FREQUENCY OF POLICE OFFICERS' PROBLEMS AND

THE SOURCES OF COUNSELLING MOST PREFERRED

BY POLICE OFFICERS

By

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ABSTRACT

The purpose of this study was to establish the
frequency of problems that members of Police Force X
experience or have experienced, and to determine which
source of counselling the members of Police Force X
would prefer most for each problem.

A single stage sample design was used for this
study. Two hundred non-commissioned police officers
were randomly selected and were mailed a questionnaire
through the police department's in-house mail system.
One hundred and fifteen police officers returned
completed and usable questionnaires. With the
exception of an under representation of female police
officers, the sample was representative of the
population.

The analysis of data showed that the five most
frequent problems reported by the respondents were
anxiety that interferes with the enjoyment of life,
alcohol abuse, depression, financial problems, marital
problems and sleep disturbance (these problems are
presented in alphabetical order, and not in order of
frequency). Further, for thirteen of fifteen presented
problems the majority of respondents selected outside
psychiatrist or psychologist as the most preferred
source of counselling. For the problem of boredom and

alienation members were equally divided between outside
psychiatrist or psychologist and peer counselling as
the most preferred source of counselling.

The study concluded with a discussion of practical
implications and recommendations for further research
were presented.

TABLE OF CONTENT

LIST OF TABLES

ACKNOWLEDGEMENTS

Chapter I

INTRODUCTION

Police Officer Problems

In general, police officers at the beginning of
their career are emotionally more stable than the
general population (Blackmore, 1978, Stratton, 1977).
However, many officers experience psychological and
physiological difficulties that are attributable to the
pressures of policing (Stratton, 1977; Alkus & Padesky,
1983; Donahue, 1977; Blackmore, 1978). Some of the
psychological and physiological difficulties that
police officers may experience include marital
difficulties, alcohol abuse, uncalled-for aggression,
backaches, migraine headaches, and heart disease
(Blackmore, 1978; Somodevilla, 1978; Shook, 1978;
Klyver, 1983). However, the intensity and frequency of
psychological problems that police officers experience
is difficult to determine because police officers are
reluctant to report psychological problems and police
departments tend to keep secret those problems that are
psychological in nature (Blackmore, 1978).

Counselling For Police Officers

Police officers could benefit greatly by receiving some form of counselling (Stratton, 1977; Shev, 1977; Blackmore, 1978; Alkus & Padesky, 1983). According to Depue (1979) most police officers do not require intensive psychotherapy, but do require some counselling for successful resolution of personal problems.

There are a variety of different counselling methods available to police officers. The providers of these counselling services include psychiatrists, psychologists, religious leaders, and police peer counsellors. Of these counselling services, it appears that peer counselling is most preferred (Donahue, 1977). Police officers appear to reject professional services because of their basic distrust for mental health professionals (Alkus & Padesky, 1983).

Research Questions

While Donahue (1977) has conjectured that police officers prefer peer counselling over any other sources of counselling, there is no empirical evidence to support this position. Therefore, to increase the effectiveness and efficiency of a counselling service of a particular police force, it is prudent to survey the members to establish the problems that members

experience, and the sources of counselling they prefer to address those problems. It was toward these two issues that the present research was directed. More specifically, a survey of a random sample of members of a large metropolitan police force was completed to obtain answers to the following questions:

1) What problems do members of Police Force X perceive as being important to them?

2) To what extent do the members believe the problems exist in Police Force X?

3) For each problem, which source of counselling do members of Police Force X prefer?

4) To what extent do members of Police Force X prefer peer counselling?

Definition of Terms

Terms used in this study are defined as follows:

1) Police Force X:

This is a specific police force situated in Canada. To ensure confidentiality, as requested by the cooperating police force, the name of the police force is not disclosed.

2) Police Force Member or Member:

A member of the cooperating police force who is equal to or lower in rank than a Staff Sergeant.

3)   Peer Counsellor:

A fellow police officer trained in counselling who voluntarily responds to a request for counselling by a colleague. Peer counsellors have approximately 100 hours of counsellor training, but do not hold a degree beyond the Masters level in counselling or a related field.

4)   Mental Health Professional:

A person who holds a Doctorate in Counselling or Clinical Psychology, or a Medical Degree with a specialty in Psychiatry.

Chapter II

REVIEW OF THE LITERATURE

Police Work Stressors

Police officers' stress is generated from a myriad of different areas. Loo (1985) suggests that stressors for police officers can be grouped into the following four categories: 1) police organization and policies, 2) nature of responsibility involved in police work, 3) unsatisfactory criminal justice system, and 4) public and media attitudes. According to Depue (1979), police officers experience psychological discomfort resulting from role conflict, unrealistic media image, development of police subculture, situational crisis, public apathy, poor equipment and frustration and boredom with assignments. Donahue (1977) states, "physical and emotional violence, the isolation of the police officer, the unconventional work hours, all affect officers in differing ways" (p.23).

When a person first enters policing he or she is above average intellectually and emotionally, but eventually experiences psychological problems arising from situational difficulties (Stratton, 1977). Alkus and Padesky (1983) agree with Stratton. They believe

that it is myth that "disturbed persons become police officers. Rather, police undergo extreme stress in their jobs which can cause problems for them individually and with their families" (p.62). According to Donahue (1977) no police officer can navigate a career unscathed from psychological damage.

Police Problems

Compared to other occupations, police work is a high stress occupation (Kroes, Margolis & Hurrell, 1974). Unlike many other occupations, police work "has a potent adverse effect on the total life of the worker" (Kroes, Margolis & Hurrell, 1974, p.155).

Psychologists who exclusively counsel police officers report that the most common presenting problems of police officers are (these are in random order, not order of most prevalent) marital problems, sexual problems, family problems, alcohol problems, displacement of aggression, psychosomatic problems, headaches, gastrointestinal problems and parenting problems (Somodevilla, 1978). Alkus and Padesky (1983) cite Blackmore's (1978) findings from a survey of 2300 police officers across twenty-nine police forces that thirty seven percent had serious marital problems, thirty-six percent serious health problems, twenty-three percent serious alcohol problems, twenty percent

serious problems with their children and ten percent with serious drug problems. Shook (1978) states, "Alcoholism, inappropriate job behavior, divorce and mental illness are included with the 'pitfalls in policing' that are being reported in ever increasing numbers within the police service" (p.8). Craig (1979) cites a National Institute of Health and Occupational Safety report that the police profession has the highest degree of stress induced illnesses.

Counselling Intervention

While the situation concerning the psychological well being of police officers raises concerns, some solutions are being sought. Among these solutions is the prospect of providing officers with counselling services. According to Alkus and Padesky (1983) police officers may benefit a great deal from receiving counselling. Talking with another person can be extremely beneficial in helping to resolve the psychological problems that many police officers encounter (Stratton, 1977). According to Shev (1977) approximately sixty percent of all police officers require some form of counselling to help overcome the adverse effects from the pressures of police work. Undoubtedly, some police officers do receive counselling. It is indicated from this review of the

literature of police problems, that counselling
services for police officers are available from
religious leaders, psychiatrists, psychologists and
police peer counsellors (Stratton, 1977; Depue, 1979;
Reiser, 1986; Klyver, 1983). A description of these
different sources of counselling is as follows:

A. Pastoral Counselling

Both lay people and clergy are involved in
pastoral counselling (Fosket, 1985). Pastoral
counselling differs from that of secular psychotherapy
(Bollinger, 1985). Pastoral counselling stands "for
something recognisably but not offensively religious -
that is, religious in a broad and philosophical sense"
(Fosket, 1985, p.100). Pastoral counselling is
concerned with education, prevention and societal
change (Fosket, 1985). Pastoral counsellors use a
variety of different counselling paradigms ranging from
client-centered to psychoanalytic (Fosket, 1985;
Fuller, 1984). However, regardless of the
psychological paradigm, the pastoral counsellor does
not abandon the religious perspective, but includes it
in the counselling process ((Bollinger, 1985).

Historically, one of the first attempts to help
police officers deal with their psychological problems
was conducted by the police chaplain (Depue, 1979).

However, resulting from the range of problems experienced by police officers, and police officers preferences for a variety of different counselling methods, additional methods of counselling were required (Depue, 1979).

