Chapter 12
Assessing for Trauma in Psychological Evaluations for Law Enforcement Candidates and Personnel

Michelle Casarella and Amy Beebe

Assessing for Trauma in Psychological Evaluations for Law Enforcement Candidates and Personnel: Pre-employment Evaluations

Evaluations within the workplace typically fall within two categories: pre-employment psychological evaluations (PPEs) and fitness-for-duty evaluations (FDEs). The former is typically conducted on all job applicants for a specific title, while the latter occurs only when an employee is referred for a specific reason. Within the realm of law enforcement, the International Association of Chiefs of Police (IACP) have set forth specific guidelines for evaluations. It is recommended for clinicians to be extremely familiar with such guidelines and structure their evaluations accordingly. The IACP guidelines assert that clinicians conducting pre-employment and fitness-for-duty evaluations generally be doctoral-level practitioners, except for some jurisdictions that allow for masters-level clinicians.

According to the guidelines, the purpose of a PPE is to "determine whether a public safety applicant meets the minimum requirements for psychological suitability mandated by jurisdictional statutes and regulations, as well as any other criteria established by the hiring agency" (2014, pg. 1). As per the majority of jurisdictions, the minimum requirements for suitability mandate the candidate does not have any emotional or psychological condition that would negatively impact his or her ability to perform the duties inherent to the position.

M. Casarella (✉)
Expert Forensic Psych Consulting, INC., New York City Police Department (NYPD), New York, NY, USA
e-mail: drcasarella@expertforensicpsych.com

A. Beebe
New York City Police Department (NYPD), New York, NY, USA

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The ethics set forth in the guidelines are similar to the practices cited in the American Psychological Association's Ethical Principals of Psychologists and Codes of Conduct. Clinicians should only provide evaluation services within the scope of their competence. This is generally based on education, training, and professional experience. Furthermore, it is imperative to seek supervision and consultation as necessary. Clinicians performing this type of work should have general assessment skills, as well as more specific skills related to assessment of personality, psychopathology, and personnel selection. Just as in any other evaluations, a clinician should avoid circumstances which pose conflicts of interest personally, professionally, financially, or legally. Furthermore, situations that could reasonably expect to impair a clinician's objectivity or pose harm upon the individual should be completely avoided.

Confidentiality issues pose unique challenges given the forensic setting. Generally, the hiring agency or police department is your client rather than the individual who is being evaluated. Despite the fact that confidentiality does not apply, informed consent is still necessary. As per the IACP guidelines, the candidate should be notified in writing of "the nature and objectives of the evaluation, the intended recipients, a statement that the hiring agency is the client, the probable uses of the evaluation, and the information obtained and the limits of confidentiality" (2014, pg. 3).

Prior to the face-to-face interview, the clinician should review the data yielded from the testing battery. While specific tests within the battery may vary, it is imperative to use instruments with documented reliability and validity as well as specific law enforcement norms. Test results should be interpreted in accordance with professionally accepted standards. Cutoff scores should only be used when there is an abundance of evidence indicating it is predictive of issues related to job performance. Of particular importance is that clinicians cannot use different norms or cutoff scores for individuals of protected class. Protected class, as defined by the U.S. federal Civil Rights Act, includes the following nine classes: sex, race, age, disability, color, creed, national origin, religion, or genetic information. Upon reviewing the data, the interview must be conducted face-to-face before making a final determination. Conducting interviews via telehealth is strongly discouraged given the difficulty this medium presents with when evaluating nuanced behavior and interpersonal style. Generally, interviews are semi-structured, with more emphasis placed on specific aspects of an individual's functioning and history. Topics covered include: school and work history, interpersonal relationships, trauma history, legal history, substance use, mental health treatment, and relevant medical treatment.

As part of the hiring process, a background investigation is conducted, and relevant information should be made available to the clinician. If such information is not available at the time of the evaluation, it is recommended for the clinician to make contact with the hiring agency to determine if any issues arose over the course of the investigation. Information made available during the background investigation is especially useful in order to reconcile any discrepancies in the candidate's self-reported history.

It is encouraged that the clinician request records when a determination has been made that it is relevant to their psychological suitability regarding the position. The purpose is to either confirm a suspected issue in which the candidate appeared

less than forthcoming or to resolve a concern that arose over the course of the evaluation. However, it is imperative that the clinician carefully evaluate the need for specific records. One must consider an applicant's confidentiality given the private nature of such records and the ethical obligations of a mental health provider. Additionally, requesting unnecessary records adds to a clinician's workload. If records are deemed necessary yet unavailable, it may be helpful to either defer the final determination or resolve the concern in another way.

Once a clinician has yielded a final determination, a report is then generated which should clearly state the candidate's psychological suitability or lack thereof. Some departments or hiring agencies request a dichotomous response: suitable or unsuitable. However, others seek a determination of low, medium, or high risk for hiring. Typically, the risk ratings equate to acceptable, meeting minimum standards, or not recommended for hiring. The main purpose is to answer the referral question of whether or not this candidate is psychologically suitable for the unique demands of the position. If the candidate is deemed suitable, any concerns that arose—and how they were offset—should be addressed. If the outcome is psychologically not suitable, it is helpful to address each concern as it relates to specific job tasks. A unique aspect of these reports is that the clinician is not diagnosing a candidate. Instead, the focus remains on whether or not they present too much risk to safely and effectively carry out the required roles inherent to the position.

One much needed area of development for pre-employment evaluations involves a better screening process for candidates with various racist attitudes toward people of color and protected classes. There are an extremely limited number of psychological tests, if any, geared toward the assessment of such biases within a law enforcement population. Within the psychological evaluation, this is an area assessed during the clinical interview if specific critical items related to bias are endorsed. It may also arise while assessing a candidate's worldview, including issues within the domains of tolerance, social competence, cynicism, and interpersonal interactions. Furthermore, this becomes an area requiring further exploration if concerning issues related to bias are uncovered throughout the course of the background investigation. Specifically, this may be the result of a social media inquiry or polygraph.

Fitness-for-Duty Evaluations

While a pre-employment evaluation is limited to the assessment of a job candidate, a fitness-for-duty evaluation is focused on an employee experiencing some difficulties at work. The referral question is similar to a pre-employment evaluation, as the main focus is whether a person can safely and effectively perform the essential functions of a particular position. However, a fitness-for-duty evaluation focuses on whether an employee is able to continue to safely perform his or her job functions. According to the guidelines set forth by the IACP, an employee may be referred for a psychological fitness-for-duty evaluation when objective evidence exists that the employee may not be able to safely perform their job functions, and there is a reasonable basis for believing the cause is rooted in a psychological issue.

