Police, RCMP, and PTSD: Integrating the Before Operational Stress (BOS) Program into Detachments

by

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Abstract

First responders, including police and Royal Canadian Mounted Police (RCMP) are frequently exposed to potentially traumatic events. Additional stressors and risk factors for PTSD include moral injuries, moral distress, operational and organizational stressors, working alone, and the stigma of mental health and setting boundaries. Recent studies and statistical findings have found concerning numbers regarding mental health disorders among members. Furthermore, there is limited research on prevention programs and the treatment of PTSD in the police and RCMP population specifically. The BOS program was recently created, helping members receive psychoeducation, establish connections, and have greater access to mental health support. This capstone describes trauma and PTSD, followed by an exploration of police workplace experiences, job stressors, risk factors, and the prevalence of mental health disorders. Treatment options will be generally explored, followed by a description of the BOS program, including recommendations for further additions.

Keywords: trauma, PTSD, operational stress, occupational stress, RCMP, police

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Table of Contents

Chapter 1: Introduction

Every day first responders are repeatedly put into the position of experiencing traumatic incidents, of a level and type that a member of our general non-responder public may rarely, if ever, experience (Arjmand et al., 2024). This high level of exposure puts first responders at increased risk of being traumatized (Collazo, 2022) and developing Post-Traumatic Stress Disorder (PTSD) (Lansing et al., 2005). Furthermore, there is stigma of talking about emotions and/or mental health in the workplace. Flannery (2015) notes: "First responders as a group are action-oriented, self-contained, deferential men and women where "complaining" is not acceptable behaviour and seeking mental health counselling for impairments arising from doing one's job is not likely to be thought about" (p. 262). Increased difficulties managing emotions can lead to the enhancement of PTSD symptoms, further highlighting the importance of identifying effective supports (Goto, 2006; Paltell et al., 2019).

Responders can develop a tendency to become hyper-focused on symptoms and engage in maladaptive coping behaviours such as substance abuse (Flannery, 2015) and development of avoidant patterns such as intentional avoidance of a scene (American Psychiatric Association, 2013). Enduring these traumatic experiences can also result in increased cortisol levels, causing sleep difficulties and changes in appetite, salivation levels, sexual arousal, and information processing (Helsel, 2015). When a person experiences or directly witnesses a potentially traumatic incident, the nervous system can become impacted, causing a person to "freeze" (dorsal vagal), fight, or flee (sympathetic activation) (Helsel, 2015). On the other hand,

practicing coping skills and being in an emotionally grounded state helps the parasympathetic nervous system; allowing a person to experience a normal salivation, blood flow to hands and face, sexual arousal, social skills, deep breathing capabilities, and stronger recall memory (Helsel, 2015).

The criteria for Acute Stress Disorder include symptoms commonly experienced after a stressful event, such as headaches, bad dreams, dissociation, substance use, and feeling emotionally disconnected (Helsel, 2015). When these symptoms exceed a month, the criteria for a PTSD diagnosis may be met (Helsel, 2015). According to Heber (2023), historically, individuals that developed trauma-related symptoms after serving in combat during war were considered lacking in morals and neurological functioning and considered their fault rather than the nation or military. This resulted in the creation of screenings intended to reject soldiers deemed psychologically incapable of managing the mental and/or emotional stress of war-time conflict. The screenings were not valid and contributed to the development of stigma still experienced by veterans today (Heber, 2023).

> Our legacy in western psychiatry and psychology is one of failing to recognize or often discounting, the sometimes devastating effects of experiencing potentially psychologically traumatic events during the course of one's work, usually by placing the responsibility for these deviating outcomes within the individual's personal psychological makeup. (Heber, 2023, p. 649)

The substantial exposure to fatal or other traumatic situations (Lanza et al., 2018), increased risk of developing PTSD (Lansing et al., 2005), and stigma (Heber, 2023), emphasizes the relevance of focusing on research for mental health support. In addition to limited treatment studies, research on how counsellors can best support first responders is also limited. Arjmand et

al. (2024) notes that clinically, first responders have unique characteristics and traumatic histories. Regardless of the theoretical approach, establishing safety and helping clients develop a strong ability to emotionally regulate are major components to treating trauma-related symptoms (Helsel, 2015).

First responders are repeatedly exposed to traumatic experiences and are sometimes traumatized in the same environments where their homes are located, impacting their ability to practice emotional regulation outside of the workplace (Arjmand et al., 2024). Limited effort has been made to adapt treatments to have the maximum efficacy for first responders. Furthermore, clinicians might benefit from supplemental training in counselling for first responder clients. Arjmand et al. (2024) noted this training could also be useful to those responsible for first responder policymakers, mental health providers, and detachment managers, as it would provide a better understanding of the levels and effects of the daily trauma and potential for trauma of first responders and the support staff.

Arjmand et al. (2024) conducted a study of 11 psychologists and one social worker that had previous experience counselling first responders (i.e.: police members, paramedics) - all with experience working with police members. The group was interviewed and the researchers identified themes from their responses. The questions were specifically regarding their clinical experiences with first responders, inquiring about challenges, training, and support systems. Regarding first responder characteristics, workplace culture was a major component to first responder lifestyle. Many stated that their workplace is a significant part of their identity, however, when organizational stressors increase, some clients said that they started to lose their sense of self, becoming enmeshed within the organization. For example, minimal separation between workplace matters and personal activities. Additional shared characteristics included

preferring an ordered approach, cognitive patterns associated with thinking in “extremes”, strong moral values, and deflecting with humour (Arjmand et al., 2024).

It is important for clinicians to acknowledge that many first responders are skilled at disconnecting from their feelings, therefore, clients attempting to connect to their feelings can be highly distressing (Arjmand et al., 2024). The participants noted that it is also common for clients to report suffering from organizational stressors and feeling as though their trauma-related symptoms are not recognized. In terms of training, participants noted clinicians could benefit from learning about the first responder organizational culture. This would include understanding of occupational stressors, operational stressors, and the impact of trauma on responders~~,~~ and their families (Arjmand et al., 2024).

Similar to the observations of Stelnicki et al.~~,~~ (2021), Arjmand et al.~~,~~ (2024) emphasizes that clinician awareness of factors such as police culture and skill from experience from working with first responders are major contributors to establishing safety and credibility in the therapeutic space. A client might become distressed when needing to explain workplace dynamics to/by a clinician. When counsellors have awareness of the workplace culture, this can also help them understand factors that may be strengthening a client’s PTSD symptoms. For example, these may include organizational stressors, stigma or lack of validation associated with their symptoms (Arjmand et al., 2024). One factor that makes first responder experience unique, especially from a clinical perspective, is the repeated/repetitious exposure to trauma - it does not end after one incident (Arjmand et al., 2024).

There are different types of first responders, however, this capstone will focus solely on the Royal Canadian Mounted Police (RCMP) and municipal or provincial police officers. Currently, there are many limitations to research studies regarding the treatment of PTSD in

police and RCMP members. This includes research targeting a specific population, self-report measures, stigma (Komarovskaya et al., 2011), lack of representation, and lack of cultural diversity within studies. Furthermore, a recent study found alarming mental health disorder rates (50.2%) among RCMP members (Carelton et al., 2018). Heber (2023) stated the following: "…we all depend on police officers to protect and service our communities - and potential recruits are watching and learning what they can expect from us when they choose to serve. Is it any wonder that police recruitment is falling?" (Heber, 2023, p. 650). The solution remains unclear except it is important to emphasize the message that trauma symptoms are valid and not a character default (Heber, 2023).