B.   Psychiatric Counselling

Psychiatrists hold a medical degree and have undergone specialized training in psychiatry (Davison & Neale, 1986). While psychiatrists may conduct physical examinations, most do not, but instead practice psychotherapy and prescribe psychoactive drugs (Davison & Neale, 1986).

In Canada, psychiatrists are included within the Medical Health Plan. Therefore, a person with a psychiatric, psychological or emotional problem may attend a general practitioner and receive a referral to a psychiatrist. With a referral a patient does not pay the psychiatrist, the psychiatrist receives payment from the Health Plan.

C.   Psychological Counselling

To qualify as a psychologist one usually requires a Ph.D. in Counselling or Clinical Psychology (Davison & Neale, 1986). Psychologists are trained in diagnosing mental disorder and providing psychotherapy, but cannot prescribe medication (Davison & Neale,

1986). Under some company and medical plans psychologists' services are covered, however, when a person does not have coverage he or she may attend a psychologist, with or without a medical referral, and pay the psychologist directly.

D.   Peer Counselling

"Peer counselling is the use of active listening and problem-solving skills, along with the knowledge about human growth and mental health, to counsel people who are our peers" (D'Andrea & Salovey, 1983, p.3).

The philosophy behind peer counselling is that given the chance people are capable of solving many of their own problems associated with daily living (D'Andrea & Salovey, 1983). The peer counsellor does not solve the counsellee's problems, but assists the counsellee to find his or her own solutions (D'Andrea & Salovey, 1983).

The Los Angeles Police Department was the first police department in North America to "develop and implement an integrated and fully department-supported peer counseling program using regularly employed officers" (Klyver, 1983, p.66).

The Los Angeles Police Department started their peer counselling program in 1981. After being selected, peer counsellors (police officers) were

trained by a psychologist in a three day workshop. The
peer counsellors were trained in crisis identification,
crisis intervention and counselling, listening skills,
assessment skills, suicide assessment and counselling
members experiencing alcohol and substance abuse.

Since the Los Angeles Police Departments
initiation of police peer counselling, many other
police departments in North America are using peer
counsellors as a source of counselling for their police
members (N. Klyver, personal communication, September,
16, 1987).

Mental Health Professionals' Counselling Police Officers

Some mental health professionals (Psychiatric and
Psychological counsellors) see themselves as the
antithesis of police officers (Stratton, 1977).
Furthermore, most mental health professionals who work
outside the police setting (outside mental health
professional) are not well prepared to counsel police
officers (Kroes, 1976). While outside mental health
professionals are of some help to the troubled police
officer, they are incapable of being fully effective
because of their lack of understanding of the pressures
of police work (Kroes, 1976). As well, outside mental
health professionals may have bias concerning police

which may interfere with the therapeutic outcome (Kroes, 1976). Somodevilla (1978) has found that not only the lack of police knowledge hinders the outside mental health professional's counselling, but they may experience difficulty in dealing with the straightforwardness of many police officers.

Many police officers are more likely to seek help from a mental health professional who is in-house with a police department than an outside mental health professional (Kroes, 1976). Stratton (1977) finds that the antagonism that frequently exists between police officers as clients and mental health professionals as counsellors, decreases when the mental health professional is in-house. Even so, police officers initially have distrust of in-house mental health professionals (Somodevilla, 1978).

In order for in-house mental health professionals to gain the trust of police officers, Stratton and Knowles (1978) suggest they go for ride-alongs, attend emergencies, and informally talk with police members.

Stratton (1977) believes that in order for mental health professionals to be successful in a police setting, there must be voluntary participation for counselling, confidentiality must be maintained and the mental health professional must have flexible hours.

Moreover, if the mental health professional is in-house, he or she must have autonomy from the police department (Stratton, 1977). Somodevilla (1978) points out that an in-house mental health professional has less opportunity to fulfill these conditions than does an outside mental health professional. In-house mental health professionals have less freedom than outside mental health professionals, for the in-house mental health professional is not only responsible to the client but is also responsible to the management of the police department (Somodevilla, 1978).

However, while outside mental health professionals may have greater freedom than in-house mental health professionals, Depue (1979) cites the following four reasons explaining why police officers tend to reject psychological help from outsiders.

1) Peer pressure discourages police officers from seeking outside help.

2) Police officers are concerned with deflating their masculine image by admitting weaknesses to an outsider.

3) Police officers fear that the mental health professional may be involved in crime, or that if involved in group counselling one of the group members may be a criminal.

4)   Police officers have a basic distrust of mental

health professionals.

Peer Counselling

Loo (1984) believes that peer counsellors act as a

good compliment to mental health professionals.

However, some mental health professionals believe that

police peers are too close to the problem to deal with

the problems objectively and effectively (Blackmore,

1978).

Those who favour police peer counselling contend

that no matter how well trained mental health

professionals are, their sophisticated training is of

no value if few police officers will voluntarily attend

for counselling (Blackmore, 1978). When police forces

offer both in-house mental health professionals and

police peer counselling, as in Detroit, Michigan and

New York City, most police officers select the peer

counsellors (Blackmore, 1978).

Police have a great deal of distrust toward mental

health professionals (Alkus & Padesky, 1983). This

distrust is understandable in that few mental health

professionals understand the "unique environmental

pressures leading to a police officer's frustration,

anxiety, and denial" (Alkus & Padesky, 1983, p.55).

Police officers tend not to communicate to those

outside the police community. Correctly or
incorrectly, police officers are concerned about
harmful press coverage and public criticism (Donahue,
1977). Therefore, police officers tend to rely on
their peers for support. Police officers have found
that only other police officers can truly understand
their feelings and experiences (Donahue, 1977).

Police officers believe there is a stigma attached
to seeking help from a mental health professional.
Peer counselling reduces the stigmatization associated
with seeking professional psychological help (Reiser,
1986).

Peer counselling can be extremely effective. With
a small amount of training the non-professional
counsellor can work effectively with many different
types of problems (Reiser, 1986). Yet, from the police
community there is virtually no literature that
empirically supports this claim.

According to Stratton (1980) police peer
counselling is appropriate in areas where the
counsellor has had personal experiences similar to that
of the counsellee, ie. alcoholism, traumatic events and
retirement. However, as Donahue (1977) points out,
this type of peer counselling is remedial and is only

implemented when the symptoms are so overt that they can no longer be ignored.

However, peer counselling may have a more diversified role than suggested by Stratton. Johnston (1975) found that the peer counselling program implemented by pilots in the United States, allows for early identification and early intervention of personal problems experienced by pilots.

In order to determine if peer counselling is a legitimate alternative to mental health professionals, it is necessary to examine the literature on peer counselling that is outside the police community.

Luborsky, Averbach, Chandler and Cohen (1971) investigated some of the factors that influence the outcome of psychotherapy. They found that therapist's empathy is a strong determinant in facilitating positive client change. Furthermore, Luborsky, Averbach, Chandler and Cohen (1971) also found that a similarity between therapist and client in "social class, interests, values and compatibility of orientation to interpersonal relations" (p.153) enhances the therapeutic outcome. This study also demonstrates that it is not necessary for the therapist to have experienced the same difficulty as the client in order to achieve a successful outcome.

Devol (1976) suggests that level of training is not related to the effectiveness of crisis intervention counselling. Devol believes that life experience of a counsellor who has a similar cultural background to the client would "offset the value of formal educational achievement" (p.31).

In Devol's study (1976) counselling effectiveness was investigated using Tucker's Client-Post Rating Scale Revised as an outcome measure. Counselling was limited to a maximum of three months. The presenting problems of the clients were symptoms of disorganization, depression and acute anxiety in response to a situational crisis.

Devol's (1976) study compares professional educated counsellors with non-educated counsellors. Devol reported a correlation coefficient of 0.00 between level of counsellor education and Tucker's Client-Post Rating Scale Revised. This indicates there is little if any correspondence between the educational level of the counsellor and how well the client rates his or her therapy experience with the counsellor.

Durlak (1979) reviewed 42 studies that compare professional counsellors to paraprofessional counsellors as they effect therapeutic outcome. Paraprofessionals achieve equal or significantly higher

results than professionals. Durlak (1979) states
"professional mental health education, training and
experience do not appear necessary prerequisites for an
effective helping person" (p.85).

Durlak (1973) found that of 300 references he
reviewed that pertain to "selection, training and
functioning of nonprofessional mental health personnel"
(p.30), only 6 references report negative results
concerning nonprofessional mental health professionals.