It is recommended that clinicians conducting such evaluations have an understanding of the essential job functions of the employee's particular title. For officers, this would include awareness of daily responsibilities such as responding to trauma-related calls, interacting with hostile citizens, notifying family members of the deceased, and navigating a bureaucratic organization. Furthermore, clinicians should have some awareness of employment law insofar as it is related to disability requirements, as legal matters such as litigation or arbitration may arise. Given the litigious nature potentially surrounding the evaluations, clinicians should be aware that their work may be subject to scrutiny and practice accordingly. As with any other area of practice, it is crucial to conduct evaluations within one's scope of practice, as based on education, training, and supervised clinical experience. Clinicians should seek out supervision and consultation as needed.

While a fitness-for-duty evaluation may essentially be mandated by the employer, it is imperative to receive both verbal and written informed consent. Given the forensic setting, the limits of confidentiality should be explained to the officer. Furthermore, collateral information will be pivotal in such evaluations to gain a more in-depth understanding of their past and present performance, conduct, and functioning. Specific documents typically requested for the assessment include performance evaluations, any applicable previous remediation plans, internal affairs investigations, formal complaints, use of excessive force reports, disciplinary records, medical records, and prior psychological or substance use evaluations or treatment records. As is the case with pre-employment evaluations, it is crucial that requests for records are limited to being directly related to job performance or the suspected psychological difficulties.

A psychological testing battery consisting of personality and risk assessment measures is typically conducted during the fitness-for-duty evaluation. It is also a helpful practice to obtain the complete pre-employment evaluation file to compare data and review if any related concerns were previously noted. A clinical interview will then be conducted, with a focus on the presenting problem and recent behavior. If deemed appropriate, a clinician may find it useful to conduct collateral interviews with third parties, such as family members or direct supervisors. The final report should assert a clear indication of the clinician's professional opinion regarding whether the officer is fit to return to unrestricted duty, unfit, or requires a specific modification at the time.

The Importance of Assessing Trauma in Employment Evaluations

The primary purpose of both the pre-employment evaluation and the fitness-for-duty evaluation is to estimate the risk an individual poses "to his or her department, supervisors, and fellow officers, as well as the community in general" (Rostow & Davis, 2004, p. 65). That estimate is broadly "calculated" by comparing the psychological attributes the applicant or member of service exhibits with the traits and behaviors his or her desired position requires. In the evaluation of current or prospective police

officers, sound judgment, stress resilience, anger management, and social competence are all psychological characteristics that have been identified by the IACP as critically important to safe and effective law enforcement.

Without question, a history of trauma does not preclude the maintenance or development of any of these key traits—nor does it necessitate an "Unsuitable" or "Unfit for Duty" determination on the part of the evaluating psychologist. Among others, a 2001 longitudinal study by Hodgins et al. found a "lack of association between prior trauma history and subsequent traumatic stress reactions" among law enforcement officers (p. 546). Many recruits who have reported sexual, verbal, or physical abuse in childhood or early adulthood possess the psychological resources to sustain long and impactful careers as law enforcement officers—and may in fact rely on their traumatic experiences to better connect and empathize with those they serve. Similarly, officers are oftentimes exposed to life-threatening situations on the job and very commonly can use those experiences to better navigate comparable circumstances and instruct their peers and subordinates in the future.

With that said, one cannot overlook the fact that a history of trauma (e.g., sexual abuse, physical abuse, exposure to domestic or community violence) *can be* detrimental to individuals' objectivity (particularly when evaluating danger), their ability to self-regulate, and/or their capacity for forging and maintaining positive and trusting relationships (with civilians, partners, and outside social supports). It is for this reason that psychologists must evaluate officers' and applicants' exposure to traumatic incidents and their subsequent responses, both positive and negative, short- and long-term.

When rendering a final determination of suitability for hire or fitness for duty, the psychologist should consider the degree to which past trauma has impacted (and/or continues to impact) the applicant's functioning, in what domains, and for how long. Substantial consideration should also be given to candidates' or current employees' means of coping with triggers, their engagement in high-risk behaviors, and the threat they may pose to themselves or others if placed in an armed position and additional, highly stressful scenarios.

The breadth of research linking the trauma narrative to the constellation and severity of posttraumatic symptoms also supports inquiry into and consideration of the *coherence* of the interviewee's autobiographical account. If the widely held belief among psychologists is true— that "it isn't what happened to you that will determine what you do, [but] how you make sense of what happened to you"—the interviewee's ability to provide an integrated understanding of the incident and its impact can be a key sign of his or her readiness for the inherent dangers and triggers that come with a career in law enforcement (Siegel, 2011).

Cultural Considerations

Cultural and societal considerations are integral components of trauma-related assessments within law enforcement populations. It is helpful to maintain a framework in which the psychological examiner does not consider culture as an "after-

thought" to the evaluation. Instead, viewing culture from a constructivist perspective will likely yield a more comprehensive evaluation. Constructivist theory asserts that humans assign meaning to their own experiences. Such meanings shape every aspect of how an individual experiences the world—including internal struggles, coping strategies, interpersonal interactions, behaviors, and cognitions. Thus, having a sense of the individual's cultural influences is highly recommended when conducting such evaluations. It is worth noting that the term "culture" may certainly apply to protected class categories; however, it extends to also include entities such as family and work culture and how both impact the experience and sequelae of trauma.

In psychotherapy, mental health professionals often consider the differences between "process" and "content" (i.e., the difference between a story's narrative/details and the speaker's nonverbal behavior, emotional reactions, and interpersonal dynamics with the listener). In law enforcement evaluations, the notion that the sequelae of trauma (i.e., "the process") may have a greater impact on job suitability than actual content has been our experience while working with this population. This is an important conceptual foundation when considering cultural and societal aspects of trauma narratives. Such cultural factors contribute to whether a candidate or officer *even* considers their experiences to be traumatic. As with various other concepts, culture influences to what degree an individual will legitimize their internal experiences—or receive validation ranging from the macro to micro levels of society. In other words, an officer's worldview and cultural influences will greatly determine how much they perceive an experience to be traumatic and how he or she responds behaviorally, cognitively, and emotionally.

Western social constructs place great emphasis on the *individual* experience of trauma, with less attention given to the overarching systemic issues that perpetuate trauma. For example, police departments may refer a single officer to psychological services for a fitness-for-duty exam when it appears their drinking may be problematic. That officer will then be evaluated and a determination will be made regarding returning to duty. If necessary, treatment programs and ongoing support will be provided in order for the officer to maintain employment. However, there is little focus on the larger societal and cultural issues contributing to issues with alcohol. Alcohol consumption related to trauma will be discussed in further detail in an upcoming section.

