.17, SD=1.82) and bureaucratic red tape (M=4.15, SD= 1.77) ranked in the top three. An interesting finding among organizational stressors included "experiencing harassment or bullying from co-workers or supervisors at work" M=2.42, SD=1.8). This item had been modified from the original measure which read "dealing with co-workers." This item was changed to reflect potential sexual harassment and bullying, widely reported by the media as occurring within the ranks of the RCMP. In this sample, both females (M=2.39, SD=1.75) and males (M=2.43, SD=1.88) reported lower levels of stress on this item, ranking it #20 out of 22 items on the PSQ-ORG-R.

Hypothesis 2**:** It was hypothesized that officers with 5 to 9 years of experience would report both the highest levels of organizational and operational stress. This was based on the assumption that the initial excitement of being a police officer would have

worn off, the officer would have been exposed to a number of traumatic events without contextual coping skills, and number of personal sacrifices would have been made outside of work. Boyd (1994) studied a group of 507 police officers in Texas and reported that stress is perceived at its highest levels when an officer is in the sixth or seventh year of service, and again at 18 or 19 years of service. Carlan and Nored (2008) reported that officers with 21 or more years of service reported the highest levels of stress. The present findings did not support any statistically significant differences among the various service categories for reported stress levels. One possible explanation for this was that the sample size was not large enough, as officers with over 20 years of service did report the highest combined PSQ-OP and PSQ-ORG (M=3.61, SD=1.12), followed by those with 5 to 9 years of service (M=3.55, SD=1.00).

As far as specific stressors, the top operational stressor identified among the various service categories changed from paper work (0-4 years, 5-9 years, 10-14 years) to fatigue in older officers (15-19 years, 20+ years). These are not surprising findings as paperwork is widely reported as a significant stressor in policing (Burns, 2014; Della-Rossa, 2014; Violanti & Aaron, 1994). Paperwork stress could be explained by the significant liability and the implications of completing thorough and accurate reports. Police in North America have been under a media microscope, and note taking and reports are under increased scrutiny. As a result, police reporting standards are onerous and can take up many hours on the shift to complete. Within her study of 14 British Columbia police officers, Burns (2014) identified an officer who felt that the only thing that mattered to his supervisor after surviving a critical incident was “completing the

paperwork." The officer felt that his own mental health and wellbeing took "second place."

Another reason paperwork could be a significant stressor is that while officers are completing this task they may feel or may be perceived by peers as not doing "real work." A majority of police officers joined the police ranks to serve the public and apprehend criminal offenders (Foley, Guarneri & Kelly, 2007). Sitting in the car or in the office typing up reports does not fit that image. This can be especially true for young officers who are trying to fit in within the police subculture, which expects them to "pay their dues." Balancing this expectation with that to be out on the road responding to crisis calls or actively investigating crime scenes can cause stress for officers acutely aware of the legal implications and importance of thoroughly completing all the required paper work.

Later in their careers, officers with 15 to19 years of service, and 20 or more years, reported fatigue as the top operational stressor. This finding is consistent with other research. A study of 175 police officers in a large city in New York reported that officers in the 16 to 25 years of service group experienced the highest levels of general burnout and emotional exhaustion (Canizzo & Liu, 1995). Internationally, a study of 466 Norwegian police officers also revealed that older officers in later stages of their career reported higher levels of exhaustion, cynicism and lower levels of efficacy (Burke & Mikkelson, 2006). More experienced front line officers have suffered long term exposure to chronic systemic frustrations as well as cumulative trauma experiences. Senior officers are also more likely to have personal life stressors such as family, relationships and divorces, and may struggle with being passed over for promotion. On

the other hand, senior officers who have been promoted to a higher rank, including senior management positions, are exposed to a number of other stressors. These include additional political pressures from police boards and community stakeholders, and bearing the responsibility for decision-making in major incidents.

Limited research exists on the effect of stress and senior police managers in North America. A study of 267 police managers and 232 private industry managers in Central Europe revealed that police managers reported higher levels of stress including workloads, relationships, daily hassles and their organizational climate (Pagon, Spector, Cooper, & Lobnikar, 2011). The authors posited that the more rigid para-military structure could play a role in reducing some of the autonomy and control available to police managers. This could be further corroborated by a study of Canadian Forces military officers who reported higher levels of job strain, depression and negative perceived mental health compared to a sample of civilian managers (Park, 2008).
In order to test whether rank, position, or other individual demographic variables were related to police stress, a number of independent sample T tests were conducted within this study. No statistically significant results were found between rank (constable vs. supervisory rank), position (patrol vs. other), marital status (single vs. married/common law), education and operational or organizational stress. The relationship between career stage and police stress continues to require further research.

Stress was further investigated through qualitative questions asking officers about which police call sticks with them. Quantitatively officers reported “responding to repeat experiences of trauma as the fourth highest operational stressor” (M=3.85, SD=1.78). Qualitative findings indicated that officers responded to a number of distressing calls,

especially those involving battered or deceased children, fatal motor vehicle accidents with distraught family or others at the scene, dangerous calls involving violent or armed subjects, responding to gruesome scenes, and next of kin notifications. Calls in which officers watched people die in front of them were particularly difficult. While these types of calls have been previously widely reported in literature, one surprising finding was the impact of the next of kin notifications. Although this item was not mentioned as the highest frequency, many officers used words like the "hardest," and "most difficult" when describing next of kin notifications with traumatized families.

Officers described a number of reasons that police calls remained with them, including personally relating or empathizing with the victim or family. An officer described looking at the deceased victim and thinking, "I remember looking at him and seeing that he was someone's husband, someone's son, a brother etc." Other officers were reminded of their own families and described questions that arose during next of kin notifications such as, "it reminds you that everyone has people that love and care for them and it makes you think about your own mortality and how your family would be affected if you died." Some officers further described being reminded on anniversaries of that call, and wondering, "how that family is coping."

It is not surprising that officers who felt personally connected to the victim or families would have a greater attachment to these calls. It does merit further discussion based on the need to recognize the effects of vicarious trauma or compassion fatigue. These are described "the natural, consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other, and the stress resulting from helping or wanting to help a suffering person (Figley, 1995). Recent

changes and training in crisis de-escalation and communication have focused on changing officer approaches to individuals in crisis. There is a renewed focus on humanizing the officer and connecting with individuals through a variety of techniques focusing on empathy and compassion (Krameddine & Silverstone, 2014). While this is an important and valuable skill set in improving outcomes with persons in distress, this may lead to greater experiences of compassion fatigue on the part of police officers. One officer wrote, "I have vivid memories because of the trauma I saw other people suffer." Figley (1995) describes individuals in a helping position absorbing traumatic stories from others, resulting in post-traumatic symptoms not unlike that of actually experiencing the trauma personally.