Purpose Statements

The general purpose of this capstone is to bring awareness to police and RCMP workplace experiences, PTSD symptoms, and to develop a workshop (BOS) that can help members connect and gain greater access to mental health supports. The specific purposes are as follows:

- To define trauma and the nature of PTSD in first responders, including the Royal Canadian Mounted Police (RCMP) and police members
- To describe the RCMP and police job stressors, risk factors, and the prevalence of PTSD in the RCMP and police force
- To identify the treatment options for RCMP and police members
- To develop a Before Operational Stress (BOS) workshop for the RCMP and/or police

Contributions to the Field

As noted previously, a recent large-scale study of 5813 Public Safety Personnel found that 50.2% of RCMP members reported being diagnosed, or had "screened positive", for at least one mental health condition (Carleton et al., 2018). Furthermore, first responders have an

interactive relationship with the public, and the ability to serve could be affected by the state of their mental health, creating greater risks for the general public (Lanza et al., 2018). This highlights the need for clinical counsellors, mental health support workers, and detachment managers to be aware of this statistic when supporting the mental health of first responder clients or detachment employees. For clinical counsellors, understanding elements such as mental health statistics, stigma, cultural factors, and the nature of potentially traumatic scenes that RCMP and police frequently witness could also align with the British Columbia Association of Clinical Counsellors (BCACC) Code of Ethical Conduct, specifically "Principle II - Respect for the Dignity of All Peoples - Respect for Peoples" and "Principle III - Responsible Caring - Competent Caring" –(BC Association of Clinical Counsellors, 2024, p. 8-9). Furthermore, counsellors being aware of first responder-specific aspects, such as terminology, could help build therapeutic rapport and safety (Stelnicki et al., 2021). For example, certain lingo or understanding differences in ranks.

According to a recent Statistics Canada report, 71,-472 officers (federal, municipal, and provincial) were employed across Canada in the year 2023 (Statistics Canada, 2024). The 2023 statistics were compared to a Statistics Canada report published in 2021. In 2021, 26.5% described being of a minority group, decreasing to 13% in 2023. This means that currently, less than 1 in 10 members identify as being part of a minority. Furthermore, 23% reported being female and 7% of RCMP identified as Indigenous (First Nations, Métis or Inuit) in 2023 (Statistics Canada, 2024). I believe this is relevant information for clinical counsellors, mental health support workers, and detachment members for a few reasons: It provides important information with respect to cultural representation within research samples and workplace environments, highlighting a factor that could impact client well-being. Additionally, counsellors

being aware of their social location and the current statistics regarding cultural representation could help prevent the projection of Westernized views when creating a first responder mental health support program.

Overall, designing a treatment plan and/or creating a program that is inclusive, supportive, ethical, and culture-infused is of utmost importance (Arthur, 2019). Clients with a first responder background and detachment management could benefit from learning about trauma, risk factors for developing PTSD, and preventative measures. For example, increased exposure to trauma could be classified as a "occupational hazard" (Tamrakar et al., 2019, p. 146) due to the increased likeliness of development of PTSD symptoms among members (Paltell et al., 2019). First responder clients could gain familiarity of the stigma, gaps in resources, risk factors, and first responder terminology that could help create a foundation of safety and therapeutic rapport (Stelnicki et al., 2021). Researchers could benefit from becoming aware that there are several limitations of the research, highlighting a need for further development in this area.

Reflectivity and Positionality Statement

I identify as a white, heterosexual, cis-gendered, able-bodied female. Through personal and professional experience, and completing the City University Master of Counselling program, I am reflecting on my lens and social location. I recognize that being part of the dominant population contributed to minimal awareness of social injustice throughout my childhood. As a result, I frequently learn and reflect on how factors such as privilege and westernized views could create blind spots, impacting my lens inside and outside of the therapeutic space. Furthermore, I am continually learning and integrating culture-infused counselling practices when interacting with clients (Arthur, 2019).

I currently work as a counsellor and co-lead for a first responder trauma program. The program is specifically created for RCMP, city police, firefighters, paramedics, corrections officers, and military veterans struggling with PTSD. Some clients are treated for substance use and other co-occurring disorders as well. I had previously worked in the veterinary field for eight years - my experiences witnessing clients manage grief from the loss of their pet was a major catalyst for entering the mental health field. I also started to develop a strong passion for mental health, however, this was primarily directed toward reducing the stigma in the veterinary medicine field. My connection with first responders was unexpected and impacted me to the extent of changing my long-desired and expected career of veterinarian. It is an honour to be a part of the healing process for first responders and to provide support to those struggling with mental health conditions. However, it can be painful to witness the “weight” of emotional trauma many first responders, and sometimes their family members, have been carrying, some often for a lengthy period.

I have noticed many first responders have a strong skill for using different types of techniques to hide how they are feeling, which sometimes requires a clinician that is willing to challenge them to authentically connect with their emotions. I have witnessed the power of first responder peer connections, because of creating a safe space that helps members share traumatic experiences, support one another, and reduce the stigma associated with these topics. They often stay in contact long after completing the program as well. My observation frequently causes me to ask myself if a program that provides safe spaces, education, prevention, and resources could be created. Through completion of the Master of Counselling program, I have learned to recognize the ethical layers for integrating a program into a detachment.

Some of the ethical layers could include consent and acknowledging that elements such as psychoeducation could help clients experience greater agency in the process. Culture-infused practices are major components to ethical practices, including the acknowledgement of social injustice in relation to ethical practice within the field of emergency response. For example, the majority of first responders identify as white males, which indicates being part of the dominant population. I believe that being aware of different emotional expressions, depending on cultural background, is paramount to ethical practice. Being witness to many trauma-related symptoms and hearing clients state the impact of these traumatic experiences, my hope is to help take a proactive role in mental health awareness within the first responder profession.

Definition of Terms

Avoidant Behaviour Patterns

Avoidance of stressful emotions, cognitive processes, memories, and triggers (i.e.: material reminders, dialogue, environmental settings, human beings) that serve as reminders of the event.

Dissociation

A protective response that allows a person to distance self from feelings, trauma (Protocol, 2014; Schimmenti, 2018), time, identity, and experiences (Protocol, 2014).

Dorsal Vagal

A state of hypoarousal, involving symptoms of freeze, depression, and dissociation (McAdam, 2022).

Intrusive Memories

Repeated stressful memories, dreams, dissociative responses, flashbacks, lengthy psychological or physical distress from triggers (American Psychiatric Association, 2013).

Flashback

A flashback is a "hallucinatory" response to a traumatic experience, resulting in a person re-experiencing the event after it has occurred (American Psychiatric Association, 2013, p. 104).

Peri-traumatic Dissociation

Dissociating at the time of an event or soon after the event has concluded (Galatzer-Levy et al., 2011; Ozer et al., 2003).

Moral Distress

"Moral dilemma[s]" associated with personal actions or the actions of others. For example, disagreeing with a fellow officer's actions, struggling with the organization, or needing to use force when managing crowds with minors (Papazoglou & Chopko, 2017, p. 3).

Moral Injury

An injury from an event that typically involves mortality, involving significant feelings of shame, anger, and guilt (Papazoglou & Chopko, 2017).

Re-enactment

A present moment re-creation of the traumatic event, driven by the subconscious mind (Protocol, 2014). For example, a child recreating what they witnessed during a traumatic event, such as crashing toy planes (Protocol, 2014).

Sympathetic

A state of hyperarousal or nervous system activation, involving symptoms of anxiety, anger, fight, and/or flight (McAdam, 2022).

Trigger

A stimulus that reminds a person of a traumatic event or a specific moment from the traumatic event (Protocol, 2014). This can lead to a flashback, as described above.

Ventral Vagal

An active parasympathetic state, involving symptoms of calmness and socialization (Rothschild, 2017).

Outline of the Capstone Project Chapters

The first chapter introduced the topic, including research findings and limitations. This was followed by describing contributions to the field, a reflectivity and positionality statement, and term definitions. Chapter two will begin with a definition of trauma and the nature of PTSD in first responders, particularly the RCMP) and municipal or provincial police members. This will include a description of how trauma impacts the brain, types of traumas, responses (i.e.: physiological, cognitive, behavioural), and criteria for a PTSD diagnosis. From here, treatment options and preventative measures will be described, including a description of the Before Operational Stress (BOS) program. Chapter three will be focused on the development of a BOS workshop for RCMP and police members.