Assessing Trauma in Pre-employment Evaluations

As previously noted, pre-employment evaluations are typically composed of three parts: (1) a written psychological evaluation, wherein the law enforcement candidate is administered a range of written testing measures (e.g., objective personality measures, projective tests, biopsychosocial questionnaires), (2) a semi-structured clinical interview with a psychologist or Master's level clinician, and (3) a review of collateral records from both the candidate's background investigator and other

sources (e.g., medical professionals, previous or contemporary employers) as the psychologist has deemed appropriate and necessary to render a decision. None of the above components should be used in isolation to make a determination of suitability, and in most cases, each step should be used to inform the focus of the next. (In other words, concerns raised by the written testing results should be explored thoroughly in the oral interview with the psychologist; interview responses or behavioral presentations that cast doubts upon the applicant's credibility or true level of functioning should inform which records are requested subsequent to the interview.) Each aspect of the pre-employment evaluation should also be used to develop an understanding of the candidate's trauma history and to ascertain the degree to which that history has and/or may continue to interfere with his or her functioning in the workplace, either directly or indirectly.

Written Testing Measures

Selected psychological testing instruments vary between law enforcement agencies but typically include objective measures such as the Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF), the Personality Assessment Inventory (PAI), and/or the California Psychological Inventory (CPI). The MMPI-2-RF and PAI can be particularly helpful in identifying psychopathology among law enforcement candidates in the pre-employment process. Among other attributes, the MMPI-2-RF touts fewer questions than the MMPI-2, greater homogeneity/specificity in its scales, and a complementary Police Candidate Interpretive Report (PCIR) which utilizes the instrument's normative sample of more than two thousand law enforcement officers and validated correlations to post-hire behavior (Corey & Ben-Porath, 2018). The PAI, which has demonstrated good convergent validity with the MMPI-2-RF, may be preferred given its lower reading level and four-point (versus dichotomous, true-false) questions.

In pre-employment evaluations, the CPI oftentimes serves as a complement to the MMPI-2-RF or PAI, as it (1) measures normal-range behaviors such as assertiveness, self-acceptance, tolerance, and flexibility and (2) includes its own Police and Public Safety Selection Report (created by Johnson, Roberts, and Associates, Inc.), which is "based on a normative sample of more than fifty-thousand public safety job applicants" and computes the risk for a variety of issues on the job (e.g., involuntary departure; use of unnecessary force; issues with problem-solving, communication, and citizen relations).

There is no one scale on any of the aforementioned instruments which will inform the evaluating clinician of a history of trauma or generate a conclusion about the applicant's risk of re-experiencing, developing, or abating post-traumatic symptoms after hire. With that said, the results of the MMPI-2-RF, PAI, and CPI can shed light on a candidate's proclivity for anxiety, his or her history of post-traumatic symptoms or reliance on maladaptive coping mechanisms, and his or her current level of emotion regulation and wellbeing. The Demoralization (RCd), Low Positive

Emotions (RC2), and Dysfunctional Negative Emotions (RC7) scales of the MMPI-2-RF, for example, have all been correlated with Post-Traumatic Stress Disorder (PTSD) symptoms and diagnoses (Ben-Porath, 2012). An evaluating psychologist who identifies elevations on these scales may wish to review the specific endorsements which yielded these results and then discuss them in further detail with the candidate in person. The California Psychological Inventory, though not symptom-based, may similarly offer hypotheses and specific items for the psychologist to explore further with the applicant.

Though other assessment instruments do not present the same degree of forensic validity and should be weighted accordingly in one's ultimate determination and report, it is certainly worth considering their inclusion as part of the written testing administration. This is due to the wealth of information an evaluator may gather about the candidate's history even if they are either unable or unwilling to share such information, or if it is occurring at the unconscious level. Projective measures such as the House-Tree-Person, for example, can offer salient indicators of a trauma history (e.g., reinforced walls and barriers on the house, overemphasis on the person's genitals, holes/defects/damage to the tree) which may not have been reported when asked in more direct terms on an objective measure (Buck, 1948). Open-ended prompts, such as those asking the applicant to briefly describe his or her most stressful or threatening event and how he or she responded to it, can also elicit a richer understanding of the psychosocial history, a fragmentation or coherence of the candidate's trauma narrative, and events that could potentially color his or her perceptions and behaviors once in law enforcement.

In our work, we have noted that a basic written history of the applicant's functioning at school and in the workplace can raise important questions for the oral interview and offer supporting data for the psychologist's ultimate determination—either to justify a qualification (in instances where the candidate was functioning well despite stressors and triggers) or to support a disqualification (by illustrating how external stressors or previous traumas impeded his or her ability to meet demands in another setting or at another time).

The Clinical Interview

The pre-employment interview is fraught with unique challenges and limitations in assessing trauma. First, time constraints and the wide range of domains of functioning that require some level of inquiry allow little time for basic rapport building. (In most agencies, each candidate is allotted one 45- to 60-minute session for the oral interview, a meeting that should result in a reasonably complete conceptualization of the candidate's employment, academic, medical, psychological, and relational history of functioning). Second, the relationship between the evaluator and the law enforcement applicant is inherently strained by a number of extenuating factors: the fact that the agency—and not the interviewee—is the identified "client" and the motivation for the interviewee to present his or her history as unblemished, among others.

In some instances, inquiry into other areas of functioning may naturally elicit discussion of traumatic events. When reviewing a candidate's academic history, for example, concrete questions like "Why do you think your grades were lower that semester?" or "What led you to leave the school?" may reveal their difficulties in the school environment were secondary to a traumatic event (e.g., an incident of sexual assault on campus, an incident wherein they witnessed domestic violence between parents). When the interviewee spontaneously and openly introduces the traumatic incident, the psychologist should aim to both support and focus the discussion, asking follow-up questions about the event itself (e.g., whether it was isolated incident or recurrent, the seriousness of the threat) and the applicant's interpretation of and response to the event. Specific questions about depressive and anxiety symptoms (e.g., anhedonia, irritability, suicidality, panic, flashbacks), maladaptive coping (e.g., high-risk behavior, substance misuse), and/or adaptive coping strategies (e.g., engagement in psychotherapy, reliance on appropriate social supports) should also be included—with focus on the frequency, severity, duration, and most recent occurrence of the former. For those who report a negligible or distant history of posttraumatic symptoms, asking questions about their exposure to triggers and other stressful events in the months or years since can help the evaluator assess their likelihood of symptom recurrence.