Some of the emotions described by officers on calls that remained with them included feelings of sadness, helplessness, fear or guilt. One officer described a traffic accident in which they administered CPR on a driver, "I felt helpless that I couldn't keep him alive." Another officer described spending many hours with a family of a deceased child and feeling powerless to "make the situation better." Other officers described being injured on duty and associated emotions such as, "at the moment of impact, I feared my death." Others feared being in further traumatic calls, "and not coping with the call". Some described being unable to erase "the memories" or the "sights and sounds". This is consistent with other police trauma literature, including a study involving 162 Swedish police officers who reported having vivid visual, tactile, and olfactory memories of traumatic events more than 20 years later (Karlsson & Christianson, 2003).

The incidents described raise concerns around the potential development of post-traumatic stress disorder. Officers clearly meet the exposure criteria of PTSD as defined in the diagnostics and statistical manual of mental disorders (DSM 5), "exposure to actual or threatened death, serious injury, or sexual violence" (American Psychiatric Association, 2013). Police officers are specifically mentioned in the exposure definition including personally experienced, witnessed or being exposed to aversive particulars such as details of child abuse. Some research suggests that police officers are exposed to greater likelihood of tramatic events than other first responders such as firefighters (Carlier, Voerman & Gersons, 1999).

PTSD rates among police officers are not widely known, and estimates have varied greatly. In a study of 53 American police officers, Martin, Mckean and Veltrkarm (1986) reported that 26% of their sample reported symptoms meeting criteria for PTSD following exposure to psychologically traumatic on-the-job events. A more recent larger study involving 1,071 police officers from two large cities in British Columbia and Alberta reported finding that 29% of the sample met the criteria for PTSD (Kitt, 2016). The lifetime prevalence among the general population is estimated at 8.7% as cited in the DSM 5 (American Psychiatric Association, 2013).

Senior officers in this sample, referring to a period of many years, felt it was not a single incident but rather a cumulative effect of responding to countless tragedies over that time. An officer explained that "everyone has a breaking point", and you "cannot attend situations like a robot and not think that people crying and begging for help is not going to affect you or someone you work with". Papazoglou (2013) conceptualized officers' trauma in terms of police complex spiral trauma (PCST). It was suggested that

as officers move through their career, they will experience traumatic events which will vary, based on the frequency, duration and intervention received. Each new traumatic event they will encounter can expand the density and width of the spiral, mimicking a spring being stretched further and further. This phenomenon of police complex spiral trauma would be better researched through qualitative exploration as this approach is more likely to reveal the true impact of the officers multi-dimensional traumatic experience. This may explain why officers did not rate "repeat exposure to traumatic events" as highly as could be expected. Quantitatively it may also be easier to think about other stressors, such as organizational practices, with less emotional impact. In fact, when asked about what call sticks with them, one officer even stated, "I don't want to think about it".

A second qualitative question involved asking officers about their experience with independent conduct review processes involving the Office of the Police Complaints Commission (OPCC) and the Independent Investigations Office (IIO). On the PSQ-ORG-R external investigations (IIO, OPCC) ranked as the fifth highest organizational stressor (M=3.96, SD=2.15). No known research exists on the experience of British Columbia police officers with the IIO, which was formed in 2012. The IIO is responsible for investigating officer-related incidents of death or serious harm and determining whether or not an officer may have a committed a criminal offence. The OPCC is a civilian organization responsible for overseeing the investigation involving complaints against police officers in British Columbia. A limitation of this question is that officers were not asked to specify which process they were involved in while

describing their experience. As such, the responses are grouped in general terms as part of the experience of external conduct reviews, and are exploratory in nature.

Many officers reported feeling that the external oversight process was overly long and biased against them, “what makes this more frustrating is that although we are held to a higher standard, a person can make an outright lie about your (police officer's) involvement with no legal repercussions.” Another officer stated, the investigations are far too long and there is never feedback when the investigation determines you are not at fault.”

Some officers reported feeling minimal stress, while many reported feeling significantly distressed throughout the process (N=21, 41.65%). One officer described that this “experience was one of the most stressful situations I've had to deal with." Another officer described the effect as causing “great stress- worry, anxiousness, lack of sleep”. Some officers described the lasting impact that these processes can have, “completely took away my excitement and motivation in my career. Destroyed my confidence.” On the other hand, one officer described the positive effect support from the organization had on him, “I received a lot of support from the department and the union, was kept in the loop for the entire process, and was never made to feel as if I had made a significant mistake."

These findings are difficult to place in the context of limited research or compared to other professions. In some regards, policing is a unique profession as it pertains to civilian oversight. For example, an officer can follow all training, policy and regulations, and be charged with a criminal offence. An example reported in this study involved an officer responding as member of the Emergency Response Tactical Team to

a call of an armed hostage-taker. The hostage-taker was shot after all efforts were exhausted in negotiating with the male, less lethal options had failed, and the subject pointed his firearm in the direction of the officer. This is a somewhat unique stressor of having the possibility of being charged with an offence as serious as murder while in the execution of regular duties. Although these processes are a necessary requirement of police oversight to maintain public confidence, recognition of the impact of the stress caused is equally important, and efforts need to be made to mitigate those effects. Further research is warranted.

Attitudes Towards Seeking Professional Psychological Help

As the first known Canadian study looking at attitudes towards seeking professional psychological help among police officers, findings were significant and surprising.

Hypothesis 3: It was hypothesized that police officers would hold more negative attitudes towards seeking psychological help than the civilian normative sample. Contrary to similar samples from the American studies of law enforcement, this hypothesis was not supported. In fact, this group held significantly more positive attitudes than the civilian normative sample of college students, two trial groups of American law enforcement, as well as a sample of Canadian teachers (Fischer & Farina, 1995; Karaffa, 2012; Sanders-Guererro, 2013; Linseman, 2016). See Table 23.

The findings from this sample were more in line with a group of graduate scholars who included counseling students (McCarthy, Bruno & Sherman, 2010). Women also held significantly more positive attitudes than men, which is consistent with student populations, other professions such as teaching, as well as policing research

(Berg, Hem, Lau & Ekberg, 2006; Fischer & Farina, 1995; Linseman, 2016; Karaffa, 2012).

Overall attitudes also confirm a recent qualitative study involving 10 British Columbia police officers, in which 8 out of 10 reported being open to counseling and further mental health resources (Conn & Butterfield, 2013). This is an important finding, as it suggests that this sample of police officers does see the value of psychological help and is potentially open to counseling. Attitudes are also an indicator of future behaviour, and a study involving medical patients and college students linked attitudes with recent service utilization of mental health services (Elhai, Schweinle & Anderson, 2008). These findings were also further reinforced with positive officer attitudes towards mandatory counselling and psychoeducation. While this is an important initial finding, further research on actual service utilization needs to be done.