According to Durlak (1973) there is no support
that the non-professional counsellor will hurt their
clients therapeutic outcome more frequently than
professional counsellors. Durlak (1973) cites Carkhuff
& Truax, 1965; Ludwig & Max, 1969; Rioch, Elkes, Flint,
Usdansky, Newman & Silber, 1963, who found that 3
clients out of 151 treated by non-professionals
exhibited negative changes following treatment. Durlak
(1973) has found no studies that show lay persons have
been "significantly" inferior to professionals. He
also reports that with a small amount of training, non-
professionals can acquire high levels of empathy,
warmth and genuineness.

Therapist's empathy, unconditional positive regard
and genuineness are good indicators of therapeutic
outcome (Rogers, 1957; Truax & Lister, 1970). Carkhuff

and Truax (1965) report that lay counsellors can acquire high levels of empathy, unconditional positive regard and genuineness in less than 100 hours of training. In Carkhuff's and Truax's (1965) study they used lay counsellors to lead group sessions. The lay counsellors received less than 100 hours of training in empathy, unconditional positive regard and genuineness. The clients that comprised the groups, all clients were institutionalized, suffered from manic-depression, schizophrenia, psychoneurotic anxiety reaction, sociopathic personality disturbances, passive aggression and transient adult situational personality.

At the conclusion of Carkhuff's and Truax's (1965) study, it was found that all patients treated by lay counsellors had improved significantly compared to the control group.

According to Carkhuff (1968) lay counsellors function equal to or better than professionals in providing positive client change. He believes lay counsellors can help clients improve significantly even if they are "normals, situationally distressed or otherwise" (p.119). Carkhuff (1968) cites the following six reasons as to why he believes lay counsellors have advantage over professional counsellors:

a)   The increased ability to enter the
       milieu of the distressed.

b)   The ability to establish a peer-like
       relationship with the needy.

c)   the abilities to take an active part in
       the client's total life situation.

d)   the ability to empathize more
       effectively with the client's style of
       life.

e)   the abilities to teach the client, from
       within the clients form of reference,
       more successful actions, and

f)   the ability to provide clients with more
       effective levels of functioning within
       the social system (p.121-122).

Carkhuff (1968) argues that training inhibits the professional from exercising the above six points. Carkhuff calls into question the intention of the "prospective professional helper" compared to that of the lay counsellor.

The studies referred to so far make many statements that are in favour of peer counselling. However, none of these studies discuss specific counselling interventions that may be necessary for specific problems. The following literature is reviewed to examine this issue. Russell and Wise's (1976) study, in part, examines the effectiveness of professionals and paraprofessionals using cue controlled relaxation to treat speech anxiety. The

three professionals were Ph.D. psychologists who were compared to three undergraduates (paraprofessionals) with no counselling experience. Russell and Wise (1976) trained the professionals and paraprofessionals in the use of systematic desensitization and cue controlled relaxation.

Russell and Wise (1976) found that the paraprofessionals were as effective as professionals in reducing the speech anxiety. The paraprofessionals proved equally effective as the professionals in systematic desensitization and cue controlled relaxation.

Desensitization is used for treating a variety of psychological problems. Therefore, Russell's and Wise's (1976) study has far reaching implications about the use of paraprofessionals who are trained in such procedures.

Lick and Heffler (1977) investigated which of two relaxation methods was most effective in treating severe insomniacs. The two relaxation methods used in the study were muscle relaxation and muscle relaxation accompanied by a tape. These two methods were compared to a placebo and no treatment group. The two relaxation methods proved superior to the placebo and control group. Lick and Heffler (1977) also found that

relaxation training was an effective method of treating most aspects of insomnia.

However, of particular interest in Lick's and Heffler's (1977) study is that the therapist was an undergraduate student trained in teaching relaxation. The undergraduate, a non-professional, proved effective in this study.

Peer counsellors have also proven to be effective in crisis situations and while working with suicide prone people.

Tucker and Canton (1975) found that peer counsellors can be empathic and non-judgmental with suicide attempters and therefore "provide a non-threatening therapeutic experience" (p.428).

Getz, Fujita and Allen (1975) examined the effectiveness of paraprofessionals performing single session counselling in an emergency room of a hospital. Eighty-one percent of the clients who experienced depression, anxiety, family discord or suicide proneness, described the paraprofessional counsellors as helpful or very helpful. However, only thirty-one percent of those with psychosis or drug abuse described the paraprofessional as helpful. Follow-up inquiries showed long lasting positive effects on the clients who

received paraprofessional counselling (Getz, Fujita and Allen, 1975).

Getz, Fujita and Allen (1975) suggest that their study indicates that paraprofessional crisis counselling at the correct time may have positive long lasting effects on problems such as depression, anxiety, family discord and suicidal problems.

Furthermore, Getz, Fujita and Allen (1975) found that paraprofessional counsellors accurately assessed the severity of problems. When necessary, paraprofessional counsellors made referrals to the most appropriate agency or person (Getz, Fujita and Allen, 1975).

Aside from making proper and precise referrals, Zwiberman and Hinrichsen (1977) found that peer counsellors realize their own limitations and tend not to counsel in areas where they do not have adequate knowledge. Zwiberman and Hinrichsen (1977) observed that peer counsellors who had received special training in human sexuality problems referred clients who presented problems that did not involve human sexuality.

Non-professional counsellors work effectively in the field of marriage counselling (Harvey, 1964). Harvey (1964) reports that in Australia, New Zealand

and Great Britain, marriage counselling services are staffed by lay counsellors.

As well as peer counsellors helping their clients resolve problems, it would appear the peer counsellors may also receive benefit from the counselling process (Kahn & Fua, 1985). Kahn & Fua (1985), in a study examining alcohol counselling by peers, found that the counsellors also received therapeutic value by helping their peers. Kahn & Fua (1985) cite Kahn and Stephen (1981) who found in a study of American alcoholics, that peer counsellors had continued sobriety, improved interpersonal skills and improved career functioning. In studies by Kahn & Fua (1985) and Kahn and Stephen (1981), the peer counsellors reported increases in self-esteem and sense of adequacy.

Peer counsellors are frequently more accepted by clients than are mental health professionals (Tucker and Canton, 1975). Tucker and Canton (1975) cite Mechanick et al. (1969) who found that peer counsellors are more approachable than professional counsellors. People who felt their concerns were trivial were far less reluctant to approach peer counsellors than professional counsellors (Tucker and Canton, 1975). An implication from Tucker and Canton's (1975) study is

that peer counselling has the possibility of being preventative rather then remedial.

Lamb and Clack (1974) found that college students, during orientation, were equally impressed with peer and professional counsellors. However, a disproportionately high number of clients who were initially exposed to the peer counsellors, sought further counselling from the peers (Lamb & Clack, 1974).

It would be irresponsible to conclude that peer counsellors can handle all problems and that professional counsellors are not required. Professional counsellors are required for counselling difficult cases, and for teaching peer counsellors specific skills. However, even when the professional counsellor is required, this does not mean the peer counsellor is not required. Gruver (1971) cites Reiff, 1967; Pearl and Riessman, 1965 who believe that non-professionals make a valuable link between the client and the professional. Gruver (1971) states, "To be an effective bridge the non-professional must be indigenous of the target population and speak the vernacular of both the target population and the professional" (p.111).

Summary of Literature Review

Police officers experience a variety of psychological problems (Somodevilla, 1978; Alkus & Padesky, 1983). Those providing police officers with counselling services include pastoral counsellors, psychiatrists, psychologists and peer counsellors (Stratton, 1977; Depue, 1979; Reiser, 1986; Klyver, 1983).

Pastoral counselling was the first formal counselling service offered to police officers (Depue, 1979). However, police officers required other sources of counselling to meet their needs (Depue, 1979).

Police officers prefer to use in-house mental health professionals as opposed to outside mental health professionals (Kroes, 1976). It is indicated in the literature that police officers trust in-house mental health professionals more than they trust outside mental health professionals (Kroes, 1976). In-house mental health professionals are more sensitized to police issues and problems, and therefore are more effective than their counterparts outside the police department (Kroes, 1976).

It is indicated in the literature that police officers prefer peer counselling over any other source of counselling (Blackmore, 1978). As well, there is

literature, outside the police milieu, in which peer counselling is reported to be an effective method of counselling (Durlak, 1979).

