Beneath the Uniform: Understanding the Psychological Toll of Public Safety Work and the Systems that Sustain It

by

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Abstract

Public safety personnel (PSP) are faced with a multifaceted array of psychological stressors that extend beyond individual trauma. While many have highlighted operational stress injuries, this capstone examines how identity, culture, and organizational design converge with operational stress injuries to shape long-term mental health outcomes (Carleton et al., 2017). Drawing on the concepts of trauma-informed care (Kim et al., 2021), Bronfenbrenner's ecological systems theory (1979), and the transactional model of stress and coping (Lazarus & Folkman, 1984), the discussion turns to the literature for an understanding of how distress is manifested within and outside of the PSP work environment. Trends such as burnout, moral injury, and stigma are more than just individual symptoms; often, they are symptomatic of broader systemic issues. In response, this capstone offers a set of recommendations according to cultural significance and experience: building on peer support; increasing flexibility in service delivery; and involving families more actively. The purpose of this capstone is not to provide one specific final solution, but to help change how care is considered and delivered to those who are responsible for keeping others safe.

Keywords: burnout, compassion fatigue, cumulative trauma, dehumanization, eusociality, family spillover effect, fearless dominant personality, first responders, help-seeking barriers, mental health stigma, moral injury, organizational stress, public safety personnel, workplace violence.

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To my mom and dad: thank you for standing by me, always. No matter what I am up against, I know I can count on you both to be there without question. Your love and support have carried me through more than you know.

To my best friend, Janessa – you are my biggest cheerleader, and I am so lucky to have you in my corner. You have reminded me to keep going when I wanted to quit, and you have helped me laugh through some really hard moments.

And to everyone who was part of my life when I was writing this capstone, whether you encouraged me directly or unknowingly crossed my path at the right time: thank you. This year hasn't been easy. In fact, it has been one of the hardest. But your presence, your words, and sometimes just your timing, helped me prove to myself that I can get through hard things.

Writing about resiliency in PSP while having to lean on my own has been both challenging and oddly poetic. This work means more to me than I can fully put into words because it holds pieces of what I've lived through too.

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Chapter 1: Introduction

Forensic psychology brings to mind courtrooms, criminal assessments, and expert witnesses. However, it also plays a significant role in helping frontline professionals tasked with public safety (Bartol & Bartol, 2019). First responders, or public safety personnel (PSP), include police officers, firefighters, paramedics, emergency medical technicians (EMTs), dispatches, correctional officers, search and rescue personnel, ambulance drivers, military personnel, command staff, and detectives. These individuals regularly come in contact with high-risk environments and are exposed to potentially traumatic incidents. What they witness and carry with them is often invisible to the public, yet it can profoundly and cumulatively impact their mental health. These professionals are required to remain composed under pressure, deliver care in complex and urgent situations, and make critical decisions in real time. The ongoing nature of these demands contributes to the unique psychological burden that sets PSP apart from the general population (Wild et al., 2020). Despite increased attention to mental health in high-risk professions, the psychological needs of PSP remain widely misunderstood and under-supported.

Current research shows extremely high rates of PTSD, depression, substance use disorders, and suicidal ideation among PSP. In one national study, Carleton et al. (2017) identified that nearly 45% of Canadian PSP were positive for one or more mental disorders—a rate more than four times that of the general population. The statistic above, which comes from self-report screening instruments, will be discussed in more detail later, but what is striking to note about this statistic is how it might be indicative of the multi-layered, cumulative, sometimes conflicting experiences that contribute to psychological distress. It is not generally one event, in and of itself, that does this. More often, it is ongoing exposure to trauma, scrutiny, organizational

disarray, and moral conflict that progressively depletes the emotional resilience of PSP (Koopmans et al., 2017; Mika-Lude et al., 2023; Rodrigues et al., 2023; Wild et al., 2020).

Although services exist and mental health initiatives are expanding, they often fail to align with the practical realities and occupational culture of PSP work. Although psychological risks are often identified, the development of interventions that reflect the specific realities of the context lags behind. For psychologists working with this population, an understanding of the latter becomes important; understanding occupational and cultural dynamics and how they shape help-seeking behavior is critical. This capstone explores those dynamics—both in the presence of mental health symptoms, as well as the systems and identities that shape the way distress is felt, expressed, and responded to within PSP. The discussion goes beyond acknowledgement of trauma as an occupational hazard of work to also examine how trauma overlaps with professional identity, institutional demands and expectations of work, including moral stressors.