Table 23
T-Test Comparisons of mean ATSPPH-SF scores among various reported studies

	Sample (N)	M	SD
Present Study - British Columbia police officers	95	21.38	4.56
Elhai (2009) - primary care patients	187	20.45	5.51
* Fischer & Farina (1995) - normative sample of undergraduate students in the United States	389	17.45	5.97
* Karaffa (2012) - Texas Police officers	158	15.61	3.77
* Linseman (2016) - Ontario Teachers	470	16.45	4.53
Mcarthy, Bruno & Sherman (2010) Graduate students	217	21.52	5.28
* Sanders - Guerrero (2013) - Texas Police Officers	333	16.64	5.86

* $p < 0.01$, 2-tailed.

Preference for Mental Health Provider:

Officers were given a number of questions and asked if they would prefer a critical incident / peer supporter or a mental health professional for a variety of

workplace and personal issues. Officers were not given the option of choosing both or neither.

Hypothesis 4: It was hypothesized that officers would prefer to speak to a critical incident peer support representative rather than a professional for a number of workplace issues. This hypothesis was based on findings from Karaffa (2012), in which a sample of law enforcement officers preferred to speak to CISM / peer supporters more often than a mental health professional regarding issues affecting the workplace. This hypothesis was unsupported in this sample. On all workplace items except for frustration with the court system, officers indicated that they preferred or strongly preferred a mental health professional. On the other hand, officers were not given the option of potentially speaking to both regarding the issue. A number of officers still indicated that they would prefer or strongly prefer to speak to CISM/peer support for items including career hopelessness (N=24, 25.3%), organizational issues (N=41, 43.2%), and critical incident stress (N=43, 45.3%). Some officers indicated that they would not approach CISM for mental health issues, as they felt CISM members were "not adequately trained in this area." This finding does not discount the value of CISM / peer support, but rather reinforces the perception that officers do understand the value in seeing a qualified mental health professional for serious issues.

Hypothesis 5: It was hypothesized that officers would prefer to speak to a mental health professional for personal and family issues such as relationships, depression, alcohol affecting home life etc. This hypothesis was supported, and officers overwhelmingly favoured a professional on all items except for the one referring to work interfering with family. For this latter one, some officers still indicated that they would

prefer a CISM / peer supporter (N=29, 30.%). This is an important finding, as it further suggests that officers understand the need to see a mental health professional for serious problems including relationship issues, drinking too much alcohol, depression and thoughts of self-harm or suicide. Officers also selected most frequently that they would see a mental health professional because they are more qualified to deal with their issue (N=79, 83.16%). This finding also re-affirms the role of CISM/ peer supporters as a gateway point, with mental health professionals providing counseling for serious issues.

When it comes to choosing a metal health professional, a majority of officers preferred one who was familiar with law enforcement but did not have any specific ties to the organization. A preference for providers familiar with law enforcement is a common finding among police stress studies and among other populations with strong cultures around strength and composure such as within the military (Bloodgood, 2005; Burns, 2014; Carlan & Nored, 2008; Conn & Butterfield, 2013; Goss, 2013; Westwood, Kuhl & Shields, 2011). A professional familiar with the culture and the various operational and organizational issues can make an officer feel more comfortable and assist with establishing trust- an important feature in the counseling process. One officer emphasized that officers have access to "good mental health professionals", and that it is vital that the "first visit is successful and they see the person can help."

Insight into service provider preference also illuminated a number of potential barriers to accessing care. Officers identified a number of issues including time delay, "I need help now but having to wait for weeks or months is frustrating." Delays in being able to access a mental health professional when needed have been reported in a number of population samples trying to access care (Linseman, 2016). This is especially

concerning, as officers who have identified that they need help are likely in significant distress. One police officer explained that they would only access a mental health professional "as a last resort." Burns (2014) had a similar finding in which an officer described only "when there was absolutely no other option." This is also consistent with other literature suggesting that people seek out counseling after other coping mechanisms have failed or based on the advice of others (Hinson & Swanson, 1993). While some approaches like the RCMP helpline and some employee family assistance programs are available by phone 24/7, investigating ways to improve access to urgent competent mental health professionals is warranted.

Further to appointment delays, distance was identified as another barrier. One officer explained that there needs to be "someone close by." This sentiment is mirrored in a sample of graduate students living off campus who highlighted distance to seeing a mental health professional on campus as the top reason they would not access care (McCarthy, Bruno & Sherman, 2010). This also further highlights the need for the departments to maintain an up to date list of mental health professionals in various geographic areas depending on where the officers live. One officer explained, "make it more readily available currently now you have to either research it on your own or go talk with someone in HR that you do not even know." CISM / peer support personnel should be familiar with different psychologists operating in different areas, and maintain a list that is available through anonymous access online through the department internal website.

Support After a Critical Incident:

Officers were asked about what they would most prefer after a critical incident in terms of a department- led initiative. Findings suggest officers need support from their colleagues and their senior management team, and suitable follow-up involving professionally trained psychologists. One officer wrote, "the more serious, the more involvement from everyone." In a study of 7 police officers in Australia discharged after being diagnosed with PTSD, officers reported feeling betrayed and unsupported by their organizations. One officer described it as being "hurled from the nest" (McCormack & Riley, 2016). This concern has been echoed in a number of other studies among police officers who reported being unsupported after a critical incident such as a police shooting (Artwohl & Christiensen, 1997; Tuckey, Windwood & Dollard, 2012). On the other hand, one of the officers in this study described the mitigating effect on stress coming from the "support from the department and union throughout the process." Huddleston, Stephons and Paton (2007) further reported that the level of organizational support officers received after a traumatic event had a significant impact on their stress levels. The extent and the nature of senior management personnel involvement with each member after a significant critical incident requires further research.

Within organizational support, the CISM team was most frequently selected as the most important department initiative after a critical incident (N=60, 63.16%). This finding was supported by a law enforcement study in the United States where officers identified that they valued peer support programs more than any other mental health service initiative (Goss, 2013). High satisfaction rates with peer support programs within the United States military have also been reported within the "vet to vet" program

(Barber, Rosenheck, Armstrong & Resnick, 2008). Peer supporters can share lived experience and play an essential role in acting as a referral agent to further resources or qualified mental health professionals. Evans, Billings and Pistrang (2013) who looked at suicidal ideation among police officers identified peer support initiatives as a significant protective factor for law enforcement officers.