Chapter 2: Literature Review

Police and RCMP (Royal Canadian Mounted Police) are exposed to many dysregulating events (Beshai et al., 2022), including tragedies, expressions of anger (Cohen et al., 2019), and potentially traumatizing scenes (Galatzer-Levy et al., 2011; Ricciardelli, 2015). The frequency in which police are exposed to traumatic experiences suggests that they are at elevated risk for being traumatized (Collazo, 2022) and developing Post-Traumatic Stress Disorder (PTSD) (Lansing et al., 2005). Complex trauma symptoms can impact a person's wellbeing and particularly, their capacity to cope in a healthy manner (Collazo, 2022). Poor treatment or lack of preventative measures could result in persistence of symptoms, employment loss (Smid et al., 2018), and negative impact on a person's support system, who can also experience secondary re-traumatization (Protocol, 2014). This section will begin by defining trauma and PTSD, followed by a description of officer (RCMP and police) workplace experiences, job, stressors, risk factors, and prevalence. Finally, a brief review of treatment options, preventative programs, including the

Before Operational Stress (BOS) program. Though there are findings on developmental experiences, attachment, and PTSD, this paper will solely focus on workplace experiences.

Theme A: Defining Trauma and PTSD

Defining Trauma

Trauma comes from the Greek word ""τραύμα," meaning a physical or mental wound (Schimmenti, 2018) that impacts areas of the brain such as the hypothalamic-pituitary-adrenal (HPA) axis, amygdala, brain stem, hippocampus, and pre-frontal cortex (van der Kolk, 2015). When trauma occurs, the amygdala releases hormones which then impact the functioning of the hippocampus, disrupting memory processing (Ho et al., 2021). The pre-frontal cortex or "rational" center of the brain becomes deactivated, and this results in hyperactivity in the "fear" center or amygdala (Bandura-Brack et al., 2018; Ho et al., 2021). The definition of trauma as a wound (Schimmenti, 2018) with biological consequences (van der Kolk, 2015) is encompassed in a recent statement by physician Dr. Gabor Maté: "Trauma is not what happens to you, it is what happens inside you (Skoll.org, 0:00-0:04).

There are several types of traumas, including individual, group, cultural, historical, familial, generational, systemic, and developmental (Protocol, 2014). This can include psychological, emotional, physical, and sexual assault (Schimmenti, 2018). First responders typically endure "group" traumas given they are responding to calls as a team (Protocol, 2014). Sources of trauma can extend beyond 911 calls – officers can be negatively impacted by operational and organizational stressors (Cohen et al., 2019). Many officers begin to develop mental health challenges (Knaak et al., 2019) and different responses to traumatic experiences.

There are a range of instant reactions to trauma - a person may dissociate (Protocol, 2014; Schimmenti, 2018), fight, freeze, or flee (Protocol, 2014).

They may experience physiological responses (i.e.: change in temperature, faintness, stomach difficulties) and cognitive symptoms (i.e.: rumination) (Protocol, 2014). Survivors can experience prolonged emotional states of fear and shame (Protocol, 2014). For example, this can include fear of being re-traumatized or shame associated with perceived responsibility (Protocol, 2014). It is important to note, however, that trauma can lay dormant for some time, resulting in delayed onset of symptoms (American Psychiatric Association, 2013; Lansing et al., 2005). Long term emotional or psychological symptoms can be expressed as physical symptoms (Protocol, 2014). This can include clients reporting fluctuating appetite, and exhaustion levels. Behaviourally, a client may report substance use, avoidant behaviour patterns, intrusive memories, flashbacks, and re-enactments (Protocol, 2014).

Research results are contradictory; however, it is possible that re-enactments can help a person sub-consciously feel a sense of control over the traumatic experience(s) (Protocol, 2014). Re-enactments can also highlight some of the long-term behavioural effects of traumatic experiences, including relationship difficulties, risky behaviours, self-harm, and increased sexual arousal (Protocol, 2014). All this being said, the effects of trauma can extend far past the event, impacting a person's sense of self, self-esteem, spirituality (Schimmenti & Caretti, 2016), and safety (Protocol, 2014). As previously mentioned, first responder exposure to traumatic events can increase their risk of developing PTSD (Lansing et al., 2005).

Defining PTSD

According to Ozer et al. (2003), throughout the 1900’s, war times resulted in a spike in interest about the effects of trauma on well-being. The Manual of International Statistical

Classification was published in 1969 and was the beginning of references to symptoms reported by military individuals (Ozer et al., 2003). When the Vietnam War occurred in the 1960's, soldiers started experiencing symptoms like what is described in the criteria for a PTSD diagnosis today (Ozer et al., 2003). This included avoidance, disconnecting from their feelings, sleep difficulties, hypervigilance, intrusive thoughts, paranoia, and flashbacks (Ozer et al., 2003). PTSD was not a formal diagnosis at the time and dissociative symptoms such as flashbacks were sometimes mistakenly diagnosed as a psychotic disorder (Ozer et al., 2003). A formal PTSD diagnosis was introduced in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition) (DSM-III), published in 1980, which has involved revisions and the current DSM (Fifth Edition, Text Revision) (DSM-5-TR) today (Ozer et al., 2003).

The criteria for PTSD, outlined in the DSM-5, is multi-faceted (American Psychiatric Association, 2013). It includes being exposed to a traumatic event (i.e.: "actual or threatened death, serious injury, or sexual violence") through direct personal experience, exposure to details (i.e.: crime scene investigation), and/or being informed that it happened to a friend or family member (Criterion A) (American Psychiatric Association, 2013, p. 271). With respect to first responders, the American Psychiatric Association notes that Criterion A can include directly experiencing war, natural disasters, vehicle accidents, and/or assaults (2013). For a minimum of one month (Criterion F) the client has experienced a minimum of one intrusive symptom (Criterion B), avoidance symptom (Criterion C), change in thought pattern and mood (Criterion D), and "marked alterations in arousal and reactivity" (Criterion E) as a result of the traumatic experience (American Psychiatric Association, 2013, p. 272).

Furthermore, the client's interpersonal functioning has been negatively impacted (Criterion G), and symptoms are not attributable to substance use or a different health condition

(Criterion H) (American Psychiatric Association, 2013). Schimmenti (2018) argues that the DSM-5 is limited with respect to the focus on clinical symptoms that solely occur after traumatic events. Furthermore, the DSM-5 emphasized psychological symptoms, neglecting to note the onset of physical symptoms expressed from repressed emotions (Protocol, 2014). Cultural considerations with respect to trauma and PTSD will be addressed later.

Theme B: RCMP and police workplace experiences, job stressors, risk factors and Prevalence of Mental Health Disorders

Workplace Experiences and Job Stressors

Police officer is one of the riskiest jobs (Galatzer-Levy et al., 2011; McCaslin et al., 2006) due to the responsibility for responding to potentially traumatic or life-threatening situations (Galatzer-Levy et al., 2011; Ricciardelli, 2018). First responders, including police officers, can experience many stressors in the workplace, such as witnessing traumatic events (Galatzer-Levy et al., 2011) and photographing crime scenes (Protocol, 2014), causing them to be exposed to details associated with disturbing incidents (American Psychiatric Association, 2013). According to Huey et al., (2023), RCMP support members, including Detachment Service Assistants, are also exposed to potentially traumatic events, and sometimes experience trauma vicariously. Studies based on observation and direct input with police officers were conducted to further increase understanding of the experiences and stressors in their workplace.

A study by McCaslin et al. (2006) distributed a Critical Incident History Questionnaire (CIHQ) to help researchers gain in-depth insights for officer workplace experiences. The study authors reported non-traumatic routine work stressors, emergency response to natural disasters, violence involving weapons, sexual assaults, and fatalities. Additional studies have found that RCMP respond to similar calls. With the help of the Life Events Check List, Carleton (2019)

found that RCMP and municipal police have been exposed to similar events, including natural disasters, violence involving weapons, sexual assaults, motor vehicle accidents, and fatalities. Notably, studies have found that exposure to these life-threatening and potentially traumatic experiences can occur early in an officer's career, sometimes soon after graduation from their training academy.

A study collected responses for three years from 178 police officers in New York City San Francisco, Oakland, and San Jose (Galatzer-Levy et al., 2011). The results showed that 88.76% of these officers had experienced a Life-Threatening Event (including being threatened with a weapon and/or physically assaulted) within six months of graduation (Galatzer-Levy et al., 2011). Carelton's (2019) study also found that RCMP and police officers had one of the highest exposure rates and "the odds of screening positive for PTSD, generalized anxiety disorder, panic disorder, and social anxiety disorder all increased as the total number of exposures to different types of potentially traumatic events increased" (Carleton, 2019, p. 49). These studies emphasize the vast number of stressors that police and RCMP could experience, leading to discussion regarding risk factors associated with the job and the prevalence of mental health disorders.