The premise that police officers prefer peer counselling over any other source of counselling is based largely on the belief that police officers distrust mental health professionals (Alkus & Padesky, 1983). However, no previous studies were located in which this premise was empirically tested.

This study is designed to add information about the following four points:

1) whether the problems experienced by members of Police Force X are similar to those cited in the literature about United States police force members.

2) the extent to which those problems exist in Police Force X.

3) the sources of counselling preferred by the members of Police Force X for each problem.

4) the acceptability of peers as a source of counselling for the problems identified.

Chapter III

METHODOLOGY

This chapter describes the population, sample, instrument, procedure and analysis of data used in this study.

Population

Police Force X is responsible for all police duties within a geographical area of approximately 120 square kilometers, populated by approximately 500,000 people. The population includes a variety of different ethnic, and socio-economic groups.

The rank structure of Police Force X, which includes approximately 1000 police officers, is hierarchial: the lowest rank is Constable, followed in ascending order by supervisors holding the rank of Corporal (the rank of Detective is on par with Corporal), Sergeant, Staff Sergeant, Inspector, Superintendent, Deputy Chief Constable and Chief Constable. Police officers holding the rank of Inspector or higher are commissioned (approximately 4% of the force); the remainder are non-commissioned.

Approximately 66% of the members hold the rank of Constable, approximately 30% of the members hold the rank of Corporal, Detective, Sergeant or Staff

Sergeant. Six percent of the members of Police Force X are female; of which one and one half percent are supervisors. There are no females who hold the rank of Inspector or above.

The request for the study was received from the Union of Police Force X. It was the desire of the union that the study only involve its members. Therefore, respecting this request, the population was restricted to include only the noncommissioned officers of the force. Further, to protect the anonymity of Police Force X, exact numbers describing the force are not mentioned.

Sample

A single stage sample design was used in which 200 non-commissioned police officers were randomly selected from the approximate 900 non-commissioned officers comprising the force. Each non-commissioned officer was assigned a number and then the selections were made using a prepared table of random numbers (Shavelson, 1981, pp.637-638). The target sample size was 100 members (approximately 10% of the population). However, based on response rates for mail surveys similar to the present one, the population was oversampled so that 200 non-commissioned police officers were actually selected.

Instrument

A questionnaire (Appendix A) was constructed to identify the problems experienced by members and the relative frequency of occurrence of those problems, and to establish the preferred source of counselling assistance for each problem.

The questionnaire was divided into four parts. Part I involved a needs assessment in which officers were asked to indicate the prevalence of a list of 15 problems from each of three different perspectives - officers in general, their ten closest officer friends and then themselves. The 15 problems supplied in the needs assessment were identified from a review of literature. The first perspective (see page 2, Appendix A) is concerned with the frequency of problems based on the member's overall impression of police officers. Members were asked to rank in order the 15 problems identified. The most frequent problem was ranked number 1 and the least frequent problem was ranked 15. For the second perspective (see page 3, Appendix A) of the needs assessment, respondents were asked to specify how many of their ten closest colleagues on the police force were experiencing or had experienced each of these 15 problems. Finally in the third perspective (see page 4, Appendix A) respondents

were asked to indicate if they personally were
experiencing or had experienced each of the 15
problems. The three perspectives of the needs
assessment were included to provide a cross-validation
of the accuracy of reporting by respondents.

Since the supplied list of problems may not have
been comprehensive and exhaustive for each respondent,
an open ended question (see bottom of page 4,
Appendix A) was added in which respondents were invited
to list any additional problems that they have
experienced themselves or that they knew other members
to have experienced.

Part II of the questionnaire (see page 5 and 6,
Appendix A) was concerned with the officers' preference
for source of counselling. Five sources, outside
psychiatrist and psychologist, in-house psychologist,
psychologist on retainer, religious leader, and peer
counsellor were identified from the review of
literature. Prior to the respondents selecting a
source of counselling they were provided with a
description of the counselling sources (see page 5,
Appendix A). Respondents were asked to select the
source of counselling they most preferred for each of
the 15 problems presented in Part I. This part
concluded with an open ended question (see page 7,

Appendix A) to allow respondents to list additional counselling sources not included in the original list of five.

The third part of the questionnaire (see page 8, Appendix A) was directed toward preliminary considerations preparatory to the implementation of a peer counselling program. Those questions were developed by union officials (executives) and were included upon their request. The union officials believed that, as suggested in the literature, peer counselling would be the most preferred source of counselling by police officers. Given this belief, the union requested information about each respondent's willingness to be a peer counsellor, and at which rank (eg. higher, lower, same or does not matter, in relation to the respondent) each member preferred peer counsellors to be.

In Part IV (see page 9, Appendix A) of the questionnaire respondents were asked to indicate their gender, age, rank (supervisor or not), years of service and marital status, At the request of the Union further bio-demographic information was not requested (i.e. socio-economic status and number of children per respondent).

Procedure

Packages containing a cover letter, questionnaire and an addressed return envelope were mailed to each selected officer using the police force's in-house mail system. The cover letter (see Appendix A), signed by the Chairman of the Health and Safety Committee of the union of Police Force X, explained the purpose of the study and asked the selected members to complete and return the enclosed questionnaire in the envelope provided. In the introduction to the questionnaire (see Appendix A), the purpose of the study was briefly described and respondents were asked to return the questionnaire in the supplied self-addressed envelope to the Union Office via the in-house mail system.

Within two weeks of the administration of the questionnaire, 97 completed questionnaires were returned. Since the union of the participating force requested that all members receiving questionnaires remain anonymous, it was not possible to keep track of the officers who had or had not returned the questionnaire. Therefore, individual follow-up was not possible. Instead, at the end of the second week following the initial administration of the questionnaire, a follow up letter (Appendix B) was sent through the in-house mail system to each member in the

original sample. In this follow-up letter, signed by the Union Chairman of Health and Safety, each member was asked to answer the questionnaire and return it completed to the Union Office if they had not already done so. Further, the letter advised members that if they had misplaced or lost the questionnaire, another copy could be picked up at the Union Office. Within ten days of the follow-up letter being mailed, eighteen additional completed questionnaires were returned. Thus, altogether 115 completed questionnaires were received.

Analysis of Data

Each questionnaire was examined to ensure that it was filled in completely and correctly, and to check for responses to each of the two open-ended questions. Of the 115 returned questionnaires, three respondents did not completely answer the first section of Part I (see pages 2, Appendix A); all other questions were answered completed. Therefore, for the first section of Part I, analysis was based upon the information of 112 respondents; the remaining sections analysis was based upon the information of 115 respondents.

Examination of the first of the two open ended questions led to the identification of a 16th problem. The 16th problem was classified as 'poor relationship

with peers'. A common response to the second open ended section was that a financial counsellor would be beneficial for members who experience financial difficulties.

The data from the questionnaires were entered onto Fortran Coding Forms, and then entered into a computer file. The complete file was then checked for accuracy against the original questionnaires. Four errors (0.051%) were found and corrected.

The Condescriptive command of the Statistical Package For the Social Sciences (S.P.S.S.) (Lai, 1986) was used to obtain summary statistics. Frequencies, percentages, means and standard deviations were used to describe the frequency of problems in the three perspectives of the needs assessment.

To test the consistency found in the three perspectives of Part I, the items of each perspective were re-ranked and Spearman's rho was calculated for each pair of perspectives. In the case of the overall impressions and ten closest police colleagues (first and second perspective) the mean rank was used as the item score from which new ranks were assigned, while for the third perspective the affirmative response was used as the item score from which new ranks were assigned. Frequencies, percentages and modes were

obtained to describe the preferred sources of counselling, as well as to describe Part III which dealt with considerations for implementation of peer counselling. Frequencies, percentages, and means were used to summarize the demographic data obtained from Part IV of the questionnaire.

All analyses were completed using the Amdahl 470/V8 computer located at the UBC Computer Sciences Centre.

Chapter IV

RESULTS

The results are presented in four parts. The first part describes the characteristics of the sample. In the second part the results of the needs assessment, are presented including overall impressions, ten closet police colleagues and self report (see pages 2, 3, 4, Appendix A). The results of the respondents preference for sources of counselling are presented in part three. Finally, in the fourth part is described the respondents' willingness to be a peer counsellor, and at which rank members preferred peer counsellors to be.