More often, the law enforcement candidate will be (understandably) reticent or unwilling to disclose his or her history of abuse or trauma. In circumstances where a history of abuse is known or suspected given information from the background investigator (e.g., police reports, orders of protection) or another collateral source but the applicant appears guarded, exercising clinical judgment is particularly key. If the candidate has already presented a substantial and unambiguous risk that will render him or her unsuitable for the position, to broach the topic of trauma is both unethical and potentially harmful. In other situations, where the candidate's experience of, reaction to, and present insight into a traumatic event or events will in part inform the final determination, the evaluator should introduce the topic empathically and carefully, with the expressly stated goal of understanding the candidate's history and a brief explanation as to the import of this history in the broader evaluation process. (When discussing a history of domestic violence, for example, it may be helpful to remind the candidate that he or she may be tasked with responding to similar incidents as a law enforcement officer.) From there, the clinician should be careful to maintain appropriate boundaries, asking only what is necessary to understand the traumatic event, its impact, and the candidate's understanding of both.

Collateral Records

Oftentimes, the results of the written testing and the candidate's responses during the semi-structured interview provide sufficient information to render a reliable determination of suitability or unsuitability. In some cases, however, collateral

records may be required to clarify historical events and ascertain the veracity of the candidate's self-reports. Potentially helpful collateral records include but are not limited to the following: police reports (e.g., domestic incident reports, civilian complaint reports, arrest reports), orders of protection, medical records (e.g., emergency room visits), and psychotherapy notes.

Case Example

In the following case example, all identifying information has been altered to ensure the confidentiality and anonymity of the subject.

Candidate A

Candidate A was an unmarried female candidate in her late-20s when she was evaluated for the position of Police Officer at a large urban police department on the East coast. Though she had left high school at the age of 16—before earning her diploma—she subsequently attained her GED and then an Associate's degree from a local community college with above-average grades. She reported that she was a single mother with two school-aged children who held a number of brief, part-time jobs in retail stores and restaurants and was financially reliant on her parents for most of her 20s. In the 3 years leading up to her pre-employment evaluation, however, she had been working full-time as the office manager of a law firm. According to preliminary background investigation findings, Ms. A was well-liked by her coworkers and supervisors and had no history of disciplinary issues in her current role. She also had no history of arrests, criminal summonses, or moving violations, and the only notable police records wherein Ms. A was named at all were two domestic incident reports wherein she was identified as the victim of physical abuse.

For the written testing, Ms. A was administered the MMPI-2-RF, the CPI, and the House-Tree-Person. She was also asked to write a brief narrative on her most stressful event and to complete a questionnaire about her employment, academic, medical, and psychological history. On the MMPI-2-RF and the CPI, the majority of the candidate's scale scores fell within 1 standard deviation of the mean compared to the test's sample of law enforcement applicants. Neither could be regarded as a valid, reliable measure of Ms. A's true functioning, however, as both showed evidence (or at the very least, raised questions) of her impression management. The candidate's Uncommon Virtues score on the MMPI-2-RF (L-r; T = 95) fell well above the typical range for applicants and suggested she was presenting herself as unusually principled. (Worth noting here, the MMPI-2-RF's L-r scale should not be mistaken for the "Lie" [L] scale of the MMPI-2—but it may be similarly elevated when an individual is presenting herself unrealistically.) Similarly, the candidate's Good Impression score on the CPI (Gi; T = 63) was elevated and suggested she was "faking good" in the hopes of appearing more suitable.

With regard to her most stressful event, Ms. A detailed a week in her mid-20s in which she had several difficult final exams scheduled and her work supervisor assigned her extra hours at the supermarket. Prompted to reflect on how she handled that stressor, Ms. A wrote that she made a "To Do" list and effectively managed all of her responsibilities, albeit with slightly less sleep.

While the candidate's years of inconsistent employment raised some questions about her stability in early adulthood, her 3 years of stable employment—without incident—indicated she was capable of managing and sustaining full-time work. The evaluator's greatest concerns from the outset of the oral interview, then, were Ms. A's credibility (given notable elevations on the L-r and Gi scales) and her apparent involvement in multiple domestic incidents (which was not disclosed anywhere on her self-report questionnaires).

Ms. A arrived to the oral interview on time and neatly groomed. She presented as poised, articulate, and well-prepared, preemptively presenting her evaluator with a letter of recommendation from her employer and referring to a typed resume as she was asked about her work history. When asked about her departures from various jobs, she often stated she had pursued a higher paying position or had moved to another neighborhood and had no choice but to leave given the commute, issues with childcare, etc. Over the course of the evaluation, Ms. A was asked if she had ever filed a police report, had an incident that involved police, or was granted an order of protection, to which she repeatedly and unequivocally stated she hadn't.

Nearing the end of the oral psychological evaluation, the evaluating psychologist began to ask questions about the candidate's relational history: her relationships with immediate family members, her relationship with her children's father, and any other significant or long-term romantic relationships. Ms. A reported that her only notable romantic relationship to date was the one with her children's father. She described it as "on-and-off" and indicated that it spanned nearly 10 years, from her late adolescence until a year-and-a-half before the evaluation itself. Ms. A casually referred to her ex's recurrent infidelity, difficulties sustaining work, and "immaturity" over the course of their dating but stated their ultimate break-up was amicable and described him as an engaged and supportive co-parent.

When Ms. A again denied any history of domestic violence in her relationship with her ex, the undersigned noted that the background investigator had found two police reports wherein the candidate was named; in one, Ms. A was alleged to have been pushed, kicked, punched, and choked by a boyfriend, and in the other (which occurred 2 years before the oral interview), police responded to a call made by a concerned neighbor, who had allegedly witnessed a physical confrontation between Ms. A and this same partner in the street. (According to the report, Ms. A refused to speak with police and/or press charges.)

When presenting these reports, the evaluating psychologist was careful to express understanding of possible discomfort around the topic and to explain the purpose of this line of inquiry (i.e., its relevance to Ms. A's desired career as a Police Officer). Despite these efforts, however, Ms. A became notably guarded, dismissive, and minimizing. With regard to the earlier incident—wherein substantial physical force

and injuries were noted—the candidate reported that she had "forgotten" all about what happened (given its temporal distance). Having been reminded of it by the evaluator, though, she could now recall one occasion wherein she and her then-partner were arguing about infidelity and grappling with a cell phone. In the struggle, he lost his grip, let go, and she fell back into a dresser, sustaining a minor bruise. Ms. A insisted this was (1) the only manner in which their altercation was physical and (2) the only occasion on which their arguing escalated and involved physical contact. Referring to the more recent incident, Ms. A reported that she and her ex *had* had a *verbal* disagreement about picking up the children from school a few years earlier but asserted it was in no way physical, that there was no justification for her neighbor's concern, and that the two promptly resolved the conflict (and in fact resumed the relationship shortly thereafter, dating for another 6 months).