Despite the finding that officers identified CISM / peer support as the most important department initiative after a critical incident, some concerns were noted. One officer reported, "I worry on how trustworthy CISM will be with the information told to them." This emphasizes the need to be highly selective of CISM members and to review their ongoing commitment and fit on the team. It also merits the consideration of strict protocols for membership on the team including confidentiality agreements, for which a breach would mean immediate removal from the team. Another concern was identified around training, "I wouldn't. CISM members are inadequately trained in mental health issues." Mental health literacy, communication, and especially listening skills, are essential for CISM peer support members. In order to maintain skills in these areas as well as retain confidence and respect from fellow officers in police organizations, peer support members require ongoing training.

Another officer identified "too bad there is nothing for senior managers." This raises a good question on how to best address the needs of that particular group. Primary interventions, such as CISM / peer support, are typically aimed at frontline operational police officers. As such they are typically made of constables who make up the bulk of a police department. Within a small or medium sized police departments relatively small groups of senior managers exist. They face a unique set of stressors, and general

initiatives aimed at the frontline officer may not be suitable for this group. Representation of higher ranks on the CISM / peer support team may diminish the trust in the team from frontline officers who would worry that this higher ranking personnel may use that information against them and negatively affect their career opportunities. Frontline officers are also more likely to be exposed to traumatic events in the field, which usually forms the basis of the mandate for CISM / peer support teams. On the other hand, senior police managers are exposed to high levels of organizational stress and merit further research on initiatives to best support them.

Mandatory Counseling and Psychoeducation

Hypothesis 7: It was hypothesized that officers would agree to psychoeducational training programs and support them within their organization. Ninety-two percent of officers supported this idea, suggesting that organizations continue to develop and implement psychoeducational training as part of their curriculum. One officer further noted that, "no quick fix, can't be a one off training program." Police departments need to maintain an ongoing commitment to training in mental health resiliency to sustain positive effects, as recommended in similar studies (Goss, 2013; Thompson, 2012).

Hypothesis 8: It was hypothesized that officers would agree that mandatory counseling would lessen stigma, and they would support its adoption within their organization. Officers supported this initiative with (N=83, 87.37%) of officers agreeing or strongly agreeing with its implementation. One officer stated, "if mandatory check-ins were required, we may find that seeking professional help becomes the norm and open conversations about our mental health will become routine." This finding is

supported by a study of law enforcement officers who were part of a randomized control trial involving a group of police officers that received counseling, while a control group did not (Tanigoshi, Kontos & Remley, 2008). Findings included that the group that received counseling had a significant increase in reported wellbeing scores, compared to the control group whose wellness scores remained unchanged pre- and post-test. Carlan & Nored (2008) further reviewed a number of police organizations in the United States who promoted counseling, compared to organizations that did not. Findings included that officers within organizations who promoted counseling had lower reported levels of stress. With these findings comes a growing body of research suggesting that law enforcement agencies adopt mandatory counseling sessions as a means of improving psychological health in the workplace (Burns, 2014; Carlan & Nored, 2008; Conn & Butterfield, 2013). While officer support for mandatory counseling is a significant finding, it needs further investigation. A number of practical and ethical questions arise around the practice of mandatory counseling such as costs, involuntariness, and confidentiality.

Limitations

This study involved a relatively small sample of 100 participants who self-selected themselves in response to an email request sent out to three medium- sized police agencies in the Lower Mainland of British Columbia. Utilizing a cross-sectional primarily quantitative study design has its own limitations when studying a complex behavioral phenomenon such as stress. Given that there is an interplay between individual characteristics, situational workplace and personal factors, it may be difficult

for a person to accurately self-identify a source of stress. Officers are more likely to be more aware of chronic daily hassles such as organizational stress while completing the survey as compared to less frequent traumatic events. Officers may also be prone to under- report levels of stress based on the understanding that they chose to join policing, which inherently exposes officers to traumatic events and paramilitary style organizational pressures. Despite measures to ensure officer confidentiality, some still reported concerns, such as "I am not comfortable answering this question, as it could identify me." A sample size of 100 officers may have also led to less variability within the data, and as such potentially reducing the likelihood of finding statistically significant relationships between variables.

Implications for Research and the Counselling Profession

Police Stress. Findings on police stress add to the existing body of research in which officers readily identify daily hassles, such as paperwork or staff shortages, as significant causes of stress. New findings emerged from the assessment of the emotional impact on officers who found themselves being investigated by one of British Columbia's police oversight bodies. One officer described these investigations as "detrimental to one's mental health" and another stated, "the experience was one of the most stressful situations I've had to deal with." Even when the complaints were unfounded, officers described being left with shattered confidence in both their work and the criminal justice system. Qualitative stress data further revealed the emotional impact of some of the unsparing trauma officers encounter on a regular basis, including child victimizations and death, tragic and gruesome accidents, and consoling distraught family

members. As highlighted by Kitt (2016), elevated rates of exposure to post-traumatic stress continue to be a concern in policing.

Investigating differences among officers' experience of stress based on their levels of service revealed some interesting trends despite a lack of statistically significant findings. Among newer officers, high levels of stress appeared to be associated with exposure to critical incidents, as well as external oversight investigations. Officers in the middle of their careers tended to identify concerns with getting promoted, feeling like they always had to prove themselves, and that different rules applied to different people. Officers later in their careers appeared more likely to associate higher stress with the negative effects of media coverage, with feeling like they were always on duty, with fatigue, and with repeated exposure to trauma. While this study provided an introduction to some of the stressors experienced by police officers at different stages in their careers, further research is need to confirm these findings.

Attitudes Towards Seeking Professional Psychological Help. This study is believed to be the first in Canada to examine the attitudes of police officers towards seeking professional psychological help. Notably, participants in this sample held significantly more positive attitudes than the civilian normative sample of college students, two trial groups of American law enforcement, as well as a sample of Canadian teachers (Fischer & Farina, 1995; Karaffa, 2012; Sanders-Guerro, 2016; Linseman, 2016). These findings suggest that police officers do see the value of mental health professionals, but may not access psychological support due to other stigmas such as, a fear of loss of reputation or career opportunities. This promising new finding requires

future study replication among Canadian law enforcement populations in conjunction with additional research into psychological service utilization rates among police officers.

Despite officers holding a more positive outlook towards psychological help as compared to other population samples, age was found to be negatively correlated with attitudes towards seeking help. Experienced officers with 15 or more years of service held the least positive attitudes towards professional help. These findings are noteworthy, as veteran officers also reported high levels of fatigue and cumulative stress and could likely benefit from professional psychological support. Experienced officers further contain a subgroup of police managers. Those in police management are subject to a unique set of stressors, political pressures, and responsibilities for the police membership. Traditional models of peer support may not be appropriate for this group, and further research is required for specialized modalities to better support the experienced officer as well as the police manager.