Characteristics of the Sample

Response Rate

Two hundred questionnaires were mailed to the officers through the in-house mail system, 115 of these were returned. This represents a 57.5% return rate. All of the 115 returned questionnaires were usable, however, three respondents failed to complete the first question.

Bio-demographics

The bio-demographics of the sample are listed in Table 1.

Table 1

<u>Characteristics of the Sample</u>

<u>Respondents' gender:</u>   112 males   3 females

<u>Total number of respondents:</u>   115

	No. of respondents	% of respondents
Age: 19-24	1	.9
25-30	22	19.1
31-36	38	33.0
37-42	35	30.4
43-48	9	7.8
49-54	8	7.0
55 years or over	2	1.7

<u>Supervisor:</u>   No = 74 (64.3%)   Yes = 41 (35.7%)

Years of Service	No. of respondents	% of respondents
Less than 3.5 yrs	6	5.2
3.5- 6.4	5	4.3
6.5- 9.4	22	19.1
9.5-12.4	19	16.5
12.5-15.4	24	20.9
15.5-18.4	19	16.5
18.5-21.4	6	5.2
More than 21.4 yrs	14	12.2

Marital Status:	No. of respondents	% of respondents
Single	12	10.4
Married	77	67.0
Separated	5	4.3
Divorced	4	3.5
Remarried	16	13.9
Widower	1	.9

As shown in Table 1 three (2.6%) of the 115 respondents were female. The under representation of female officers is ascribed to a low response rate by female officers.

The largest number of respondents (38 respondents or 33.0%) were between 31 and 36 years of age and had between 12.50 and 15.4 (24 of the respondents or 20.9%) years of service.

Seventy four (64.3%) of the respondents were constables and forty-one (35.7%) of the respondents were supervisors. This is approximately the same ratio of constables to supervisors as found in the population.

Finally, as shown in Table 1, the largest number of respondents (77 respondents or 67.0%) were married.

Needs Assessment

As discussed in the previous chapter, needs assessment was established from three perspectives; these perspectives were titled, 'overall impression', 'ten closest police colleagues' and 'self report'.

The data for 'overall impression' (see page 2, Appendix A) are presented in Table 2.

Table 2

Percentage and Mean Ranking for Problem Type

Ranking

Problems

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Mean	S.D.
Alcohol Abuse	42.9	16.1	9.8	7.1	5.4	5.4	3.6	3.6	2.7	1.8	0.0	0.9	0.0	0.9	0.0	3.107	2.794
Anxiety	14.3	15.2	13.4	8.9	7.1	8.0	5.4	6.3	6.3	2.7	2.7	3.6	3.6	0.9	1.8	4.973	3.794
Boredom	0.0	3.6	7.1	11.6	11.6	8.0	5.4	8.9	8.9	1.8	4.5	8.0	10.7	5.4	5.4	8.214	3.986
Depression	0.9	7.1	10.7	8.9	11.6	8.9	8.9	8.0	8.9	5.4	8.9	2.7	4.5	3.6	0.9	7.250	3.497
Drugs (illegal)	0.0	0.0	0.0	0.0	0.0	0.9	0.9	0.9	0.9	4.5	3.6	6.3	10.7	19.6	51.8	13.767	3.497
Drugs (prescribed)	0.0	0.0	0.9	4.5	3.6	1.8	0.9	2.7	5.4	5.4	6.3	12.5	15.2	35.7	5.4	11.750	1.855
Alienation	6.3	4.5	5.4	11.6	11.6	10.7	10.7	5.4	7.1	9.8	8.9	5.4	2.7	0.0	0.0	6.776	3.293
Financial	5.4	1.8	15.2	9.8	8.9	6.3	9.8	11.6	8.9	7.1	3.6	8.0	0.0	3.6	0.0	6.750	3.405
Freq. Headaches	0.0	3.6	1.8	3.6	5.4	2.7	2.7	5.4	7.1	17.0	14.3	17.0	12.5	3.6	3.6	9.919	3.199
Marital	19.6	33.9	9.8	7.1	6.3	3.6	4.5	8.0	0.9	0.0	2.7	0.9	0.9	0.9	0.9	3.857	3.157
Parenting	0.9	10.0	1.9	5.4	6.3	8.0	9.8	7.1	8.0	12.5	11.6	12.5	7.1	4.5	4.5	9.303	3.213
Sexual Dysfunction	0.0	0.9	0.9	1.7	1.7	6.1	4.5	2.7	6.3	5.4	8.0	8.9	20.5	11.6	20.5	11.616	3.269
Sleep	4.5	7.1	6.3	8.9	3.6	11.6	10.7	10.7	10.7	12.5	1.8	4.5	3.6	2.7	0.9	7.133	3.431
Stomach	2.7	2.7	8.0	4.5	2.7	8.0	13.4	11.6	11.6	5.4	11.6	7.1	4.5	5.4	0.9	8.160	3.432
Aggression	0.9	2.7	8.9	6.3	15.2	9.8	8.9	8.0	7.1	8.9	10.7	4.5	2.7	2.7	2.7	7.571	3.384

N = 112

Note.   The percentage of members for each ranking of
a problem is presented in Table 2. Number 1
ranking is most frequent problem and Number
15 is least frequent problem.

As shown in Table 2, five of the fifteen problems (alcohol abuse, marital problems, anxiety, financial problems and feelings of alienation) received a mean rank of 6.77 or less making them the most frequent problems cited. The five least frequent problems cited (illegal drug abuse, drug abuse of prescribed drugs, sexual dysfunction, frequent headaches and problems with parenting skills) received a mean rank of 9.30 to 13.76.

The data for 'ten closest police colleagues' (see page 3, Appendix A) are presented in Table 3.

Table 3

Mean Number of Colleagues by Problem Type[1]

Problems	X̄ number of Colleagues	S.D.
Alcohol Abuse	3.409	2.376
Anxiety	3.087	2.634
Boredom	2.704	2.388
Depression	2.557	2.542
Drugs (Illegal)	0.043	0.308
Drugs (Prescribed)	0.400	1.007
Alienation	2.470	2.624
Financial	3.487	2.604
Freq. Headaches	1.313	1.651
Marital	4.322	2.716
Parenting	1.513	2.378
Sexual Dysfunction	0.661	1.622
Sleep	3.026	3.004
Stomach	2.513	2.486
Aggression	2.374	2.206

N = 115

[1]Number of Colleagues out of 10 who have experienced or are experiencing problems.

Four of the most frequent problems (marital problems,
financial problems, alcohol abuse and anxiety) are the
same as the four most frequent problems found in the
first perspective. Further, the five least frequent
problems (illegal drug abuse, drug abuse of prescribed
drugs, sexual dysfunction, frequent headaches and
problems with parenting skills) are the same as the
five least frequent problems found in the first
perspective.

Lastly, the data for 'self report' (see page 4,
Appendix A) are presented in Table 4.

Table 4
Self Report
Frequency and Percent of Members self-reporting
Specific Problems (N=115)

Problems	# Resp. YES	% Yes	α	# Resp. NO	% No
Alcohol Abuse	35	30.4	8	80	69.6
Anxiety	78	67.8	1	37	32.2
Boredom	55	47.8	4	60	52.2
Depression	56	48.7	3	59	51.3
Drugs (Illegal)	1	0.9	15	114	99.1
Drugs (Prescribed)	3	2.6	14	112	97.4
Alienation	46	40.0	6	69	60.0
Financial	53	46.1	5	62	53.9
Freq. Headaches	30	26.1	10	85	73.9
Marital	55	47.8	4	60	52.2
Parenting	12	10.4	13	103	89.6
Sexual Dysfunction	13	11.3	12	102	88.7
Sleep	66	57.4	2	49	42.6
Stomach	45	39.1	7	70	60.9
Aggression	34	29.6	9	70	70.4
Peer Problems	16	13.9	11	99	86.1

α – Position Ranked

Note: Percentage of members who have or currently
are experiencing the problems listed.

As shown in Table 4 the four most frequent
problems respondents report experiencing or having
experienced were anxiety, sleep disturbances,
depression and marital problems and boredom. Marital
problems and problems of boredom attracted the same
number of responses. A sixth problem, financial
problems also was cited by over one-half of the members
surveyed (53%). Of the four most frequent problems
found in this perspective, only anxiety and marital
problems correspond with the four most frequent
problems in the first and second perspective. The two
least frequent problems that members report
experiencing or having experienced are illegal drug
abuse and drug abuse of prescribed drugs. These
correspond with the least frequent problems found in
the first and second perspective of the needs
assessment.