Ms. A also reported in a rather defensive tone that neither of these events had any effect on her or her children whatsoever. She reiterated that she and her children's father were "young" and "immature" at the time, that brief engagement in psychotherapy allowed her to move forward and prioritize herself and her career goals over her partner, and that the two had a stable, healthy relationship as co-parents to date.

In this case, the discrepancies between the police department's reports and Ms. A's self-reports to the psychologist substantiated concerns about Ms. A's credibility and, in combination with her marked and abrupt change in demeanor, raised serious questions about the true severity, frequency, duration, and impact of physical abuse in her relationship with her children's father. Ms. A's failure to recall either incident without prompting, her guarded approach to the discussion, her tendency to minimize, and the apparent fact she had reunited with this partner after both documented incidents also raised alarm about the narrative she had constructed for herself, her likelihood of reunification (or development of similarly maladaptive relationships) in the future, and her ability to maintain objectivity and take appropriate action when responding to incidents of domestic violence as a law enforcement officer.

While the above concerns would sufficiently warrant disqualification by themselves, the evaluating psychologist obtained treatment records (with the candidate's consent) from Ms. A's mental health provider subsequent to the oral interview. Somewhat unsurprisingly, the duration of Ms. A's involvement in psychotherapy was substantially longer than she disclosed to her evaluator—and had included discussion of *multiple* instances of domestic violence and notable personal and professional issues: low self-esteem, depressed mood, anxiety, and recurrent tardiness. While, to her credit, Ms. A was apparently managing her responsibilities to her children and her employer at the time of her oral interview, her inability to provide a cohesive narrative of the trauma she experienced, her notable guardedness, her justification and minimizing of her ex's aggressive behavior, and her history of psychological symptoms suggested she was not psychologically suitable for the interpersonally demanding and highly triggering career she was pursuing.

Assessing Trauma in Fitness-for-Duty Evaluations

Much like the pre-employment evaluation, the fitness-for-duty evaluation typically comprises three components: the completion of objective psychological testing measures (e.g., the PAI, the MMPI-2-RF, the Inward Personality Inventory), a clinical interview by a trained mental health professional, and the integration of information from collateral sources. The overarching goal of the fitness-for-duty evaluation is also comparable, essentially gauging the risk of recurrence in problematic/risk-laden behavior (grounded in a distinctly psychological concern) and/or the interference by psychopathology in specific job-related tasks (International Association Chiefs of Police (2013).

While many of the key approaches of the pre-employment evaluation can be applied here, however, the psychological fitness-for-duty evaluation is also distinctly different in several ways. First, the FFD evaluation is initiated *in response to* a specific incident or concerning behavior—one that denotes either "positive risk… such as threats of harm against others, irrational acts, racist or sexist conduct, explosiveness, or aggression," or "negative risk… [e.g.] dereliction of duty, distractibility because of substance abuse, or rejection of supervision needed to conduct the normal operations associated with his position" (Rostow & Davis, 2004, p. 65). Second, and by extension, the FFD evaluation typically *begins* with collateral data (e.g., a conversation with a superior, an incident report, an alarming record of absences and tardies, a specific complaint filed by a coworker or civilian) and then proceeds to focus on this singular, identified concern.

Third, and of greatest relevance to this particular discussion, is the underlying understanding that the member of service being evaluated, simply by the nature of police work and the responsibilities it entails, is very likely to have been exposed to disturbing, potentially traumatic events at some point (or, more likely, on many occasions) (Liberman, et al., 2002).

The member of service may have experienced or continue to suffer from the well-established symptoms of PTSD (e.g., nightmares, flashbacks, emotional distress, physical reactivity) or from the lesser-known and lesser-discussed signs of secondary post-traumatic stress (e.g., chronic exhaustion, cynicism, numbing, grandiosity, helplessness), if they have been exposed to trauma (Lipsky, 2009). The pervasiveness of traumatic events, the tendency to normalize or dismiss maladaptive reactions to these events by members of service, and the relative usefulness and omnipresence of suspiciousness and hyper masculinity in police culture (discussed in greater detail below) are all important considerations when evaluating the presence, impact, and risk of trauma in an officer (Andersen, Papazoglou, & Koskelainen, 2015; Follette, Polusny, & Milbeck, 1994; Hodgins, Creamer, & Bell, 2001).

Vicarious Trauma

According to Pearlman and Saakvitne (1995), vicarious trauma is the emotional difficulty that is inherent to employment involving exposure to others' trauma on a daily basis. Vicarious trauma is also referred to as compassion fatigue or secondary

victimization/traumatic stress. As described by Figley (1982), it is the "cost of caring" for others. It includes bearing witness to traumatic events, hearing stories of traumas, or simply having detailed knowledge of others' trauma. There is long-established literature citing the association between exposure to trauma as part of employment and experience of trauma-related symptoms. Follette et al. (1994) found law enforcement personnel have a greater risk of experiencing psychological symptoms from vicarious trauma than mental health professionals.

Vicarious trauma develops initially as a facet of the officers' ability to have empathy for others. However, it can become consuming and impact their ability to perform the essential functions of the position. It is marked by "increased cynicism, loss of enjoyment of career, and can eventually transform into depression and stress-related illnesses" (Mathieu, 2007, pg. 1). Vicarious trauma can be manifested by avoidance behaviors, a constant state of hyperarousal, or some combination of the two. It is often experienced as a feeling of tension and preoccupation, whether or not this is at the officer's conscious level of awareness.

According to the American Counseling Association (2011), there are ways in which vicarious trauma is manifested emotionally (e.g., symptoms consistent with depression, anxiety, and post-traumatic stress), behaviorally (tardiness, absenteeism, overworking, discontinuing community activities or hobbies), interpersonally (e.g., blaming others, decreasing communication, impatience with others, isolating from colleagues), cognitively (e.g., negative perception of self/others, general apathy, questioning their beliefs/worldview), and within work settings (e.g., perfectionism, increased errors, low motivation).

The risk of experiencing vicarious trauma tends to be higher among those with a personal history of trauma. Other predictors include overall psychological well-being, social support, age, gender, education, socio-economic status, and preference of coping styles. One reason that those with a trauma history are at greater risk is because they may be attempting to manage their own post-traumatic reaction, including active symptoms of depressed mood and anxiety. Furthermore, bearing witness to another person's trauma may alone be a traumatic experience. While officers may believe they "put it in the past," repeated exposure to various traumas or simply being exposed to a specific *type* of trauma can result in the resurgence of numerous symptoms.