Police Preferences around Psychological Service Providers. These findings provided the first known look at Canadian police preferences around peer supporters or mental health professionals for a variety of work and personal issues. In contrast to an American law enforcement sample, this sample of officers primarily identified a preference in seeking a mental health professional for a majority of workplace and personal emotional issues (Karaffa, 2012). The responses may have indicated the participants' understanding of the severity of the issues presented and that these were likely best served through professional intervention. Additional findings from this study

indicated that participants were most likely to identify professionals as "more qualified to deal with their issue," while peer supporters were seen as "a good place to start."

Psychoeducational Training. More recent approaches to combat stress in law enforcement have included a preventive psychoeducational component. The Road to Mental Readiness (R2MR) training program was adopted from the Canadian Forces specifically for police officers and has recently been implemented among many police organizations across Canada. Early feedback on the R2MR program has been positive, and a further 92% of participants from this sample expressed support for psychoeducational training within their organization. Despite the early promise of the R2MR program, further research on psychoeducational training for police officers is greatly needed.

Mandatory Counselling. Participants in this sample supported mandatory counseling sessions within their organizations as a means of improving psychological support for police. This finding builds on previous research in which a group of officers who attended counselling sessions, compared to a group on the wait list, reported higher levels of well-being (Tanigoshi, Kontos, & Remley, 2008). As one officer in this sample described, "if mandatory check-ins were required, we may find that seeking professional help becomes the norm and open conversations about our mental health will become routine." While this finding contributes to the call for mandatory counselling, further research examining the many ethical and financial considerations of such plan is needed.

Recommendations for Police Organizations:

Based on the findings from this study, the following recommendations are being recommended to enhance access to psychological care within police organizations.

Recommendation 1*: Consider adopting the Canadian national standard for psychological health in the workplace*.

Rationale: The implementation of the Canadian National Standard would provide an overarching framework and direction for police organization to ensure that various levels of psychological supports are implemented and maintained. It would simultaneously send a message to the membership that mental health is supported at the highest levels.

Recommendation 2: ***Police Organizations should consider reviewing their extended health benefit plans with a goal of including registered clinical counselors*** in addition to registered psychologists.

Rationale: A specific request to see a clinical counsellor was noted by an officer who stated that it was important to be "able to see a counselor of our choice, not just a psychologist." Some officers may have pre-existing relationships with counsellors prior to entering policing, or may be put off by long waits to see a registered psychologist. One officer noted, "I need help now but having to wait for weeks or months is frustrating." Broadening the pool of accessible mental health professionals could lead to timelier interventions and much needed care for police officers in distress.

Recommendation 3: ***Police Organizations should consider reviewing their extended health benefit plans with a goal of adding group counselling.***

Rationale: Officers identified CISM peer support as the most important organizational support after a critical incident. While police research has focused on short-term critical incident group defusings and debriefings, recent research among military veterans suggest that group counselling is effective. Within a study of 18 Canadian military veterans, participants identified being among "other military personnel" as the number one most helpful factor of their group treatment program (Westwood, McLean, Cave, Borgen & Slakov, 2010).

Recommendation 4: ***Continue to conduct psychoeducational training (i.e. R2MR) on police stress and coping mechanisms throughout a police officer's career,*** starting in the police academy, and continuously every 3 years as part of a police departmental training cycle.

Rationale: Ninety-two percent of officers in this sample supported ongoing psychoeducational training, and one officer further noted, "no quick fix, can't be a one off training program." Given the cost of abseentism and presenteesim related to mental health issues, ongoing investments in preventative training are warranted. This training also provides an opportunity to remind officers about psychological services available to them and their entitlements within their benefits.

Recommendation 5: ***Provide education for police spouses at various stages of a police officer's career*** on the effects of occupational stress, signs and symptoms to look out for, as well as family resources**.**

Rationale: Social supports, including family, have been well documented as mitigating against the effects of PTSD. Spouses have also been reported as often times being the first to notice behavioural changes in their partners, and may assist in proactive support for an affected officer (Thompson, 2012).

Recommendation 6: ***Provide a transition program for retiring officers.***

Rationale: Within this study, officers with 20 or more years of service reported the highest mean levels of stress. This group also reported the highest levels of stress with regards to exposure to repeated traumas. Many of these officers are in the later stages of their career and nearing retirement. A program that would allow them to address some of the cumulative trauma they have experienced, prior to exiting policing and losing extended their health benefits would likely be beneficial.

Recommendation 7: ***Educate supervisors on signs and symptoms to look out for within their subordinates.*** Encourage supervisors to check-in with their members regularly and especially after involvement in critical incidents. Supervisors should monitor employee workloads and ensure there is adequate operational staffing to allow for officer breaks to include physical fitness. Officers should be encouraged to exercise during breaks.

Rationale: In a previous study of 1,000 Canadian workers only 26% felt that their supervisor effectively manages mental health issues (Thorpe & Chener, 2011). Further, only 44% of managers reported having any training in how to manage employees with mental health issues. In another study involving 60 Ontario paramedics, front line staff identified supervisor support as crucial following a critical incident (Halpern, Gurevich, Schwartz & Brazeau, 2009). Within the same study supervisors identified a lack of training as a barrier to supporting front line staff after a critical incident.

Recommendation 8: ***Adequately screen, staff and train Critical Incident Stress Management (CISM) peer support teams.***

Rationale: CISM team peer support was identified by 63% of participants as the most important department- led initiative following a critical incident. This finding was supported by a law enforcement study in the United States where officers identified that they valued peer support programs more than any other mental health service initiative (Goss, 2013). Despite strong support for the program, concerns were raised by officers within this study, "I worry on how trustworthy CISM will be with information told to them." This highlights the importance of a selective screening processes and a confidentiality agreement among its members. Another officer identified, "CISM members are inadequately trained in mental health issues." This response highlights the need for appropriate standardized peer support training in order to provide an effective and credible service for the police membership.

Recommendation 9: ***CISM peer support teams should be notified when a serious investigation into officer conduct is being investigated*** by the Office of the Police Complaint Commission (OPCC) or by the Independent Investigations Office (IIO)**.** Special emphasis on support and education should be given to rookie officers based on their high stress appraisal of external police conduct investigations.

Rationale: External investigations were identified as a significant stressor, including an officer who described, "the experience was one of the most stressful situations I have ever had to deal with." Another officer described how it was, a "blind and frightening process." CISM peer support teams should work with senior management teams, as well as police unions in order to ensure that officers are supported throughout the conduct review process.

Recommendation 10: ***CISM peer support teams should be notified when a next of kin death notification*** involves children, unexpected or tragic deaths, or in which family members are unusually distraught.