Risk Factors and Prevalence of Mental Health Disorders

First responders endure repetitious exposures to traumatic events without a break for debriefing the experience(s) (Flannery, 2015), increasing the likelihood that members such as the RCMP will experience PTSD symptoms (Goto, 2006; Maguen et al., 2009). Due to frequent exposure, they are also vulnerable to an elevated risk of being re-traumatized (Protocol, 2014). The risk factors of developing PTSD increase with the intensity of trauma that a person is witnessing (American Psychiatric Association, 2013). As previously described, there are many

ways that a person can immediately respond to a traumatic event, including dissociation. According to the American Psychiatric Association (2013), dissociation is a risk factor to developing PTSD. Galatzer-Levy et al.'s (2011) study of 178 police officers found a relationship between peritraumatic dissociation and trait dissociation with PTSD symptoms, with peritraumatic dissociation being the stronger predictor.

MarMar et al. (2006) notes that risk factors for developing PTSD can be present before, during, and after the event. Prior to the event, factors such as gender, history, biology, role adaptation, and ability to practice coping skills can impact an officer's risk for developing PTSD (MarMar et al., 2006). An officer's response during a call can be a mediating factor between witnessing potentially traumatic events and developing PTSD symptoms (MarMar et al., 2006). This can include increased heart rate, fear of risking their life, suppressing emotions, trembling, sweating, depersonalization, and derealization. All these symptoms can result in a spike of adrenaline levels, change in memory processing, and prolonged emotional dysregulation (MarMar et al., 2006).

As noted in the literature and DSM-5, traumatic experiences can involve a person perceiving that their life was at risk, resulting in a spike of adrenaline (Ozer et al., 2003). Ozer et al. (2003) conducted a meta-analysis focused on the predictors of symptoms or diagnosis of PTSD. The 2,647 studies were eventually narrowed to 68 studies when they focused on the following seven variables: (a) subject had experienced one trauma before the primary traumatic experience (b) psychological stability before the primary traumatic experience (c) family history of PTSD (d) subject felt their life had been threatened during the trauma (e) social support (f) peritraumatic emotional response (g) peritraumatic dissociation. Of the 7 variables, peritraumatic dissociation was the most significant predictor of PTSD symptoms. Ozer et al. (2003) argues that

a factor such as dissociating at the time of a call could be a greater predictor of activating the HPA axis compared to a person's family history with PTSD.

Furthering on traumatic experiences being a risk factor, Komarovskaya et al. (2011) collected data from a longitudinal study of 400 police officers graduating from police academy. Various elements were used, including demographics, depression symptoms, PTSD symptoms, alcohol consumption, quality of relationships, and workplace experiences. Data was collected every six months; by 36 months (about 3 years), 39 officers reported that they killed or "seriously injured" another person (p. 4). The results revealed that having to kill or seriously injure a person was a significant predictor of the development of PTSD symptoms; variables were controlled when considering the correlation (Komarovskaya et al., 2011).

Police officers are expected to attend to many people on any given call including criminals, victims of assault, and distressed family members (Papazoglou & Chopko, 2017). Furthermore, elements such as commitment, sacrifice, and maintaining law and order are instilled from the beginning of their career. The combination of instilled qualities and being in situations involving the need to help many people at once can result in moral injuries (Papazoglou & Chopko, 2017). It is important to acknowledge the difference between moral injuries and moral distress. As previously described, moral distress means "moral dilemma" and police officers can frequently experience moral distress on any given shift (Papazoglou & Chopko, 2017, p. 3). This can include disagreeing with a fellow officer's actions, struggling with the organization, or needing to use force when managing crowds with minors (Papazoglou & Chopko, 2017).

Moral distress can be suppressed over time and can have a cumulative impact on an officer's wellbeing (Papazoglou & Chopko, 2017). This can be particularly true when officers

choose to avoid conflict and disengage from talking about how they are feeling (Papazoglou & Chopko, 2017). On the other hand, moral injury typically involves mortality and can be followed by significant feelings of shame, anger, and guilt (Papazoglou & Chopko, 2017). For example, the study by Komarovskaya et al., (2011) found that 39 officers had killed or "seriously injured" another person by 36 months (about 3 years) of active duty (p. 4). The combination of moral distress and moral injuries can create increased risk of developing compassion fatigue (Papazoglou & Chopko, 2017). Furthermore, compassion fatigue can increase the risk of developing PTSD (Papazoglou & Chopko, 2017). Papazoglou and Chopko (2017) noted that there is limited research specifically focusing on the relationship between police officers and moral injuries.

Trauma responses can be further elevated due to reaction and attitude from the public, media, and trauma experienced during follow-up investigations (Komarovskaya et al., 2011). RCMP also experience stress or pressure from the community and their responses to the calls (Ricciardelli et al., 2020). Lack of social support as well as poor coping skills when enduring these stressors can be risk factors as well (American Psychiatric Association, 2013). Additionally, the stigma can cause the need to find maladaptive ways to repress feelings, such as starting avoidant behaviour patterns in response to traumatic event(s) (Protocol, 2014). Some police members may also resist talking about their mental health, fearing that discussion will acknowledge repressed symptoms (Protocol, 2014). This highlights a risk factor as a progressively avoidant behaviour pattern can lead to higher levels of anxiety and stress (Protocol, 2014).

Galatzer-Levy et al. (2011) argues that the general awareness of trauma exposure could help prepare officers, however, McCaslin et al. (2006) states that no amount of preparation could

help if a person witnesses something that has personal relevance. For example, witnessing a traumatic event that reminds them of their children (McCaslin et al., 2006). Overall, first responders report increased rates of PTSD due to prolonged exposure to traumatic events (American Psychiatric Association, 2013). A large-scale study of 5813 Public Safety Personnel found that 50.2% of the RCMP members reported being diagnosed or had "screened positive" for at least one mental health condition (Carleton et al., 2018). Di Nota et al. (2020) also noted a "...strong association between positive screens for all assessed mental disorders and significantly increased odds of suicidal ideation among sworn officers" (Di Nota et al., 2020, p. 188).

Heber (2023) emphasizes the importance of focusing on stressors, including occupational, when striving to understand the development of PTSD symptoms. RCMP and police experience organizational and operational stressors within the detachment (Carleton et al., 2020; Cohen et al., 2019). Organizational considerations include work-life balance and exhaustion from workplace duties, and operational include access to support and relationships with authority (Carleton et al., 2020). These organizational stressors can contribute to the risk of developing PTSD (Collazo, 2022).

A study of Public Safety Personnel found that RCMP reported the highest organizational and operational scores, in addition to correctional officers and paramedics, respectively (Carleton et al., 2020). RCMP particularly noted stress with paperwork and taking care of their physical wellbeing (Carleton et al., 2020). Correlations between the development of mental health conditions (PTSD, Major Depressive Disorder (MDD), and/or Panic Disorder (PD) and witnessing of Potentially Psychologically Traumatic Events (PPTE) were observed (Carleton et al., 2020). While there was also a correlation between organizational and operational stressors

and mental health disorders (including Alcohol Use Disorder [AUD]), there was none for PPTEs (Carleton et al., 2020).

This highlights relevant information for management, and given the difficulty of reducing exposure to PPTE's, the focus could be placed on reducing organizational and operational stressors (Carleton et al., 2020). RCMP provided qualitative statements regarding these organizational stressors, including frequently responding to calls alone (Carleton et al., 2020; Duxbury et al., 2015) along with the expectation or pressure to sacrifice their safety (Carleton et al., 2020). Some officers experience "constant stressors - no relief," and fear of making the wrong decision (Carleton et al., 2020). Like Carleton et al. (2020)'s study of RCMP, Ricciardelli et al. (2020) found that RCMP experience stress due to work-life imbalance, paperwork, and minimal access to additional officer support.