Police Culture

In order to conduct a comprehensive evaluation with any population, it is imperative for the clinician to utilize an approach that considers all aspects of culture. Thus, a trauma-informed evaluation of law enforcement personnel will include knowledge and application of police culture. Police culture is a specific occupational culture that influences the beliefs, behaviors, and motivations of law enforcement personnel. An occupational culture is typically formed when individual members are trained as a unit in the same format and are indoctrinated with specific values. Occupational cultures manifest in several ways, such as language, dress, and coping styles.

One specific manifestation of police culture is the uniform. Wearing the same uniform separates officers from civilians, communicates their rank (e.g., white shirts typically indicate higher ranks), and immediately provides fellow officers with a sense of camaraderie. Regarding the latter, such a sense of devotedness conveys a degree of belonging and support that others without the uniform are not privy to and cannot fully comprehend. An extension of the uniform is the "brotherhood" inherently created by the sheer dangerousness associated with the position. Individuals become both instantaneously and more deeply bonded when sharing experiences that threaten their safety and overall well-being. There is a very valid sense that only others who share this uniform truly understand how it feels to do this type of work.

Another crucial component of police culture is the jargon utilized by members of the police department. Language is often a critical component of any culture, as it is a common thread that reinforces a sense of community. Furthermore, using codes and jargon is necessary in law enforcement as it provides a much more efficient and safe way of communicating over the radio. Specific language features include utilization of military-based language. Examples include referring to 2 p.m. as 1400 hours, or an officer citing their daily shift as a tour-of-duty. The literature on police culture describes some aspects born from the daily struggles and dangerousness of interacting with the public, as well as a work environment characterized by a bureaucratic system. Current police culture qualities are reflective of the white, heterosexual male dominant culture. While some strides have been made for a more diverse and inclusive police culture, European–American values remain largely ingrained (Addis & Mahalik, 2003; Chan 1997). Specific descriptions include a hyper-masculine culture marked by cynicism, self-reliance, reluctance to change, and expectations for all to express homogenous beliefs (Kingshott, Bailey, & Wolfe, 2004; Prenzler, 1997).

The culture of masculinity is reinforced by the stereotype of a police officer as someone who is strong and brave as well as limited in their emotional expression. While some of these characteristics may be inherently useful to the position, it perpetuates the notion that officers are more like superheroes than actual humans. When a male displays any emotion other than anger, we are indoctrinated to perceive their expression as weakness. This is also the case for police officers, as a significant portion of police culture mandates them to be "stronger and braver" than civilians (Kingshott, Bailey, & Wolfe, 2004). While this may certainly be part of their role as an officer, it contributes to the fact that officers are often reluctant to seek psychological support.

Bureaucratic issues also play a significant role in an officer's potential resistance to psychological treatment. Being referred "to psych" bears a negative connotation as it is viewed as a punishment for wrongdoing or a feeling that they are emotionally unable to handle the role of a police officer. The general consensus is an internal feeling of some degree of incompetency or weakness and subsequently a belief they will be treated unfavorably by the clinician. In our work, our experience has been officers' anticipation of negative employment or treatment outcomes exacerbates the feeling of stigma surrounding psychological services.

Occupational Stress and Alcohol Use

Given the nature of police work, officers are inevitably exposed to high levels of occupational stress. There is a wide range of potential traumatic events or experiences a police officer may be exposed to on any given day. At the lower end, it can include daily interpersonal interactions (e.g., a particularly hostile interaction with a member of the community) or bureaucratic issues out of their control (e.g., limited notice that their command, or the location where they report for duty, has been changed). At the higher end, stressors can include the following: physical injury while on duty, discharging their firearm/officer-involved shooting, fellow officer suicide, terrorism, exposure to dead bodies, hearing accounts of various person-on-person crimes such as rape, domestic violence, and maltreatment of children. Such traumatic events and experiences can be the catalyst for the development of various symptoms consistent with post-traumatic stress. For example, officers involved in shootings commonly report issues such as disturbed perception of time, sleep problems, episodes of tearfulness, and erratic emotions. Of particular importance is that post-traumatic stress symptoms are often accompanied by co-morbid disorders, such as substance abuse (Stewart, Ouimette, & Brown, 2002).

The literature on police officers and alcohol use has been somewhat scarce in the United States over the past two decades. Research during the 1970s and 1980s in the U.S. indicated approximately 25% of police officers had marked difficulties with alcohol (Dietrich & Smith, 1986; Kroes, 1985; Violanti, Marshall, & Howe, 1985). However, notable large studies were conducted more recently in other countries, including Australia and Norway. One study of over 800 police officers in an urban section of Australia indicated nearly half of the male officers, and 40% of the female officers, indicated they engaged in either binge drinking or hazarded/excessive drinking (Richmond, Kehoe, & Heather, 1998). More recently, the Norwegian sample included over 2000 officers from an urban setting. Problematic rates of alcohol use were much lower: approximately 17% of males and 9% of females. While purely speculative, the reason for such discrepancies in problematic use may be accounted for by cultural attitudes toward drinking.

Despite the dearth of research available, we have noted that alcohol use is normalized within police culture. While we believe one possible explanation may be due to the emphasis on "numbing" emotional aspects of the job—which is precisely the behavioral function when individuals turn to alcohol to escape problematic realities. Our anecdotal experiences illustrate the frequent involvement of alcohol in varying capacities during numerous emergency interventions.

Case Example

In the following case example, all identifying information has been altered to ensure the confidentiality and anonymity of the subject.

Officer X Officer X was a married male police officer in his mid-30s—who had been working in law enforcement for over 10 years—when he was referred for a fitness-for-duty evaluation by his superior. According to the referral, both Officer X and his partner had been involved and injured in a robbery approximately 3 months prior to the evaluation. Though neither sustained life-threatening injuries, Officer X sustained a bullet wound to his left shoulder which required emergency medical attention and necessitated months of recovery. When he returned to work, Officer X was noted to be more distractible and dysphoric. He confided in his partner that he had been experiencing severe sleep difficulties and headaches and that he felt uneasy coming to work each day. His coworkers and superiors also noted a dramatic decline in his social engagement; wherein Officer X used to be the "life of the party," he was now quick to leave and avoid social engagements. Officer X's wife disclosed to his former partner, a close friend of the family, that he had been similarly isolative at home and easily agitated by minor, rather normative disagreements with her and their children.