Stress builds over time in PSP roles. It is usually not a single dramatic event that causes strain, but a buildup of psychologically stressing events (some extreme, some more subtle) that compound on one another (Wild et al., 2020). When combined with long shifts, bad sleep, and the pressure to maintain a stoic exterior, the result is a psychological pressure cooker. Despite this context, the organizational culture of PSP does not provide space for processing or decompression, further exacerbating stress.

Another common theme across the literature is the role of organizational strain (Reynolds & Wagner, 2008; Wild et al., 2020). In addition to having direct exposure to traumatic events, organizational systems are also accountable for the psychological suffering that PSP endure. Hierarchy within top-down management, procedural obstacles, and inadequate communication contribute to feelings of disempowerment and isolation (Baker et al., 2023; Shane, 2010).

Frustration can arise not only due to the demands of the task, but also due to organizational demands and constraints that unnecessarily place pressure on PSP.

A theme that is equally important in the literature is the concept of moral injury and how this also creates strain among PSP. Rodrigues et al. (2023) describe moral injury as the result of actions or circumstances that violate a person's deeply held values. This may be through direct mission, silence, or complicity within organizational structures. It is within these instances that the dominant source of stress is not fear but guilt, shame, and a sense of internal conflict. This type of injury becomes tough to name, let alone diagnose, because moral injuries are tied to identity and meaning-making rather than external events alone.

Another consideration highlighted in the literature is how PSP culture is a distinct form of workplace culture—one that honors control, decisiveness, emotional restraint, loyalty to the team, and a strong sense of duty (Koopmans et al., 2017; Wild et al., 2020). Although there are many differences in terms of operational tasks between various PSP professions, they often share the same ethos characterized by exposure to crisis, chain-of-command hierarchy, and normalization of acute stress (Reynolds & Wagner, 2008; Shane, 2010). This ethos can be protective or it can be isolating, depending on how individuals respond to vulnerability.

Stigma within PSP culture also complicates help-seeking. Strength in most PSP environments is conflated with emotional containment and a lack of it can be stigmatized within PSP culture. Even where psychological treatment is available, concerns regarding stigma, peer criticism, or professional consequences can discourage engagement (Burzee et al., 2022; Haugen et al., 2017). Under such circumstances, vulnerability is often hidden. The consumption of alcohol is often justified as a coping mechanism, rather than presented and addressed as a risk factor (Beauchamp et al., 2022; Rotunda et al., 2024).

This capstone does not suggest that there are not any mental health resources available within the PSP workplace or that progress has not been made. Rather, it examines the mismatch between existing supports and the unique needs of this population. Specifically, it investigates how trauma intersects with loyalty, identity, and institutional silence, and how cumulative exposure affects psychological functioning in ways that may not be addressed by conventional models. By mapping these themes through a review of current literature, the goal is to inform more contextually grounded mental health support for those in first responder or PSP roles.

Purpose of the Study

PSP work in environments that are known for constant or recurring exposure to trauma, moral tension (or moral injury, a term that will be discussed later), and systemic demands. What PSP go through emotionally is not only about what they see on the job. It is also tied to how their roles are organized, how their workplaces respond when they are struggling, and how they have been taught to think about things like strength, vulnerability, and reaching out for support (Cogan et al., 2024; Haugen et al., 2017). Although there have been improvements in mental health initiatives, there remains a gap between the services that are provided and the unique and nuanced needs of PSP. This capstone examines that gap through a structured analysis of existing literature focused on trauma accumulation, moral injury, organizational strain, and stigma stemming from PSP culture. This project examines the psychological challenges faced by PSP through an integrative review of current research, identifying recurring patterns, systemic stressors, and underexplored dynamics that are unique to this population.

Rather than focusing solely on symptomatology, this capstone considers the broader occupational, organizational, and cultural systems that affect how mental health struggles begin and evolve. The project looks to draw out insights from the literature that show how trauma,

workplace culture, and identity pressures overlap and build over time. Exploring how these forces interact supports a more holistic understanding of mental health challenges of PSP within specific structural contexts.