Police officers also report no work-life balance, and fear that setting boundaries will impact professional advancement (Duxbury et al., 2015). These factors contribute to greater nervous system dysregulation (Duxbury et al., 2015). It is critical to acknowledge that the RCMP and police officers may work in urban and rural settings, influencing their workplace experiences, stressors and risk factors. Police officers working in rural communities have minimal officer support and can experience lengthy wait times for additional backup as a result (Ricciardelli, 2018). This increases the risk for officers and community members, adding to the stress level. Insufficient officer personnel can increase personal safety risks, such as using diminished or low-quality weapons, and routine equipment maintenance (Ricciardelli, 2018). Being the lone responder to a call can induce fear for officers, as calls can be related to mental health, managing individuals under the influence of drugs (Cohen et al., 2019; Ricciardelli, 2018), and dangerous animals (Ricciardelli, 2018).

Officers work as a small team; this can create a struggle with work-life balance as during off-duty days they may feel the need to support team members (Ricciardelli, 2018). Some officers experience moral conflicts as limited supports can result in being selective in which calls to respond to, which can compromise the safety of members of the public (Ricciardelli, 2018). Like results found by Duxbury at al. (2015) and Carleton et al. (2020), officers can struggle to set boundaries due to fear of judgement from other officers (Ricciardelli, 2018). Overall, research supports that RCMP and police officers experience repetitious exposure to potentially traumatic events, stressors including organizational and operational variables, as well as vulnerability to the development of mental health conditions.

A study by McCanlies et al., (2017) studied 113 police officers, 80% of whom had some involvement with hurricane Katrina. The sample was 27% female and 58% of participants identified as caucasian (McCanlies et al., 2017). The participants completed a range of surveys focused on gratitude, social support, resilience, “satisfaction with life” and PTSD symptoms (PCL-C) (McCanlies et al., 2017). McCanlies et al., (2017) noted that previous studies have found a positive correlation between social support and PTSD symptoms, however, there is limited information on meditating factors that could be influencing the relationship. They observed a positive relationship between social support and resilience, which in turn decreased PTSD symptoms (McCanlies et al., 2017). Though the sample was limited in representation, the results highlight important information on the relationship between these variables and relevance for creating an effective prevention/support program within police and RCMP detachments.

Theme C: Treatment, Prevention Programs, and Rationale for a Before Operational Stress (BOS) Workshop

Treatment and Prevention Programs

Treatment for PTSD includes medication(s), counselling methods, and body-focused techniques, with research having focused on the following treatments (Watts et al., 2013):

- CBT (Desensitization, Cognitive Processing Therapy, Prolonged Exposure, Simulator-Based Exposure, Narrative Exposure, combination of Exposure and Cognitive approaches)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Psychodynamic Therapy
- Biofeedback
- Resilience Therapy
- Group Therapy (including CBT and Interpersonal Psychotherapy (IP))
- Hypnotherapy
- Somatic Therapy
- Self-Guided Techniques

PTSD can also be treated with cognitive processing therapy (CPT) (Held et al., 2021). Additional forms of mental health support include mindfulness practices (Chopko & Schwartz, 2013; Cohen et al., 2019) officers supporting other officers, Critical Incident Stress Debriefing (CISD), and Critical Incident Stress Management (CISM) (Cohen et al., 2019). Collazo (2022) as well as Smid et al. (2018) note that studies for the treatment of PTSD with police officers is limited. Brief Eclectic Psychotherapy (BEP) and EMDR are two major treatments studied for police struggling with PTSD. PTSD can also be treated by a combination of CBT and EMDR.

EMDR includes five major components: traumatic images, somatic responses, negative core beliefs, bilateral stimulation, and a strong client-therapist rapport (Keenan & Boyle, 2007). A case study of a police officer, Bruce, describes positive results from participating in EMDR sessions, allowing him to return to work and remain abstinent from medication (Keenan & Royle, 2007).

Smid et al. (2018) conducted a study of 534 participants that participated in BEP for the treatment of PTSD. They hypothesized that increased trauma exposure would be associated with persistence or minimal decrease in symptoms. Treatment included psychoeducation, imaginal exposure, writing about emotions, examination and restructuring of cognitive processes, and therapy termination (Smid et al., 2018). Subjects that reported having experienced trauma from violent work-related incidents and trauma from personal experiences showed a significant decrease in PTSD baseline symptoms. Those managing trauma from a loss associated with a loved one showed greater resistance to treatment (Smid et al., 2018). BEP was originally created to help clients heal one specific event, so these results were unexpected (Smid et al., 2018). Additional studies have observed significant results when treating PTSD with BEP (Lindauer et al., 2005).

One of the standard treatments for veterans with PTSD has been Trauma-Informed CBT (TF-CBT) (Collazo, 2022). Treating officers using the TF-CBT approach might include the following steps: Building a therapeutic bond (i.e.: counsellor awareness of police culture), psychoeducation (i.e.: PTSD, neuroscience, coping skills, cognition, feelings, and somatic sensations), discussing traumatic experiences (while applying coping skills), and inviting a client's partner into the session (Collazo, 2022). Evidence from a meta-analysis of randomized controlled clinical trials suggested that CBT had the most significant impact treating PTSD

(Watts et al., 2013). Overall, there is limited research on first responders, the impact of their traumatic exposure, and on proactive programs to prevent traumatization.

As noted previously, the Canadian Public Safety and National Security Committee put forth recommendations regarding the need for a greater understanding of mental health and Public Safety Officers (Oliphant, 2016). They encouraged the facilitation of evidenced-based research and programs, focusing on preventative measures and mental health treatments (Oliphant, 2016). The Road to Mental Readiness (R2MR) program was created by the Department of National Defense and has been altered to suit diverse types of first responders, including RCMP (Oliphant, 2016). The R2MR program was created in 2008 (Government of Canada, 2024b), designed as a four-or-eight-hour individual session (Stelnicki et al., 2021).

The program included vigorous elements to help members become educated about mental health (Government of Canada, 2024b), learn stress management skills, and overall improve work performance (Government of Canada, 2024a). For example, Canadian Armed Forces (CAF) members learn skills to help them cope during tours of duty and how to interact with family members when they return (Government of Canada, 2024a). Education includes the Performance Cycle: “Preparing” (education), “perform” (learning to integrate skills in the present moment), the “Big Four” (activation control, visualization, goal setting, and self-talk), “Bounce Back”/Recovery) (Government of Canada, 2024b).

The Bounce Back/Recovery phase teaches how to regain their energy in preparation for their next performance (Government of Canada, 2023, The Road to Mental Readiness). There are brief check-ins (Government of Canada, 2024b), including an R2MR technology application (Granek et al., 2019). These courses are facilitated by CAF and Department of National Defense (DND) members that have participated in a 3- or 5-day training phase (Government of Canada,

2024a). Carleton et al. (2018) conducted a study to evaluate police officers' experience with the R2MR program. There were 570 police officers that originally participated in an R2MR program. After completion, 147 members responded to the evaluation. They responded by self-reporting on alcohol consumption, resiliency, mental health awareness, PTSD symptoms, anxiety, work participation, depression, and workplace perception (Carleton et al., 2018).

The statistical test(s) results showed no significant changes correlated with participation in the program, including at the six-and twelve-month follow-up period. It is critical to note that the researchers were not dismayed by this result as the program was not designed to treat mental health symptoms; it was meant to be used as a preventative measure (Carleton et al., 2018). Responses to qualitative questions revealed positive results from the R2MR program, including increased awareness of mental health and applying coping skills. However, during the twelve-month follow-up, some participants struggled with memory retention and could not remember what was learned (Carleton et al., 2018). This identified the need for a program that includes regular check-ins and material review, hence the development of the Before Operational Stress (BOS) program.

Description and Rationale for the BOS program

There is limited empirical evidence for the R2MR program (Oliphant, 2016), and the material does not seem adequate for increasing resources available for first responders (Stelnicki et al., 2021). During the year 2016, the RCMP requested greater CBT resources that could be utilized on the job. This led to the creation of the BOS program, funded by the Wounded Warriors Association in Canada (Stelnicki et al., 2021). Seeking to find more evidence-based approaches, the three-year pilot project was approved through the Canadian Institute for Public

Safety Research and Treatment (Stelnicki et al., 2021). When creating a prevention program, it is important to consider that many first responders feel most comfortable connecting with a peer rather than a professional (Stelnicki et al., 2021). The BOS program is designed to help first responders become emotionally aware, manage stressors (i.e.: operational stressors), and enhance their relationship with self (i.e.: spirituality) and others (Stelnicki et al., 2021).