Rationale: Officers described a variety of reasons why next of kin death notifications took such an emotional toll. One officer described the experience as, "you essentially live the trauma with the family." Another officer stated, "NOK's are the worst to deal with." Officers reported feeling powerless and "not being able to make the situation better" for the family. Recognizing that these are difficult calls, and providing CISM peer support to involved officers could help to normalize their emotional reactions and experiences.

Recommendation 11: ***CISM teams should receive an annual debrief day.***

Rationale: Critical incident peer support teams have been reported as the most important organizational function after a critical incident. Many of these officers are completing their CISM team functions in addition to their normal duties. In order to prevent burnout among peer support CISM team members, annual debriefings would likely be beneficial.

Recommendation 12: ***Organizations should maintain an up to date list of psychological service providers*** covering a variety of geographical locations based on where officers are living. This information should be easily and anonymously accessible. CISM team members could be used to check-in regularly with mental health professionals to adjust recommendations as needed based on wait times and officer feedback.

Rationale: The need for simple and anonymous access to psychological provider information was highlighted in the study. One officer explained, "make it more readily available, currently you have to either research it on your own, or go talk with someone in HR that you do not even know."

Recommendation 13: ***Consider implementing mandatory counseling sessions every two years for all sworn police officers.***

Rationale: In order to overcome the stigma of seeing a mental health professional, mandatory counselling has been suggested as a means of overcoming that barrier in enhancing police officer psychological health (Carlan & Nored, 2008). Eighty-

three percent of participants within this study supported mandatory counselling within their organization. This study joins a growing body of police stress literature that is calling for the implementation of mandatory counselling among police organizations (Burns, 2014; Carlan & Nored, 2008; Conn & Butterfield, 2013).

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APPENDIX A: Participant Consent Letter

You are being invited to voluntarily participate in a graduate research study titled "Overcoming Stigma: To Serve and Protect Police Officers". This study is being lead by the principal investigator Dr. Colleen Haney, and a co-investigator Arthur Wlodyka. This research is about law enforcement stress, and attitudes toward mental health treatment providers. The purpose of this research is to identify how police officers deal with stressful or traumatic events, and further determine their preference between peer support versus professional support for a variety of work-related and interpersonal issues. This is an opportunity to participate in research that could ultimately be used to improve mental health services for law enforcement officers. Findings may also pose considerations for improving training and ways to use departmental and community resources more efficiently. Participation involves completing an electronic survey that can be completed on a computer or a mobile phone, and will take approximately 30 - 45 minutes to complete. Participation is voluntary and there are no incentives for participating in the study. You may choose not to participate or discontinue participation at any time without consequence.

Due to the personal nature of some of the questions as well as to encourage honest responses, at no time will you be asked to provide your name, specific age, specific assignment or departmental affiliation. Computer IP addresses will not be collected and any demographic information (such as your age, ethnicity, or level of education) will be

presented in group form when findings are published. No individual survey information will be given to your agency. Your consent to participate is granted in your selection that you are over 18 years old, understand the conditions of the informed consent statement, and by your participation in filling out the survey. If the questionnaire is completed, it will be assumed that consent has been given.

This online survey is hosted by a web survey company located in the USA and as such is subject to U.S. laws, in particular, the US Patriot Act which allows authorities access to the records of internet service providers. If you choose to participate in the survey, you understand that your responses to the survey questions will be stored and accessed in the USA. The security and privacy policy for the web survey company can be found at the following link: http://www.qualtrics.com/security-statement/

If you have any questions about this study you may contact the principal investigator, Dr. Colleen Haney in the Department of Education and Counselling Psychology at UBC or the co-investigatorArthur Wlodyka, Masters Student Researcher, in the Department of Education and Counselling Psychology at UBC. If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

Completing the survey could produce feelings of ambiguity or remind you of potentially traumatic past experiences. Otherwise, there are no risks involved in participating in the study in excess of those you would experience in everyday life. If you have any questions or concerns about this study or feel that you may be in need of mental health services, you may contact the researcher or the referral sources provided. If you would like a copy of the results of this study, please contact the researcher and arrangements will be made. The results will also be publicly available through UBC circle and/or any journal publications.

Q3 I have read the above disclaimer and consent to take part in this study.

- ❍ I accept (1)
- ❍ I do not accept (2)

If I do not accept Is Selected, Then Skip To End of Survey

APPENDIX B: Demographics

Q5 Please choose your age range.

- ❍ 19 - 23 (1)
- ❍ 24 - 28 (2)
- ❍ 29 - 33 (3)
- ❍ 34 - 38 (4)
- ❍ 39 - 43 (5)
- ❍ 44 - 48 (6)
- ❍ 49 - 53 (7)
- ❍ 54 - 58 (8)
- ❍ 59 and over (9)

Q8 Please indicate your gender

- ❍ Male (1)
- ❍ Female (2)

Q9 Please indicate your highest level of education

- ❍ Graduate school or higher (1)
- ❍ Some graduate school (2)
- ❍ Bachelors degree or equivalent (3)
- ❍ Some post-secondary (4)
- ❍ High school or equivalent (5)

Q89 Please indicate how many years of service completed.

Q12 Please indicate your current relationship status

- ❍ Single (1)
- ❍ Separated (2)
- ❍ Common Law (3)
- ❍ Married (4)
- ❍ Other (5)

Q13 Please indicate your current rank

- ❍ Constable / Detective or Corporal (1)
- ❍ Sergeant or Above (2)

Q14 Please indicate if you are in patrol:

- ❍ Yes (1)
- ❍ No (2)

APPENDIX C: Operational Stress Questionnaire

Q32 Part A: Operational Stress Questionnaire (McCreary & Thompson, 2006)

Q102 Part 1 of 5 (Estimated Time 10 minutes - Progress bar is at the top): Below is a list of items that describe different aspects of being a police officer. After each item, please circle how much stress it has caused you over the past 6 months, using a 7-point scale (see below) that ranges from 1 "No Stress At All" to 7 "A Lot Of Stress"

	1-No stress at all (1)	2 (2)	3 (3)	4 - Moderate Stress (4)	5 (5)	6 (6)	7 - A lot of stress (7)
Shift Work (1)	❍	❍	❍	❍	❍	❍	❍
Working alone at night (2)	❍	❍	❍	❍	❍	❍	❍
Over time demands (3)	❍	❍	❍	❍	❍	❍	❍
Risk of being injured on the job (4)	❍	❍	❍	❍	❍	❍	❍
Work related	❍	❍	❍	❍	❍	❍	❍

activities on days off (e.g. court, community events, etc.) (5)							
Experiencing critical incidents with threat to personal safety or that of another (6)	❍	❍	❍	❍	❍	❍	❍
Repeat exposure to human suffering (i.e. child sex assault victims, SIDS death, delivering	❍	❍	❍	❍	❍	❍	❍