When administered the MMPI-2-RF, Officer X showed a clinically significant elevation on the Cynicism scale (RC3; T = 65) and more moderate elevations on Inefficacy, Stress/Worry, and Disaffiliativeness. In the interview with his evaluating psychologist, he expressed some irritation with his command's referral to "Psych" but a willingness to discuss both the incident and other stressors that were exacerbating his symptoms since. Officer X indicated that he did not believe his current relational or emotional difficulties stemmed from the shooting itself but admitted he often thought about the details of the incident (apropos of nothing) and perseverated on the possibility that he may have been more seriously injured or killed, leaving his wife and children behind.

To his evaluating psychologist, both the timeline and constellation of symptoms provided by the officer, his wife, and his colleagues and superiors suggested the traumatic incident was more impactful than he was either aware of or willing to acknowledge given the context of the evaluation. With that said, as the interview progressed, Officer X appeared increasingly willing to talk about his difficulties (on the job and elsewhere) and motivated to return to his previous level of functioning. Given this, as well as his adamant and seemingly reliable denial of high-risk factors (e.g., suicidality, self-injurious behavior, physical violence, substance misuse), his evaluating psychologist deemed him fit to return to duty with the recommendation that he receive supportive services.

Emergency Interventions and Trauma Debriefings

Traumatic events of varying degrees occur on a regular basis within the daily interactions of law enforcement. Such events may remain more personal in nature (e.g., an officer in the process of a divorce or custody battle) or may be directly associated with inherent job duties (e.g., an officer-involved shooting, working

specialized units such as child abuse or sex crimes). However, there may be blurred lines regarding boundaries, given the permeability of the work. In other words, it is fairly easy for an officer to have difficulty "leaving work at work," given the tendency for such work to "bleed" into thoughts while off-duty, and vice versa. Furthermore, the very nature of police work is highly interpersonal and many interactions may "hit home." For example, an officer going through a divorce may experience increased difficulty responding to domestic calls. Thus, the sequelae of personal or work stressors requires psychological examiners and clinicians to apply emergency response interventions when appropriate. The need for emergency response interventions and trauma debriefings vary greatly by jurisdiction. A larger urban police department will certainly have greater demands than a relatively small suburban location. Furthermore, demands for such services operate on an as-needed basis, given the unpredictable nature of traumatic events.

Trauma Debriefings

The purpose of a trauma debriefing is to address immediate reactions and concerns of law enforcement personnel in the aftermath of a traumatic event. While the process may include meeting individually with officers, it tends to address officers as a group or unit. Trauma debriefings are typically in response to critical events that impact groups of law enforcement personnel. This could include an officer suicide, an officer being killed, or an act of terrorism. They may be conducted either individually or in teams by mental health professionals or specially-trained peer members. A common practice during the debriefings is to first acknowledge the traumatic event and encourage personnel to share their experiences and reactions. There is also a degree of psycho-education in order to normalize trauma-related symptoms and provide information on what can be expected in the upcoming weeks (Lipsky, 2009). Of particular importance is that members of service receive information on what they can do to mitigate any potential symptoms and steps they should take should the symptoms fail to subside after a specified range of time. Officers are often encouraged to seek out help, both formally and informally, as necessary. Finally, a crucial component of trauma debriefings includes providing information for follow-up resources. A trauma debriefing is not meant to replace treatment, but rather functions as a triage system for members of the department to return to prior functioning before the incident (Lipsky, 2009; Malcolm, Seaton, Perera, Sheehan, & van Hasselt, 2005; Miller 2006).

In our work, it has been the practice that trauma debriefing teams consist of both mental health professionals and peer support officers. As discussed in the Police Culture section, there is a certain inherent degree of mistrust of mental health professionals given the employment context. Peer support officers provide a much-needed sense of relatability and trust, while mental health professionals can offer their clinical expertise. Another crucial component of trauma debriefings includes the need for the team or individual to be mobile and highly responsive. It is strongly

recommended to arrive in person for a debriefing, at an appropriate or centralized location. For example, when addressing the officers in the command for an officer who committed suicide, it has been our experience that a centralized and appropriate location is the precinct. Given that officers are in "their own territory," it is more likely that they will feel at least somewhat more open to processing their experience and seeking assistance as necessary. Furthermore, it allows for the team members to become part of the organizational culture.

Regarding timeframe, best practices indicate debriefings should occur within 72 hours after the event. Nonetheless, within 24 hours is strongly recommended (Lipsky, 2009; Malcolm, Seaton, Perera, Sheehan, & van Hasselt, 2005; Miller 2006). As previously mentioned, the response timeframe may vary by jurisdiction given the availability of resources.

Emergency Interventions

It has been our experience that emergency interventions contain many of the components of a trauma debriefing yet tend to focus more on the individual rather than a group. Additionally, they are more likely to involve personal matters and occur while the officer is off-duty. Such interventions are more akin to crisis interventions that a clinician might employ while working with an individual client. The goal of the emergency intervention is not to provide comprehensive treatment; rather, the focus is on stabilization. The first step in an emergency intervention is assessing the individual(s) and current presenting problem(s). This is completed by conducting a semi-structured clinical interview and gathering collateral information. The former involves getting a thorough understanding of the presenting issue. In order to achieve this, the clinician can ask the law enforcement personnel to describe the issue in their own words. Afterward, the clinician's inquiry can be directed toward assessment of various psychopathology, including symptoms consistent with depression, anxiety, mania, and psychosis. Additionally, a major focus of emergency interventions is conducting a thorough risk assessment to include, at minimum, a full suicidal and homicidal risk assessment, including questions regarding thoughts, plans, attempts, access to means, and protective factors. Furthermore, inquiry regarding self-injurious behaviors and coping mechanisms are crucial. While it is generally not the time for an extensive alcohol and drug evaluation, it is imperative to assess if either or both appear problematic for the individual or play a role in the presenting problem. We believe it is beneficial to adopt a forensic mindset when applying emergency interventions. In other words, it is helpful to pay close attention to issues of malingering and not necessarily accept the personnel's narrative without any further prompting or examination. Law enforcement personnel are aware of the confidentiality limits, as well as the possible repercussions given the employment context. Thus, clinical judgment and experience become essential components of the examiner's toolkit.

Recommendations

There are a variety of recommendations and resources to utilize when working with law enforcement personnel. These are especially helpful to aide in the treatment of work-related stress and trauma.