Consistency of the Needs Assessment

To examine the consistency amongst the three
perspectives of the needs assessment, the data was re-
ranked as described in previous chapter. That is the
means of perspectives one and two (overall impression
and ten closest police colleagues) were reranked as
were the affirmative responses of perspective three

Table 5

Consistency Amongst Perspectives

Perspectives 1 and 2

A J B H G M D O N C K I L F E   1

Spearman
*Rho = .91

J H A B M C D N G O K I L F E   2

Perspectives 2 and 3

J H A B M C D N G O K I L F E   2

Spearman
*Rho = .81

B M D J C H G N A O I L K F E   3

Perspectives 1 and 3

A J B H G M D O N C K I L F E   1

Spearman
*Rho = .74

B M D J C H G N A O I L K F E   3

where:

A = Alcohol Abuse
B = Anxiety
C = Boredom
D = Depression
E = Drug Abuse (illegal)
F = Drug Abuse (prescribed)
G = Feelings of Alienation

H = Financial Problems
I = Freq. Headaches
J = Marital Problems
K = Problems with Parenting Skills
L = Sexual dysfunction
M = Sleep disturbances
N = Stomach Problems
O = Uncalled for aggression

Perspective 1 is: Overall Impression
        2 is: Ten Closest Police Colleagues
        3 is: Self Report

*p < .05

(self report) and a Spearman rank correlation
(Shavelson, 1981, p.208) was calculated for each pair.
Table 5 graphically shows the relationship amongst the
three perspectives. As well, Spearman rank
coefficients are provided in Table 5.

As shown in Table 5 the Spearman rank correlation
coefficient was high for the relationships between
perspectives. Thus, there was a high degree of
consistency across the three perspectives. Between
perspective one and two (rho=.91) agreement was
particularly high between the four most frequent
problems and the five least frequent problems.

As for the relationship between perspectives one
and three (rho=.74) the agreement was high between the
five least frequent problems.

Finally, as shown in Table 5 the agreement between
perspectives 2 and 3 (rho=.81) was particularly high
between the six least frequent problems.

Preferred Sources of Counselling

Shown in Table 6 are the sources of counselling
members preferred most for each of the fifteen problems
are presented. The sources of counselling from which
the members could select were outside psychiatrist or
psychologist, in-house psychologist, psychologist on
retainer, religious leader and peer counsellor.

Table 6

Source of Counselling

Percent of Members Preference for Counselling Source

According to Problem

Problems	A	B	C	D	E
Alcohol Abuse	51.3	12.2	7.8	0.9	27.8
Anxiety	47.8	20.9	11.3	5.2	14.8
Boredom	35.7	13.0	10.4	2.6	38.3
Depression	59.1	15.7	11.3	6.1	7.8
Drugs (Illegal)	67.8	12.2	5.2	4.3	10.4
Drugs (Prescribed)	68.7	12.2	5.2	3.5	10.4
Alienation	40.0	8.7	8.7	5.2	37.4
Financial	41.7	15.7	10.4	0.9	31.3
Freq. Headaches	73.0	14.8	7.8	0.0	4.3
Marital	58.3	16.5	11.3	7.0	9.6
Parenting	59.1	18.3	6.1	7.0	9.6
Sexual Dysfunction	87.0	7.8	2.6	0.9	1.7
Sleep	67.0	20.0	8.7	0.0	4.3
Stomach	69.6	19.1	8.7	0.0	2.6
Aggression	42.8	13.9	13.9	1.7	22.6

where:

      A = Outside Psychiatrist or Psychologist
      B = In-House Psychologist
      C = Psychologist on Retainer
      D = Religious Leader
      E = Peer Counselling

As shown in Table 6, with the exception of Boredom
and alienation the majority of members for each problem
selected outside psychiatrist or psychologist as the
source of counselling they most preferred. The
problems of Boredom and alienation were equally divided
between outside psychiatrist or psychologist and peer
counselling as the source of counselling they preferred
most.

Peer Counselling Selection

Respondents were asked if they were willing to be
peer counsellors, and at which rank in relation to
their own they preferred peer counsellors to be (see
page 8, Appendix A).

Of the 115 respondents, the majority of the
respondents 93 (80.9%) answered that they were willing
to act as peer counsellors. The remaining (22 or
19.1%) respondents answered that they were not willing
to be peer counsellors.

Seventy two (62.6%) respondents answered that if
they were to receive peer counselling it would not
matter which rank the peer counsellor held. Thirty
five (30.4%) respondents answered that if they were to
receive peer counselling, they would prefer the peer
counsellor to be the same rank as themselves.

Summary of Results

In summary, three main findings have been found in the results. Firstly, in perspectives one and two (overall impression and ten closest police colleagues) alcohol abuse, marital problems, anxiety that interferes with the enjoyment of life, and financial problems were reported by the respondents as the four most frequent problems. In perspective three (self report) anxiety that interferes with the enjoyment of life, sleep disturbances, depression, marital problems, and problems of boredom were reported by the respondents as the five most frequent problems. In perspective three marital problems and problems of boredom attracted the same number of responses. Secondly, the majority of members cited outside psychiatrist or psychologist as the preferred source of counselling for 13 of the 15 problems listed. As for the problems of boredom and alienation, the members were equally divided between outside psychiatrist or psychologist and peer counselling as the preferred source of counselling. Finally, the majority of members are willing to be peer counsellors and if they were to receive peer counselling the rank of the counsellor would not matter.

Chapter V

DISCUSSION AND SUMMARY

The questionnaire described in Chapter III was designed to gather information that after analysis would provide answers to the following research questions:

1) What problems do members of Police Force X perceive as being important to them?

2) To what extent do the members believe the problems exist in Police Force X?

3) For each problem, which source of counselling do members of Police Force X prefer?

4) To what extent do members of Police Force X prefer peer counselling?

Identification of Members' Problems

Perspectives one and two (overall impression and 10 closest police colleagues) of the needs assessment showed that respondents were in high agreement about which of the 15 presented problems were the four most frequent and the five least frequent. The four most frequent problems reported by the respondents who answered perspectives one and two were alcohol abuse,

anxiety that interferes with the enjoyment of life,
financial problems and marital problems.

Similar to Blackmore's (1978) findings, alcohol
and marital problems were rated as being frequent
problems. However, contrary to Somodevilla's (1978)
opinion, uncalled for aggression and headaches did not
figure prominently in perspectives one and two.

The five most frequent problems reported by
respondents in the self report perspective of the needs
assessment were anxiety that interferes with the
enjoyment of life, sleep disturbances, depression,
marital problems and boredom.

As suggested by Somodevilla (1978) members did
report, in the self report perspective, that marital
problems were frequent. However, contrary to
Somodevilla's (1978) opinion, officers did not report
displacement of aggression, headaches, gastrointestinal
problems, sexual problems, parenting problems or
psychosomatic problems as occurring frequently.

While alcohol abuse did not place within the five
most frequent problems in the self report perspective,
35 (30.4%) respondents did report that they do or did
have a problem with alcohol abuse. The percentage
(30.4%) of members who reported problems with alcohol

abuse is seven percent higher than reported in Blackmore's (1978) findings (23%) involving American police officers.

Further, the problem of poor relationship with peers was identified as a problem by 16 (13.9%) respondents. This problem has not been identified in any of the literature that was reviewed.

Hence, based on self report, respondents reported that anxiety that interferes with the enjoyment of life, sleep disturbance, depression, marital problems and boredom were the five most important problems. Whereas based on respondents overall impressions and 10 closest police colleagues, respondents reported that alcohol abuse, marital problems, anxiety that interferes with the enjoyment of life and financial problems were the most prevalent problems that exist in Police Force X.

From the three perspectives of the needs assessment one can see that perspectives one and two included alcohol abuse, marital problems, anxiety that interferes with the enjoyment of life and financial problems as the four most frequent problems. Perspective three overlaps with anxiety and marital problems, but differs with sleep disturbances and

depression. Beyond suspicion, it cannot be determined
which perspective supplies the most accurate
information. However, only speculative answers can be
hypothesized explaining why the four most frequent
problems in perspectives one and two differed from
perspective three. Members may have generalized their
knowledge of their closest colleagues problems to
include overall impressions of police officers; thus
accounting for the high agreement between perspectives
one and two. However, sleep disturbances, depression
and boredom may be too personal to reveal to friends,
therefore, while these appeared as frequent problems in
self report (perspective three), because they have been
kept private they did not appear with high frequency in
perspectives one and two (overall impressions and ten
closest police colleagues). It is possible that
members perceive that these problems show signs of
weakness in their masculine image (i.e. not able to
cope well with shift work or being suicidal).
According to Depue (1979) a masculine image is
important to many police officers, therefore, it is
possible that members keep private those problems that
they believe could reflect poorly upon their masculine
image.