NOK's after a tragedy) (7)							
Unable to fix the situation (i.e. responding the same domestic, seeing children repeatedly at risk) (8)	❍	❍	❍	❍	❍	❍	❍
Managing your social life outside of work (9)	❍	❍	❍	❍	❍	❍	❍
Not enough time available for friends and family (10)	❍	❍	❍	❍	❍	❍	❍

Paperwork (11)	❍	❍	❍	❍	❍	❍	❍
Eating healthy at work (12)	❍	❍	❍	❍	❍	❍	❍
Finding time to stay in good physical condition (13)	❍	❍	❍	❍	❍	❍	❍
Fatigue (e.g. shift work, over-time) (14)	❍	❍	❍	❍	❍	❍	❍
Occupation related health issues (i.e. back pain) (15)	❍	❍	❍	❍	❍	❍	❍
Lack of understanding	❍	❍	❍	❍	❍	❍	❍

from family and friends about your work (16)							
Making new friends or maintaining friendships with people outside of work (17)	❍	❍	❍	❍	❍	❍	❍
Upholding a "higher image" in public (18)	❍	❍	❍	❍	❍	❍	❍
Negative comments from the public or media (19)	❍	❍	❍	❍	❍	❍	❍
Limitations to	❍	❍	❍	❍	❍	❍	❍

your social life (e.g. who your friends are, where you socialize) (20)							
Feeling like you are always on the job (21)	❍	❍	❍	❍	❍	❍	❍
Friends / Family feel the effects of stigma associated with your job (22)	❍	❍	❍	❍	❍	❍	❍

APPENDIX D: Organizational Stress Questionnaire

Q106 Part B: Organizational Stress Questionnaire (McCreary & Thompson, 1989)

Below is a list of items that describe different aspects of being a police officer. After each item, please circle how much stress it has caused you over the past 6 months, using a 7-point scale (see below) that ranges from 1 "No Stress At All" to 7 "A Lot Of Stress":

	1-No stress at all (1)	2 (2)	3 (3)	4 - Moderate Stress (4)	5 (5)	6 (6)	7 - A lot of stress (7)
Experiencing harassment or bullying from co-workers or supervisors (1)	❍	❍	❍	❍	❍	❍	❍
The feeling that different rules apply to different people (e.g. favoritism) (2)	❍	❍	❍	❍	❍	❍	❍
Feeling like	❍	❍	❍	❍	❍	❍	❍

you always have to prove yourself to the organization (3)							
Pressure to get promoted and advance within the organization (4)	❍	❍	❍	❍	❍	❍	❍
Excessive administrative duties (5)	❍	❍	❍	❍	❍	❍	❍
Constant changes in policy / legislation (6)	❍	❍	❍	❍	❍	❍	❍
Staff shortages (7)	❍	❍	❍	❍	❍	❍	❍
Bureaucratic	❍	❍	❍	❍	❍	❍	❍

red tape (8)							
Too much computer work (9)	❍	❍	❍	❍	❍	❍	❍
Lack of training on new equipment (10)	❍	❍	❍	❍	❍	❍	❍
Perceived pressure to volunteer free time (11)	❍	❍	❍	❍	❍	❍	❍
Dealing with supervisors (12)	❍	❍	❍	❍	❍	❍	❍
Inconsistent leadership style (13)	❍	❍	❍	❍	❍	❍	❍
Lack of resources (14)	❍	❍	❍	❍	❍	❍	❍

Unequal sharing of work responsibilities (15)	❍	❍	❍	❍	❍	❍	❍
If you are sick or injured your co-workers seem to look down on you (16)	❍	❍	❍	❍	❍	❍	❍
Leaders over-emphasize the negatives (supervisor evaluations, public complaints, etc.) (17)	❍	❍	❍	❍	❍	❍	❍
Internal Investigations (Professional	❍	❍	❍	❍	❍	❍	❍

Standards) (18)							
External Investigations (Independent Investigations Office - IIO) (19)	❍	❍	❍	❍	❍	❍	❍
Dealing with the court system (20)	❍	❍	❍	❍	❍	❍	❍
The need to be accountable for doing your job (21)	❍	❍	❍	❍	❍	❍	❍
Inadequate equipment (22)	❍	❍	❍	❍	❍	❍	❍

APPENDIX E: Qualitative Stress Questions

Q103 Have you ever been the subject of an external review processes? (i.e. OPCC - Office of the Police Complaint Commissioner, or the IIO – Independent Investigations Office) If so, please describe your experience and it's effect on you.

Q15 Part 2 of 5 (Open-Ended - Estimated Time - 10 minutes - Progress Bar is at the top): Many officers have experienced, witnessed or have been confronted by stressful and/or traumatic events at some point in their career. Please answer the questions below thinking about a call that sticks with you. Below are some of those potentially stressful events: Threats to personal safety or that of co-worker (i.e. pursuit, threatened or attacked by violent suspect, riots, etc.) Using or witnessing Force (i.e. having to effect a violent arrest, discharging firearm, shooting a person, watching another officer apply significant force) Witnessing Tragedy or human suffering (i.e. fatal MVI, NOK, vulnerable people/ or children harmed, repeat domestics)

NOTE For any open-ended questions, if easier, consider typing in word and copy and pasting your responses into the survey.

Q100 When you think back on your service, what call(s) sticks with you? (Can be big or small). Please describe it.

Q34 Why do you think that call(s) stick with you over others?

APPENDIX F: Attitudes Towards Seeking Professional Psychological Help

Q108 Part 3 of 5: Attitudes Towards Seeking Professional Psychological Help Shortened Form (Fischer & Farina, 1996) - Estimated 5 minutes

Directions: Please read each statement (items 1-10) and respond according to the degree in which you agree or disagree.For the purposes of this survey, the following definitions are applicable.Professional Mental Health Provider: Any person who is trained to provide treatment for personal problems of a psychological nature such as a psychologist, psychiatrist, counselor, therapist, or social worker. For purposes of this survey, please consider that the professional mental health provider is NOT employed directly by the law enforcement agency.