The BOS program is administered by Master or PhD-level clinicians that have completed a 2-day training procedure (Stelnicki et al., 2021). These clinicians have been trained to apply an engaging demeanour and integrate their knowledge of first responder culture when interacting with the group (Stelnicki et al., 2021). It is imperative the facilitators use first-responder verbiage and terminology to secure credibility. The program is designed to give participants much time to explore the topics in a supportive environment. There is a prominent level of focus on interaction. This creates a space for clients to feel comfortable enough to start sharing their struggles and triumphs when applying their learned skills (Stelnicki et al., 2021).

The skills taught in these sessions are intended to help first responders take a "proactive role" in caring for their psychological well-being when exposed to PPTEs or workplace stressors (Stelnicki et al., 2021, p. 4). Considering that workplace stressors can impact relationships, participants also learn interpersonal skills to help reconnect with family after work. This can include learning to discuss how they are feeling to a significant other. The program consists of two phases: "active" (two-hour sessions per week over an eight-week period) and "maintenance" phase (monthly check in over a 10-month period). The active phase is to build bonds and identify signs of emotional dysregulation, covering eight modules (Stelnicki et al., 2021):

- Module 1: Identifying group expectations, education on operational stress, moral injury, compassion fatigue, and operational stress injuries

- Module 2: Relationship between physiology and operational stress
- Module 3: Relationship between physiology and organizational stress
- Module 4: Cognitive processes
- Module 5: Emotions and unhealthy cognitive processes
- Module 6: Behavioural patterns, including avoidance
- Module 7: Communication
- Module 8: Skill building (i.e.: empathy)

The maintenance phase makes the BOS program unique to other first responder programs. To further help memory retention, every session begins with a review of the previous session material. Stelnicki et al. (2021) conducted a study of the BOS program to determine if participants experienced a change in PTSD, depressive and anxiety symptoms, emotional regulation, and their perception of access to a support system. They also determined if there was a reduction of stigma on mental health. Participants were measured during a four-month period with the participants being mainly firefighters (Stelnicki et al., 2021).

Results revealed a significant reduction in PTSD symptoms and improvement in quality of life as well as perceived support (Stelnicki et al., 2021). Participants disclosed that the BOS program helped them to gain greater awareness of their emotions throughout the day. Additionally, they became aware of their avoidant behaviour patterns, which allowed them to modify this pattern and recognize the long-term benefits of doing so. Participants also reported improvement in relationships and a decreased sense of loneliness. Stelnicki et al. (2021) received feedback for changes to the BOS program, including additional needs for support (i.e.: impact of confronting maladaptive behaviour patterns), expanding the types of content delivery (i.e.: access

to online sessions, a range of timings), early education for coping skills, more check-ins, and introducing the BOS program during the early stages in a career (Stelnicki et al., 2021).

Limitations

There are several limitations when focusing on a specific population (police and RCMP) and utilizing certain measures and procedures. Studies that involved participants completing self-report measures acknowledged the limitations with subjectivity (Carleton et al., 2018; Carleton et al., 2019; Carleton et al., 2020; Galatzer-Levy et al., 2011; Komarovskaya et al., 2011), gaps in responses or missing data (Carleton et al., 2018; Carleton et al., 2019; Galatzer-Levy et al., 2011), and memory difficulties (Carleton et al., 2019). Furthermore, studies such as the one by Komarovskaya et al. (2011) involved asking police officers about their experience with having to kill or hurt another person. This kind of topic may influence participants to underreport for various reasons (Komarovskaya et al., 2011; Smid et al., 2018).

Some interviews (Carleton et al., 2018; Carleton et al., 2019) and assessments (Carleton et al., 2018; Galatzer-Levy et al., 2011; Smid et al., 2018) that have been utilized can lack formalities. Galatzer-Levy et al. (2011) noted that the process of diagnosing a client with PTSD is multifaceted, assessments such as the "PTSD Checklist-Military Version (PCL-M)" may not provide fully accurate insight into a person's symptoms. Like Carleton et al. (2019), Galatzer-Levy et al. (2011) also observed large variations in research results. They note factors that could have contributed to variation, including the selection process for the research sample. Given these studies involve specific sets of police or RCMP members (i.e.: certain locations), the samples and results may lack representation of the police or RCMP organization as a whole (Carleton et al., 2019; Carleton et al., 2020; Ricciardelli et al., 2020). Furthermore, Carleton et al.

(2018) noted that there can be discrepancies between officer experiences working in the city versus more remote areas.

It can also be difficult to determine if a program or specific treatment contributed to symptom reduction or resiliency. When reporting results, Galatzer-Levy et al. (2011) acknowledged how some officers showed greater resiliency than others. However, they noted that this could be due to individual support systems. It is imperative to acknowledge that access to support can also be influenced by many factors. For example, it could be that the particular detachment happened to have more support resources than others (Galatzer-Levy et al., 2011), highlighting Carleton et al's (2019) note that results can lack representation. Finally, some studies involve the absence of a control group (Smid et al., 2018). All being said, some studies had large sample sizes and were better able to capture the experiences of the Public Safety Personnel (Carleton et al., 2020).

It is imperative to consider cultural influences and why this must be considered when reflecting on trauma and research results. There is a range of cultural perceptions of trauma (Protocol, 2014) and development of PTSD (American Psychiatric Association, 2013). This can include individual differences in exposure, perceptions of death, and sociocultural influences (American Psychiatric Association, 2013). Further, clinicians practicing from a culture-infused lens (Arthur, 2019) should acknowledge the importance of ensuring the treatment (i.e.: TF-CBT) considers gender, race, and culture (Collazo, 2020). A client that reports noticing their physical symptoms without acknowledging their emotional state may be perceived as a client that is "avoiding" their emotions. However, clinicians must consider cultural perception of emotion and expression of emotions as well (Protocol, 2014).

Summary and Synthesis

First responders are frequently exposed to many potentially traumatic scenes (Galatzer-Levy et al., 2011; Lanza et al., 2018; Ricciardelli, 2015) including RCMP when photographing crime scenes (Protocol, 2014) and responding to violent calls (Komarovskaya et al., 2011). In addition to being exposed to these events, RCMP and police describe additional stress with paperwork (Carleton et al, 2020), setting boundaries, fear of judgement (Carelton et al., 2020; Duxbury et al., 2015), serving in isolated areas (Ricciardelli, 2018), operational stressors, and organizational stressors (Carleton et al., 2020). The exposure to violence can happen soon after graduation from police academy (Carleton, 2019). This can have a devastating impact on a member's nervous system, well-being as well as their family members witnessing the progression of trauma-related symptoms. Furthermore, RCMP and police officers play a major role in the safety of citizens, highlighting additional reasons for protecting the health and wellbeing of members (Lanza et al., 2018).

There are several ways that a person may respond to a traumatic event. Research results suggest that dissociating at the time of a call can increase the likeliness that a member will develop PTSD symptoms (Galatzer-Levy et al., 2011; Ozer et al., 2003). PTSD symptoms can arise behaviourally (American Psychiatric Association, 2013) and physiologically (American Psychiatric Association, 2013; Helsel, 2015). Despite research results indicating a high prevalence of mental health disorders among RCMP members (50.2%), there remains a stigma of talking about emotions within the RCMP and police field. As noted previously, some members experience fear that talking about their emotional difficulties will impact their career progression (Carelton et al., 2020; Duxbury et al., 2015). This stigma is historical, dating back to military members serving in war time (Heber, 2023).

There has been limited effort to create training manuals that would help counsellors adapt their clinical approaches for treating first responders (Arjmand et al., 2024). First responders, including police officers, can present unique characteristics and symptoms in a therapy session (Arjmand et al., 2024). Some therapies have been specifically studied for the treatment of PTSD, including CBT (Watts et al., 2013), EMDR (Keenan & Royle, 2007), and BEP (Lindauer et al., 2015; Smid et al., 2018). Though there have been some significant results, research studies continue to be limited (Oliphant, 2016) and as noted, there are many limitations within the research protocols. In addition to treatment, specific programs have been designed to help educate first responders, including the R2MR program (Oliphant, 2016).