Awareness of Police Culture

Perhaps of most importance is for the clinician to have an awareness and familiarity with both police culture and the specific challenges associated with policing. This includes knowledge of the values, hierarchies, policies, beliefs, and language within police culture. If you have direct access to police departments, or feel comfortable reaching out to one, you can inquire about ride-along programs offered by many departments. As the name implies, these programs allow civilians to accompany officers on a tour-of-duty to witness their day-to-day responsibilities. One way to gain access without direct contact to police departments is to subscribe to recognized law enforcement journals and magazines. Please see examples under the "Resources" section of the book.

Use of Evidence-Based Practices

As with other populations, it is recommended that clinicians engage in evidence-based practices when working with trauma issues within law enforcement. This includes following the IACP guidelines for both pre-employment and fitness-for-duty evaluations, as well as any provisions set forth by Division 18 (Police and Public Safety) of the American Psychological Association.

Including Families in Treatment

At the end of every shift, an officer arrives home and is expected to change instantaneously to family member. However, this is no easy feat given the nature of policing. They may have witnessed a death or heard detailed accounts of sexual assault during their shift and then been expected to shed all the emotional baggage when they arrive home. From a family systems perspective, the stress and trauma the officers experience will inevitably impact the entire unit to some degree. Research has indicated that communication, daily life activities, and emotion regulation are areas most impacted by the stress of the job. Therefore, it is imperative to include families in the treatment process to the degree to which the officer consents (American Psychological Association, 2002). This may include having open lines of communication with family members or joint sessions from time-to-time.

Use of Peer Support Programs

Many departments have peer-based programs aimed at supporting the emotional well-being of officers (Klein, 1989). These programs are staffed by specially trained officers within the particular department who offer emotional support in times of both personal and professional crisis. These programs are especially helpful given the ongoing support they provide. As is typical with most major life events, individuals tend to rally around others and offer support immediately following the incident. However, symptoms and challenges will likely persist far beyond that initial time period. Such programs thus serve to support the officer with the emotional and physical sequelae after "the dust settles."

Clinicians can both partner with and refer officers to these programs to offer an additional level of assistance. Officers will likely feel more comfortable talking to a peer who they can relate to prior to meeting with a clinician. This phenomenon is largely due to the nature of police culture, and the encouragement of relying on others in uniform rather than outsiders. Partnership with a peer support program can serve as an introduction to the treatment process as officers will begin to discuss their experiences and emotions with their peers. It can also serve to screen difficulties officers are manifesting in a less formal setting. Additionally, partnering with high-ranking officers or retired personnel who are willing to speak of their experiences may provide exponential benefits. Those at top tiers in the hierarchy will automatically command respect of other officers and serve to dispel the stigma associated with emotional expression and weakness. Hearing these individuals emphasize how crucial psychological support is for overall well-being means others will feel more empowered and validated to reach out in times of need.

Be Genuine

Research consistently supports the notion of the relationship between the clinician and client as the agent of change in therapy. Thus, it is strongly recommended to build a relationship marked by genuineness, trust, and collaboration. While clinicians will certainly practice from various theoretical orientations, it is recommended to incorporate principles of Carl Rogers' humanistic perspective (Schneider, Pierson, & Bugental, 2015). When the clinician presents with a limited amount of professional façade, they are modeling an authentic interpersonal style that encourages the officer to do the same. Being authentic inevitably results in experiencing basic human emotions and vulnerability—which is emphasized in police culture to be avoided at all costs. Such human connection yields exponential benefits beyond any specific technique or orientation.

It is also important to recognize and discuss the clinician's and officer's inherent differences as a civilian and uniformed member of service, respectively. Due to the

hierarchy rankings and police culture, this is likely not a topic that will be raised by the officer, and thus becomes the responsibility of the clinician. Pretending to understand the officer's experience or making assumptions will likely only present as counterproductive in treatment (Mahoney & Granvold, 2005; Pearlman & Saakvitne, 1995). An honest acknowledgement on the part of the clinician that they do not truly understand the daily struggles of policing will serve to build rapport in the relationship and increase the clinician's credibility. These are situations in which certain degrees of self-disclosure may be appropriate. While self-disclosure is a honed skill that is best used with thought and intention of the client's best interest, it can be extremely validating.

Conclusion

Police psychology is a specialized domain of assessment and clinical treatment that presents unique challenges. Just as a candidate or law enforcement personnel member is being evaluated regarding their capacity to meet the specific demands of the position, the clinician must be competent in this unique role. One major differentiating factor in this work for mental health professionals is the inherent nature of the forensic role. First and foremost, clinicians must be thoroughly familiar with the nature and ethics of such work, including issues related to confidentiality, having a third-party client, and the increased potential for malingering. The clinician must be familiar with the aforementioned practices regarding conducting pre-employment and fitness-for-duty evaluations, as well as trauma debriefings and emergency interventions. Given that risk assessment is the central focus of all law enforcement evaluations, it is imperative for the clinician to be well-versed in this domain. As with other aspects of psychology, acting within one's scope of practice is crucial; therefore, it is always recommended to seek supervision and consultation as needed.

Assessment and treatment of law enforcement personnel requires an understanding of the highly unique occupational culture within a police department. Thus, police culture has a distinct language and systems that influence the behaviors and cognitions of its members. Awareness and adoption of such culture by the clinician increases their trust factor when working with law enforcement personnel. Building trust and being perceived as a genuine, credible person is paramount when working with this population. It is especially critical when assessing for, and treating trauma and stressor-related issues.

Stress and trauma are inherent to police work, and therefore omnipresent in all law enforcement evaluations. While the *types* of traumas and stressors evaluated may differ in pre-employment and fitness-for-duty evaluations, the referral question remains the same: is the individual able to manage the inherent demands of the position?

Questions/Activities for Further Exploration

Questions

1. What are the clinician's ethical responsibilities and role within the context of Black Lives Matter and Blue Lives Matter?
2. What issues are greatly influenced by the individual clinician's judgment and inherent biases when undertaking pre-employment and fitness-for-duty evaluations?

Activities

While it may vary by jurisdiction, some police departments offer experiential activities in order for citizens to gain a more in-depth understanding of the complexities of police work. For example, some departments offer ride-alongs, where a community member spends the day in the patrol vehicle with officers. The goal is to gain first-hand experience that would otherwise not be available unless actually becoming a police officer.

Experiential trainings related to mental illness and psychopathology. One suggestion is the *Listening to Disturbing Voices* Training. The purpose of this training is to better understand how a person experiencing psychosis must try to function in society while hearing voices. This experiential activity may help the clinician gain a better understanding regarding being "in the shoes" of a person with psychosis. In turn, the clinician can use such knowledge when working with law enforcement personnel who may be triggered or experience stress when interacting with members of the community with mental illnesses.

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