Preference for Source of Counselling

The majority of respondents (80.9%) reported that after adequate selection and training they were willing to be peer counsellors. However, the majority of respondents for 13 of the 15 presented problems reported that if they were to receive counselling, they would most prefer to receive counselling from a psychiatrist or psychologist who was outside the police department. For Boredom and alienation, members were equally divided between outside psychiatrist or psychologist and peer counselling as the preferred source of counselling.

These results do not support the opinions of Blackmore (1978), Alkus and Padesky (1983), Depue (1979) and Donahue (1977) who proposed that American police officers distrust mental health professionals and prefer to speak with one another.

Without knowing the details which form the basis for Blackmore's (1978) et al. opinion, there are at least nine explanations as to why the results regarding preference for source of counselling do not support the opinions of Blackmore (1978) et al.

First, members may not wish to disclose problems
to fellow members whom they may eventually have to
compete against for promotion. Second, members may
fear that peer counselling or any other counselling
connected to the police department may lack
confidentiality. Third, members may feel more
comfortable with a mental health professional whom they
know is trained to help and who, out of professional
duty, will not betray confidentiality. Fourth,
examination of Blackmore's (1978) et al. publication
dates reveals that they are five to ten years old. It
is possible that police officers' attitudes towards
mental health professionals have changed since the
writing of those publications. Fifth, the problem of
poor relations with peers was identified in this study,
which is not a problem mentioned in the literature
reviewed. Thus, with this problem identified within
Police Force X, it is not surprising that the majority
of members did not select peer counselling as the
preferred source of counselling. Sixth, after an
extensive search of the literature, a questionnaire
concerning preference from source of counselling could
not be found. Hence, it is possible that the opinions
of Blackmore (1978) et al. do not accurately represent

the beliefs of American police officers; or members of
Police Force X have different preference for source of
counselling than those officers that had expressed
their preference to Blackmore (1978) et al. Seventh,
as shown in Tables 2 and 3 respondents perceive their
colleagues to be experiencing a variety of problems.
Therefore, it may be that members are reluctant to
receive counselling from peers because they may
intuitively disbelieve that a peer experiencing
problems can be of assistance. Perhaps after a large
percentage of members resolve manifested problems
(i.e., alcohol abuse) peer counselling will become more
attractive to members of Police Force X. The eighth
point is that American police officers can receive peer
counselling free of charge, whereas psychiatric and
psychological counselling can prove to be a financial
burden. However, in Canada psychiatric and
psychological counselling does not cost the client
money and therefore it is not a financial advantage for
members of Police Force X to use peer counselling.
Finally, it is possible that Blackmore et al. received
a positive response to peer counselling because the
members who expressed these feelings had a positive
experience with an established peer counselling

program. It is possible that if a peer program had been established in Police Force X a more favourable response would have occurred.

Practical Implications

Although no definitive conclusions can be drawn from this exploratory research study, several practical implications may be considered.

Members have indicated that they experience psychological problems and that if they were to receive counselling the majority of members would prefer to use a psychiatrist or psychologist who is outside the police department.

To increase the likelihood of members seeking psychological assistance, Police Force X may wish to consider publishing a manual that gives instructions to the members on how to access the services of mental health professionals. The manual may also include a list of psychiatrists and psychologists who have expertise in counselling certain problems and are familiar with the idiosyncrasies of police work.

It may be desireable to approach psychiatrists and psychologists who have special knowledge in counselling people who experience the most common problems presented by the members of Police Force X. While

maintaining their autonomy, these psychiatrists and psychologists could be familiarized with the nature of police work. Therefore, if Police Force X or the Union decided to familiarize psychiatrists and psychologists with policing, they should select psychiatrists and psychologists who are willing and knowledgeable to work with police officers who experience marital problems, alcohol abuse, anxiety that interferes with the enjoyment of life, depression, sleep disturbances and financial problems. It must be made clear to the members that those psychiatrists and psychologists identified are autonomous and it is not necessary to access their help through the police department.

Not all respondents selected outside psychiatrist or psychologists as the preferred source of counselling. Therefore, implementation of peer counselling should not be abandoned. As indicated earlier, peer counselling is an effective method of counselling (Reiser, 1986). As well, when required, peer counsellors can act as a bridge between the organization and mental health professional (Gruver, 1971). Therefore, establishing a small peer counselling group may prove worthwhile. For the peer counsellors to be accepted, as is the case for any

counselling service, confidentiality must be paramount
(Stratton, 1977). However, members who seek
counselling should be explicitly advised as to the
limitations of confidentiality i.e. where "clear and
imminent danger to physical safety" of others exists,
the counsellor must inform others (Eberlein, 1987,
p.2). Therefore, peer counsellors should be selected
who are trusted by the members, will maintain
confidentiality and yet will adhere to ethical rules.
Without Police Force X holding a competition for the
position of peer counsellor, the board of directors for
the union may be the best candidates.

Finally, it is possible that if members receive
counselling from outside mental health professionals
who are sensitive to police officers' needs, and peer
counselling becomes accepted, many of the members'
psychological problems may be reduced. Reduction of
psychological problems would have a positive impact on
the members, Police Force X and the public.

Limitations of the Study

There are four limitations with this study.
First, the problems listed in the questionnaire are
subject to interpretation by each respondent.
Therefore, the results that deal with problems should

be interpreted cautiously. For example, 30.4% of the respondents stated they have experienced problems with alcohol abuse. This should not be interpreted that 30.4% of the respondents are alcoholics. Each respondent likely has a different operational definition for each problem.

Second, the intensity of the problems have not been addressed by this research. Therefore, the results that deal with problems should be interpreted cautiously. For example, depression has many different levels of intensity, ranging from mild discomfort or sadness to self destructive behavior. This study does not distinguish these differences that are found within each problem.

Third, Financial Consultant was not included in the list of counselling sources. It is likely the majority of respondents would have selected Financial Consultant as the preferred source of counselling for financial problems.

Finally, the results of this study only apply to the members of Police Force X. These results should not be generalized to include police officers who are members of a different force.

Suggestions for Further Research

Further research should establish the problems experienced by female police officers. As well, the etiology and intensity of problems experienced by both male and female police officers should be studied. Learning the etiology of problems may provide answers as to how best resolve or prevent the problems.

Police officers who have received counselling from different sources should be surveyed to establish their preference for source of counselling and how they arrived at that decision. This information could then be used to strengthen existing counselling programs.

Blackmore (1978), Stratton (1977), and Alkus and Padesky (1983) argue that police officers' psychological and physiological difficulties are often attributable to policing. Research should be conducted to empirically test this position, for other factors (i.e. police officers tend to be in their early 20's when they begin their career, and therefore may experience problems that result from developmental issues) may be impacting on the psychological and physiological health of police officers. Finally,

cultural differences between Canadian and American police officers should be explored. It is possible that police officers' attitudes towards psychological problems, counselling, relationships, and work may be culturally determined.

Summary

Police officers from Police Force X experience a variety of psychological problems, some of which are the same as those reported by Blackmore (1978).

The majority of respondents indicated that if they were to receive counselling their preferred source would be an outside psychiatrist or psychologist. This finding differs from the opinion held by Blackmore (1978) who reported that American police officers prefer peer counselling over any other source of counselling.

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Appendix A

Cover letter

Introduction

Questionnaire

Questionnaire Cover Letter to
Members of Police Force X

Dear Member:

The Union is currently undertaking research with the view to establishing some form of Confidential Members Assistance Program in addition to and independent from that offered by the Department.

In order to identify the most appropriate assistance program the following questionnaire has been designed by one of our members in cooperation with the Department of Graduate Studies, University of British Columbia.

The questionnaire is <u>totally</u> confidential and voluntary. The administering of this questionnaire has been sanctioned by the department.