The R2MR program involves a single 4-8 hour session, resulting in members having trouble remembering the material (Oliphant, 2016). The BOS program involves trained clinicians facilitating two-hour sessions per week~~,~~ over an eight-week period. This is followed by a monthly check-~~-~~in and overall, coverage of eight modules (Stelnicki et al, 2021). Stelnicki et al.~~,~~ (2021) note~~s~~ the need for additional empirical research on the BOS program. Furthermore, they note the specific feedback from members that have participated in the program. The next chapter will propose a BOS program for RCMP and police detachments, including applied feedback from studies (Stelnicki et al., 2021), and my learned experience from assisting first responders in a mental health program over the past four years.

Chapter 3

Discussion

It is important to begin with a comment and description of the general steps to the BOS program as well as feedback received from participants (Stelnicki et al., 2021). As previously noted, the BOS program is divided into two phases: active and maintenance (Stelnicki et al., 2021). The active phase involves reviewing eight modules about trauma-related symptoms and emotional regulation. This is followed by the maintenance phase, which includes monthly check-ins over a 10-month period. Stelnicki et al. (2021) described the feedback they received from participants, including different forms of content delivery, more frequent check-ins, and greater access to support. It was particularly noted that participants required greater support when they were challenging avoidant and/or entrenched behaviour patterns (Stelnicki et al., 2021). According to Wounded Warriors Canada (2019), it appears that BOS has an eight-hour program delivered online. However, it is designed for first responders that feel they are practicing emotional regulation skills and are particularly seeking supplemental material

Though the BOS program is the only empirically supported program in Canada, collecting longitudinal data has been a challenge, as noted in the study by Stelnicki et al. (2021). Nonetheless, they observed positive results, particularly during the beginning of programming (Stelnicki et al., 2021). As I mentioned in my Reflectivity and Positionality Statement, practicing culture-infused counselling is of utmost importance to me. Wayfound (2023) noted that BOS clinical counsellors are trained to be culture-infused in their clinical approach. I believe it is important for clinical counsellors to display competency regarding cultural identity and workplace culture. I will propose additional elements to the BOS program, created through reflecting on my work experience and research gaps and limitations. My proposal will also inform ideas for future research.

Application

As previously noted, one of the major pieces of feedback was participants wishing for a greater number of check-ins. Working for a first responder residential treatment program over approximately three-and-a-half years now, I have witnessed the positive impact of community connections. Stelnicki et al. (2021) noted that first responders typically prefer to connect with one another rather than professionals – my work experience has also deemed this to be true. Many patients report the power in sharing their experiences with one another and being there for each other as they challenge avoidant and/or maladaptive behaviour patterns. When patients' complete treatment, they often report staying connected through phone calls, messaging, or in-person visits. Knowing each other's previous maladaptive patterns, they can also help hold one another accountable, which helps sustain recovery from trauma and/or addiction.

Furthermore, some patients have shared that they coordinated weekly check-ins with one another after completing treatment. For example, telephone calls every Monday at 1:00pm,

holding space for each person to check in and share how they are feeling, progress with changing patterns, etc. This has been possible through connections made in treatment; however, patients are also able to connect with each other through an alumni list. With patient consent, patients are added to an alumni list once they complete the program. This allows first responders, including police and RCMP, to connect with one another across Canada. Some patients have shared the strong connections they have made with officers serving in an entirely different province.

I have heard firsthand the impact of the stigma regarding talking about emotions in the workplace. This has caused me to wonder about the benefit in first responders connecting with one another across Canada. If a first responder has trouble talking about their personal challenges or feelings in their current workplace/detachment, perhaps it would help to speak to a member from a separate detachment, creating a support system that could feel more neutral and objective. Though it could be ideal for first responders from the same detachment to connect with one another, I wonder if this would be a more reasonable step toward breaking the stigma and feelings associated with talking about mental health. The BOS program focuses on helping members learn communication skills, and these connections could help members practice connecting and communicating with one another. The steps to this additional component would be as follows:

1. Step one involves RCMP and police officers completing the BOS program. This can be the online/supplemental program (eight hours) (Wounded Warriors Canada, 2019) or the in-person facilitation (16 hours) (Stelnicki et al., 2021).
2. Step two involves members providing consent for their first name and last initial to be listed on a BOS Alumni list – referred to as the BOS RCMP and police community.

3. Step three could involve members receiving access to an online list of BOS RCMP and police alumni connections. This could include reaching out to one another, coordinating informal check-ins, and connecting participants across Canada.
4. Participants are made aware that they can withdraw consent and remove their name from the community list at any time.

Alumni connections are an imperative component to recovery (North Star Transitions, 2020). Creating a BOS community or alumni list could help create greater opportunities for research as well, given members provide consent for doing so. This could include the facilitation of a qualitative study, involving members speaking about their experience in the BOS program.

An additional piece of feedback, as noted by Stelnicki et al.~~,~~ (2021), was participants receiving greater education on coping skills. Challenging avoidant behaviour patterns can be particularly distressing (Stelnicki et al., 2021) and I have witnessed this response from first responder clients as well. I have also observed the positive impact of clients developing a strong practice of coping skills, particularly when changing behaviour patterns, responding to triggers, and engaging in trauma therapy. Though psychoeducation on trauma can be validating, I have noticed that it can encourage clients to continue intellectualizing information, rather than practicing emotional regulation. For this reason, I would propose an additional module at the beginning, solely focused on the teaching and practical application of coping skills. From here, clients could track how they feel while they are learning psychoeducational material during the later modules.

They could learn coping skills that are less time consuming, helping them utilize these skills while they are on the job. For example, meditation, extended out breath (Garrett, 2022), and box breathing (Sunnybrook Hospital, 2020). Box breathing involves breathing in, holding

the breath, breathing out, and holding the breath. This is done in 1-5 second intervals and can be repeated 7-10 times (Sunnybrook Hospital, 2020). Furthermore, during my practicum, I created a feeling(s), body sensation(s), and coping skill(s) tracker that could be used as a journal prompt (see Appendix A, Table A1). For example, if a client finds they are experiencing anxiety during their personal morning check-in, they can be mindful of this state as they proceed with their day. This can also help them recognize the effectiveness of coping skills - I have learned that clients can find some coping skills more effective than others.

Support System Program

An additional recommendation is a support system program. The program could include anyone in the clients support system - friends, family members, and/or partners. The program would have four major components: psychoeducation, identifying attachment style(s), and triggers, and creating space for connection. The psychoeducation component could include educating support members on the behavioural and psychological impacts of trauma, as described in chapters one and two. Clients and their support system would then reflect on their individual attachment style(s), acknowledging how this impacts their communication dynamics with others. Those with anxious attachment tendencies tend to seek emotional closeness; those with avoidant tendencies are inclined to avoid emotional vulnerability (Levine & Heller, 2012). These two attachment styles can cause triggers during conversations- as the person with anxious tendencies strives for closeness, the person with avoidant tendencies pulls away (Levine & Heller, 2012).

The person with avoidant tendencies pulling away further triggers the person with anxious tendencies, contributing to the “anxious-avoidant trap” (Levine & Heller, 2012, p. 153). Clients and their support system could then reflect on how they could practice developing secure

communication styles (Levine & Heller, 2012). Additional reflection on triggers could include identifying trauma-related triggers. For example, some clients suffering from PTSD can become emotionally triggered when they are in a grocery store. The client could share how this experience impacts their nervous system (utilizing communication skills taught in the BOS program) and reflect on how support system members could best support them during triggering experiences. This could include co-regulating, giving the client space, etc. Members of the support system could use this as an opportunity to identify ways they feel best supported as well.

As previously noted, the BOS program includes clients learning how to describe the state of their nervous system, particularly when they are communicating with a loved one on the way home from their shift (Stelnicki et al., 2021). I would propose that the final component of the support system program would include the creation of a post-work connection routine, focused on how they can connect with one another after a shift. A post-shift connection practice could include the client returning home, taking time in solitude, meditating, and going for a walk with a member of their support system. This could also include incorporation of communication skills identified in the earlier stages of the support system program.