	Strongly Disagree (1)	Disagree (2)	Agree (3)	Strongly Agree (4)
1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention. (1)	❍	❍	❍	❍

2. The idea of talking about problems with a professional mental health provider strikes me as a poor way to get rid of emotional conflicts. (2)	❍	❍	❍	❍
3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in counselling. (3)	❍	❍	❍	❍
4. There is something	❍	❍	❍	❍

admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help. (4)				
5. I would want to get psychological help if I were worried or upset for a long period of time. (5)	❍	❍	❍	❍
6. I might want to have psychological counseling in the future. (6)	❍	❍	❍	❍

7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help. (7)	❍	❍	❍	❍
8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me. (8)	❍	❍	❍	❍
9. A person should work out his or her own problems;	❍	❍	❍	❍

getting psychological counseling would be a last resort. (9)				
10. Personal and emotional troubles, like many things, tend to work out by themselves. (10)	❍	❍	❍	❍

APPENDIX G: Mental Health Provider Preference Questionnaire

PREFERENCE TOWARDS PEER SUPPORT OR MENTAL HEALTH PROFESSIONAL

Q79 Part 4 of 5: (Estimated time - 5 minutes)

Directions: Please read each statement (items 11-24) and respond according to the degree in which you would prefer to contact a professional mental health provider or a peer supporter in each hypothetical situation. For the purposes of this survey, the following definitions are applicable. Professional Mental Health Provider: Any person who is trained to provide treatment for personal problems of a psychological nature such as a psychologist, psychiatrist, counselor, therapist, or social worker. For purposes of this survey, please consider that the professional mental health provider is NOT employed directly by the law enforcement agency. Psychological Help: Any treatment designed to help alleviate personal problems of a psychological nature. Examples include individual counseling, group therapy, crisis intervention, medication, hospitalization, etc. Psychotherapy: The process of addressing personal problems with the help of a mental health professional. Psychotherapy may also be referred to as therapy or counselling. Critical Incident Stress Management(CISM) team member: A sworn law enforcement officer trained in providing confidential peer support to other officers, in order to identify common reactions to stress, and educate members on healthy coping techniques, as well as make referrals to professional mental health providers when necessary.

	Strongly Prefer CISM Member (1)	Prefer CISM Member (2)	Prefer Professional (3)	Strongly Prefer Professional (4)
11. If I were experiencing relationship issues, or going through a relationship break-up, separation or a divorce. (1)	❍	❍	❍	❍
12. If I had trouble falling asleep or staying asleep. (2)	❍	❍	❍	❍
13. If I were drinking alcohol excessively and this behavior was negatively	❍	❍	❍	❍

affecting my relationships with friends and family. (3)				
14. If I felt hopeless about the future of my career. (4)	❍	❍	❍	❍
15. If I were frustrated with organizational politics, colleagues, or supervisors. (5)	❍	❍	❍	❍
16. If I had a difficult time controlling my emotions on the job and it was affecting my performance. (6)	❍	❍	❍	❍

17. If I felt as if the demands of the department were interfering in my relationships with friends and family. (7)	❍	❍	❍	❍
18. If I had suicidal thoughts or other thoughts related to self-injury. (8)	❍	❍	❍	❍
19. If I were drinking alcohol excessively and this behavior was negatively affecting my ability to do my job. (9)	❍	❍	❍	❍

20. If I experienced distress after a critical incident. (10)	❍	❍	❍	❍
21. If I felt sad or unhappy for several weeks. (11)	❍	❍	❍	❍
22. If I were prone to outbursts of anger towards my significant other or my children. (12)	❍	❍	❍	❍
23. If I were dealing with stress related to the court system or a particular case in which I	❍	❍	❍	❍

was involve (13) 24. If I suffered flashbacks, nightmares, or feelings of helplessness after experiencing or witnessing an event that involved serious injury or death (or the threat of serious injury or death). (14)	❍	❍	❍	❍

Q80 If you were to seek out a mental health professional. Which of the following would you prefer:

❍ Expertise in policing issues and works closely with your organization (1)
❍ Familiar with law enforcement issues but no ties to your organization (2)
❍ No law enforcement focus but is an expert in stress/trauma and coping (3)

APPENDIX H: Other Survey Questions

Q82 Part 5: Last Section (Estimated time 5 minutes)

Directions: Please read each statement (items 25-29) and respond according to the degree in which you agree or disagree.

	Strongly Disagree (1)	Disagree (2)	Agree (3)	Strongly Agree (4)
25. A mandatory counselling session every 2 years would remove the stigma of accessing psychological support. (1)	❍	❍	❍	❍
26. I would support a mandatory counselling session every 2 years within my policing	❍	❍	❍	❍

organization. (2)				
27. I believe psychological preparedness training is helpful. (3)	❍	❍	❍	❍
28. I would support psychological preparedness training within my policing organization. (4)	❍	❍	❍	❍

Q84 Directions: For items 29-32, please check all items that are important to you.

Q83 29. For what reasoning would you contact a CISM team member for mental health related issues?

- ❑ Trust a fellow officer (1)
- ❑ They understand the issues (2)
- ❑ Good place to start (3)
- ❑ Worried about stigma of seeing a professional (4)
- ❑ Other (5) _____

Q86 30. For what reasons would you contact a professional mental health provider for mental health related issues?

- ❑ Confidentiality (1)
- ❑ More qualified to deal with issue (2)
- ❑ Independent opinion separate from the work environment (3)
- ❑ Other (5) _____

Q87 31. In your opinion, in terms of a department related initiative, what do you find most helpful after a critical incident?

- ❑ CISM team support (1)
- ❑ Support from management (2)
- ❑ Critical Incident Group Debrief with a Psychologist (3)
- ❑ Individual referral to a psychologist (4)
- ❑ Other (5) _____

Q88 32. In your opinion, what conditions might improve mental health service utilization within your department?

- ❑ Mandatory Counselling (1)
- ❑ Less stigma within the organization (2)
- ❑ More training (3)
- ❑ Greater awareness of Resources (4)
- ❑ Better access to a Mental Health professional (5)
- ❑ Other (6) _____

Q29 Anything else you would like to say on the subject of police stress and accessing support.

APPENDIX I: Debrief Statement

Q47 Dear Participant, Thank you for completing this survey. Your responses could ultimately be used to improve mental health services for law enforcement officers. If you would like a copy of the results of this study, please contact the researcher and arrangements will be made. The results will also be publicly available through UBC circle and/or any journal publications.

If you have any questions or concerns about this study you may contact the principal investigator, Dr. Colleen Haney in the Department of Education and Counselling Psychology at UBC or the co-investigator Arthur Wlodyka, Masters Student Researcher, in the Department of Education and Counselling Psychology at UBC.

If you feel that you may be in need of mental health services, please contact consider any of the referral sources provided.

1. Employee Family Assistance: Call Brown & Crawshaw at 1-800-668-2055, (live operator - 24 hours a day)
2. Approaching a member of your Critical Incident Stress Management Team for local resources
3. Find or discover a registered psychologist in British Columbia at: http://www.psychologists.bc.ca/find_psychologist_full

Please click arrow below to send survey response. Thank you!