I would ask that you truthfully respond to the questions and add any suggestions/criticisms you may have. Clearly your support in this matter will ensure that a truly beneficial and vital program will be established for you. Your input counts.

Once again, thank you for your help.

Yours truly,

Chairman
Health & Safety Committee
Union

Introduction

The purpose of this questionnaire is to gather information about the nature of possible concerns and problems which police officers may encounter and the types of counselling services they believe would be useful to members experiencing such problems.

The questionnaires have been sent to 200 members randomly selected so as to represent the Police Department. Participation in this questionnaire is strictly voluntary. Please do not enter your name or number on the questionnaire or return envelope; anonymity is guaranteed. Only group results will be reported.

The questionnaire requires approximately 20 minutes to answer. Please use the in-house mail to return your questionnaire in the supplied envelope.

Part I   <u>Concerns and Problems</u>

1. Many studies have been conducted that show police officers may experience personal problems and concerns. Most of these studies have been conducted in the United States. Therefore they may or may not be applicable to this Police Department.

The concerns that have been reported most frequently are presented below in alphabetical order. Based on your overall impression of police officers, please rank order these problems in terms of their frequency of occurrence. Give the rank of 1 to the most frequent problem, followed by 2, with least being ranked as 15.

<u>Rank</u>

(a) Alcohol Abuse   _____

(b) Anxiety that interferes with the enjoyment of
     life   _____

(c) Boredom   _____

(d) Depression   _____

(e) Drug Abuse (illegal drugs)   _____

(f) Drug Abuse (prescribed drugs)   _____

(g) Feelings of Alienation (alone, no one there
     for emotional support)   _____

(h) Financial problems   _____

(i) Frequent headaches   _____

(j) Marital problems   _____

(k) Problems with Parenting Skills   _____

(l) Sexual dysfunction   _____

(m) Sleep disturbances (ie. insomnia)   _____

(n) Stomach problems (e.g. stomach aches,
     ulcers, constipation)   _____

(o) Uncalled for aggression   _____

2. Think of 10 specific police <u>colleagues</u> whom you feel you are closest to, or with whom you are most familiar. Of those 10 colleagues please list how many you believe have experienced or are currently experiencing difficulties with the following; (note: your answer will range from 0 to 10 for <u>each</u> problem depending on how many of your colleagues are experiencing difficulty.)

Number of
colleagues
<u>experiencing</u>

(a) Alcohol Abuse _____

(b) Anxiety that interferes with the enjoyment of life _____

(c) Boredom _____

(d) Depression _____

(e) Drug Abuse (illegal drugs) _____

(f) Drug Abuse (prescribed drugs) _____

(g) Feelings of Alienation (alone, no one there for emotional support) _____

(h) Financial problems _____

(i) Frequent headaches· _____

(j) Marital problems _____

(k) Problems with Parenting Skills _____

(l) Sexual dysfunction _____

(m) Sleep disturbances (ie. insomnia) _____

(n) Stomach problems (e.g. stomach aches, ulcers, constipation) _____

(o) Uncalled for aggression _____

3. Please indicate with a check (   ) which of the following problems [and/or] concerns you have experienced [and/or] are experiencing.

                                                                    Check

(a) Alcohol Abuse   _____

(b) Anxiety that interferes with the enjoyment of
     life   _____

(c) Boredom   _____

(d) Depression   _____

(e) Drug Abuse (illegal drugs)   _____

(f) Drug Abuse (prescribed drugs)   _____

(g) Feelings of Alienation (alone, no one there
     for emotional support)   _____

(h) Financial problems   _____

(i) Frequent headaches   _____

(j) Marital problems   _____

(k) Problems with Parenting Skills   _____

(l) Sexual dysfunction   _____

(m) Sleep disturbances (ie. insomnia)   _____

(n) Stomach problems (e.g. stomach aches,
     ulcers, constipation)   _____

(o) Uncalled for aggression   _____

4. Please write down any problems that you have experienced [and/or] you know other officers have experienced, which are not included in the above list. (Use as much space as required, if necessary use space on the back of this page).

    A. _____

    B. _____

    C. _____

Part II   Counselling Services

The following are a number of different methods of Counselling. In each instance confidentiality is assured.

(A)   Outside Psychiatrist or Psychologist
        You meet with your family physician who refers you to a psychiatrist or psychologist.

(B)   In House Psychologist
        You meet with a psychologist employed in the Department.

(C)   Psychologist on Retainer
        You meet with a psychologist to whom you have been referred by a member of the Department.

(D)   Religious Leader or Church Elder
        You meet and speak with a religious leader or church elder of your choice.

(E)   Peer Counselling
        You meet with a fellow police officer trained in counselling and available to help upon request.

1.   Which of the above methods of counselling would you prefer to use for each of the problems and concerns listed on the next page. Please select one method of counselling per problem [and/or] concern. Indicate the method by placing the letter for that method in the blank; e.g. If you select religious leader for a problem, place the letter "D" in the corresponding answer space.

Method of Counselling: (A) Outside Psychiatrist or Psychologist, (B) In House Psychologist, (C) Psychologist on Retainer, (D) Religious Leader, (E) Peer Counselling.

		Method of Counselling Preferred
(a)	Alcohol Abuse	_____
(b)	Anxiety that interferes with the enjoyment of life	_____
(c)	Boredom	_____
(d)	Depression	_____
(e)	Drug Abuse (illegal drugs)	_____
(f)	Drug Abuse (prescribed drugs)	_____
(g)	Feelings of Alienation (alone, no one there for emotional support)	_____
(h)	Financial problems	_____
(i)	Frequent headaches	_____
(j)	Marital problems	_____
(k)	Problems with Parenting Skills	_____
(l)	Sexual dysfunction	_____
(m)	Sleep disturbances (ie. insomnia)	_____
(n)	Stomach problems (e.g. stomach aches, ulcers, constipation)	_____
(o)	Uncalled for aggression	_____

2. Please list any method of counselling that you believe would be more beneficial for the member's than those methods already listed. (Methods already listed are (A) Outside Psychiatrist or Psychologist, (B) In House Psychologist, (C) Psychologist on Retainer, (D) Religious Leader, (E) Peer Counselling)

   A. _____

   B. _____

   C. _____

   D. _____

Part III   <u>Peer Counselling</u>

Directions: Please circle the letter corresponding to
                your choice.

1.   If you were to go to a peer counsellor for counselling,
     would you prefer a peer counsellor was

     (A) of higher rank than yourself
     (B) of lower rank than yourself
     (C) of same rank as yourself
     (D) Does not matter

2.   After adequate selection and training would you be
     willing to be a peer counsellor?

     [A] Yes   [B] No

Part IV   **Basic Data**

Directions: Please circle the letter that is appropriate
                 for each item

1.   Sex: [A] male   [B] female

2.   Age: [A] 19-24
               [B] 25-30
               [C] 31-36
               [D] 37-42
               [E] 43-48
               [F] 49-54
               [G] 55 years or over

3.   Are you a supervisor?   (Includes Cpl, Det, Sgt and
     S/Sgt)

               [A] Yes   [B] No

4.   Years of Service:

     [A] Less than 3.5 years
     [B]   3.5 - 6.4
     [C]   6.5 - 9.4
     [D]   9.5 - 12.4
     [E] 12.5 - 15.4
     [F] 15.5 - 18.4
     [G] 18.5 - 21.4
     [H] More than 21.4 years

5.   Marital Status

     [A] Single
     [B] Married (includes common law)
     [C] Separated
     [D] Divorced
     [E] Remarried
     [F] Widow(er)

THANK YOU FOR YOUR COOPERATION

Appendix B
Follow-up letter

Follow-up Letter to Members of
Police Force X

RE: CONFIDENTIAL MEMBERS ASSISTANCE PROGRAM

Dear Member:

Approximately two weeks ago a Questionnaire was sent out regarding the Assistance Program.

Since it is totally anonymous the responses cannot be traced, as such we have had to send this enquiry to everybody.

If you have already responded, I would like to thank you for your time and efforts.

If you have not completed it, I would appreciate it if you would complete it as soon as possible so that we can start analyzing the data.

If you cannot locate the Questionnaire, copies are available at our office. Should you not wish to assist it would be appreciated if you could return the Questionnaire and possibly add a short note as to why you chose not to participate.

Once again thank you for your assistance, it will help set up a worthwhile program.

Yours truly,

Chairman, Health & Safety Committee
Union