Overall, my experience has taught me that a lack of communication can foster resentment, which can fuel the development of devastating outcomes such as addictive tendencies. Many clients have reported finding significant benefits in identifying their attachment style and acknowledging how this has impacted their relationship(s). However, if the client's partner is not attending therapy, they may not be learning these elements about themselves. This emphasizes the importance of a support system program. Combining a support system program and alumni connections could help support system members connect with each other across Canada as well.

Ethical Considerations

Maintaining client dignity, confidentiality, and specific cultural and individual considerations are factors included as the major component to ethical practice (Lanza et al., 2018) and should be considered in the development or addition to a program. Principle 1 of the British Columbia Association of Clinical Counsellors (BCACC) Code of Ethical Conduct includes "Respect for the Dignity of all Persons" and clinicians need to "Demonstrate respect for clients through respect for chosen customs and beliefs" (2023, p. 6). As noted previously, there is a high level of stigma associated with mental health within the first responder professions that can cause a person to feel vulnerable when discussing and managing their feelings (Flannery, 2015). Therefore, facilitating programs such as the BOS program may influence a range of responses based on one's culture and history - clinicians must strive to do no harm (BC Association of Clinical Counsellors, 2014).

As I have proposed creating a BOS community and connections list, consent would be a major ethical consideration. Principle 1 of the BCACC code of ethical conduct also includes "Informed Consent" and "ongoing informed consent for services and actions affecting a client" (BC Association of Clinical Counsellors, 2023, p. 7). This additional component would need to be regulated by a BOS staff member as well, ensuring information remains updated with respect to consent and confidentiality.

Reflections on Personal Learning

The reading, writing, and application process to my capstone project has been a substantial learning curve. I have reflected on the possibilities of proactive mental health interventions since I started working with first responders in a residential setting, witnessing the devastating impact of culminative trauma exposure. I have also witnessed distress associated with operational and organizational stressors, contributing to my desire to help first responders.

My passion to help first responders was expressed during residency intensives throughout the completion of my degree. Initially, I frequently discussed ideas with Critical Stress Debriefing, until one of my instructors reminded me that debriefs are not intended to prevent PTSD. My professor then introduced me to the BOS program, which sparked a shift in my focus for a capstone research topic.

I am drawn to the BOS program for many reasons. Through my experience of witnessing the devastating impact of traumatic exposure, I have observed how this can impact family members involved too. It is relieving to know that the BOS program provides education on communicating with family members, particularly with respect to partners communicating on the state of their nervous system when they have completed a shift (Stelnicki et al., 2021). I believe this education could help family members further understand trauma, and perhaps help members feel less alone in the process. Additionally, help members receive effective support when they are feeling emotionally triggered.

When considering the module content, I appreciated the emphasis on the physiological impact of traumatic experiences. I have observed how first responders develop skills around intellectualizing their feelings and how “talk therapy” can create difficulty for members to discharge traumatic residue from their body. With respect to my proposal to add an additional module, I wondered about the potential benefit in first responders proactively learning coping skills early in the process. With this addition, members could talk about the application of coping skills. I have observed that member-to-member can be just as strong, if not stronger, as a counsellor-client bond.

The BOS program places emphasis on counsellor-participant connection and counsellor credibility. Some clients have also shared the importance of working with a counsellor that does

not hesitate to compassionately challenge them on maladaptive emotional processes. I have witnessed the importance of a strong therapeutic alliance when working with first responders. One of the most important lessons I have learned is the value of practicing self-care and developing a strong coping skill practice. I believe displaying strong co-regulation skills helps first responders manage the distressing experience of feeling emotions they have typically suppressed. This can further enhance trust as well. Creating a safe space for clients to share their emotions seems to enhance secure attachment within the therapeutic alliance as well.

I practice being a co-regulator by displaying relaxed body language, practicing coping skills, and being mindful of my facial expressions and/or reactions when a client is sharing their experience. For example, if a client is displaying expressions of anger and rigid body language while they are in my office, I refrain from mirroring their expressions. This would mean maintaining a relaxed rather than rigid disposition. Furthermore, I strive to maintain a nonjudgemental, neutral facial expression, remembering that expressions of anger can be accompanied with feelings of shame and guilt. It is also imperative that I am mindful of vicarious traumatization. According to Rothschild (2017), trauma counsellors are particularly vulnerable to being vicariously traumatized. This is due to factors including empathy and listening to detailed stories (Rothschild, 2017).

A combination of these factors can lead to the trauma counsellor becoming emotionally dysregulated and negatively impacting their cognitive processing (Rothschild, 2017). There are specific practices that can help reduce the risk of being vicariously traumatized (Rothschild, 2017). To begin, a counsellor may prompt a client to pause when the client is sharing significant details and becoming emotionally dysregulated. Though this has been a controversial therapeutic technique, Rothschild (2017) argues that clients typically attend therapy to learn emotional

regulation skills, particularly when they are emotionally distressed. That said, when a trauma counsellor pauses a client and asks how they are feeling, it can be helpful for them to check in on their feelings well. The counsellor may also lead the client through coping skills during this time (Rothschild, 2017).

It is imperative that counsellors reflect on their triggers and acknowledge factors that contribute to nervous system activation (Rothschild, 2017). Counsellors being mindful of their own emotional regulation is a considerable component of safety in the therapeutic space. If a counsellor is working with a client which they are noticing they have considerable empathy for, they can also practice leaning back in their chair, mindfully noticing how the chair feels, and creating "breathing space" as they continue listening to the client (Rothschild, 2017, p. 159). Overall, being mindful of emotional dysregulation, practicing coping skills, understanding personal triggers, and leaning back in the chair are techniques that can help reduce the risk of vicarious traumatization.

From an ethical perspective, clinicians must consent to risks associated with providing this form of support and are highly encouraged to be mindful of their mental and physical well-being (Lanza et al., 2018). In accordance with the BCACC Code of Ethical Conduct, Principle 2 includes "Responsible Caring", which outlines components such as supervision, clinical proficiency, and caring for mental and physical well-being (BC Association of Clinical Counsellors, 2023, p. 10). As noted previously, first responders are frequently exposed to potentially traumatic situations (Arjmand et al., 2024), meaning that they typically arrive in the residential program having carried many emotional memories. I have acknowledged the importance of counsellor self-care, particularly when listening to many traumatic experiences.

Throughout the writing of my capstone project, I quickly became aware of the difficulties in finding large research samples of solely police or RCMP. This included difficulty with researchers staying connected with participants and gathering longitudinal data as well. From a mental health and social justice perspective, I recognize how participants may have varied access to mental health support, and unique developmental experiences. This can create difficulty in determining if a participant was solely impacted by the prevention program or if progress was witnessed because of a combination of support resources and impacting factors such as validity. It seems there is difficulty creating representative samples from a culture and gender perspective. My hope is that future research studies can be done, including samples that are more representative from a culture and gender-based perspective.

Conclusions

Currently, 23% of first responders have been diagnosed with PTSD (Wayfound, 2023). First responders, including RCMP and police, are regularly exposed to potentially traumatic (Galatzer-Levy et al., 2011; Ricciardelli, 2015) or dysregulating events (Beshai et al., 2022). Family and other support system members can experience secondary traumatization as well (Protocol, 2014). Studies are finding alarming rates associated with mental health disorders (Carleton et al., 2018). This can have devastating impacts including difficulty coping in a healthy manner (Collazo, 2022), persistence of symptoms, and employment loss (Smid et al., 2018). Despite recommendations from the Canadian Public Safety and National Security Committee, studies on police and RCMP remain limited (Oliphant, 2016). The BOS program is the first empirically supported prevention program in Canada, showing promising results (Stelnicki et al., 2021). However, there is currently only one research publication on the BOS program. My hope is that additional research funding can be provided, while giving ideas for how first responders

can actively practice emotional regulation skills, connect with one another, and connect with their support system as well.

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Appendix A

Check in Time	Feeling(s)	Body Sensation(s)	Coping Skill(s) Applied	Re-Check – Feeling(s) and Body Sensation(s)
Woke up – 6:00am	Anxious	Increased heart rate, tightness in my chest	Box Breathing Mindful Walk	Calm Decreased heart rate

Table A1. A journal prompt and framework, helping first responders check in on their feelings, body sensations, and coping skills before and after a shift.