With these objectives in mind, this capstone is guided by a set of central questions:

- What are the distinct psychological challenges that PSPs encounter as a result of the work they do, and how do those challenges interact with the organizational structures and PSP-specific cultural pressures surrounding them?
- In what ways do moral injury, stigma, and repeated exposure to trauma contribute to their experience of distress?
- And finally, what does the literature suggest psychologists need to understand in order to offer treatment that is not only clinically sound, but also tailored to the lived realities of this uniquely complex population?

Theoretical Orientation

This capstone pulls from three major theories to help provide a holistic understanding of the mental health experiences of PSP: trauma-informed care (Kim et al., 2021), the transactional theory of stress and coping (Lazarus & Folkman, 1984), and Bronfenbrenner's (1979) ecological systems theory. Each one of these theories was chosen early on in the process to help frame the way in which trauma, culture, and systems are explored within this capstone.

The trauma-informed care (TIC) model (Kim et al.,2021) encourages practitioners to consider not only how trauma affects individuals, but how it affects their functioning and expression within systems (including institutional structures) and within their relationships. At the core of this is TIC's challenge to the prevalent labeling of trauma reactions—such as withdrawal, irritability, dissociation, or defiance—as individual shortcomings rather than

adaptive responses to recurring experiences of being overwhelmed. For PSP who are under constant exposure to life-threatening or emotionally overwhelming situations, this lens becomes fundamental. Emotional hypervigilance, detachment, and suppression can appear as stoicism or disengagement, but these reactions typically stem from internal dysregulation due to cumulative trauma, and are thus a trauma response (Rodrigues et al., 2023; Wild et al., 2020).

TIC also emphasizes the need to create environments that focus on building safety, trust, empowerment, and collaboration (Kim et al., 2021). These values are principles that may be particularly significant when dealing with PSP. Furthermore, when applied to PSP populations, TIC frames questions of whether the support systems in place are adequately attuned to the real, lived experiences of these professionals, or without realizing it, whether they inadvertently reproduce the dynamics that compromise psychological safety. For example, well-intentioned interventions may be experienced as punitive or performative if they ignore the broader culture of silence, stigma, or surveillance common in many PSP environments (Koopmans et al., 2017). A trauma-informed perspective encourages a shift in interpretation from asking "What's wrong with them?" towards asking "What have they been through—and how are they managing within the systems they are embedded in?" This framework provides a useful lens for exploring and interpreting both psychological outcomes and the broader environmental contributors to PSP mental health.

The second model, the transactional theory of stress and coping, addresses the ways people appraise stress and deal with it (Lazarus & Folkman, 1984). At its core, this model views stress as the result of an interaction, or "transaction", between an individual and their environment. It has three key processes: cognitive appraisal, coping, and reappraisal. Cognitive appraisal is the individual's assessment of the situation as threatening or as one that is

controllable; coping is the behavioral and cognitive activity aimed at controlling the situation; and reappraisal is reappraisal of the situation upon or during its occurrence.

This model is especially relevant to PSP who continually need to make decisions in highly stressful situations. Possessing the ability to automatically assess risk (primary appraisal), select among existing resources to respond (secondary appraisal), and shift methods throughout a span of time (reappraisal) can be what distinguishes being overwhelmed from being in control. It explains how some people try to take control of a stressful situation, while others focus more on managing how they feel in response to it. Both approaches are common and often overlap, but when stress is ongoing or when options are limited, even familiar coping strategies can start to wear thin or stop working altogether (Wild et al., 2020). Understanding these processes gives us an idea of how coping processes are generated under chronic stress exposure (Mika-Lude et al., 2023; Rodrigues et al., 2023).

Ecological systems theory, the third model adopted for this capstone, places individual experience within a contextual framework recognizing how connected systems influence development and behavior (Bronfenbrenner, 1979). Bronfenbrenner (1979) suggested that knowing can only occur when the surrounding systems can be accounted for, including workplace culture, home and family, social norms, and public perception. The ecological systems theory consists of five inter-nested systems: microsystem (direct environments like family or coworkers), mesosystem (interactions between microsystems), exosystem (indirect influences like organizational policies or media), macrosystems (broader cultural or societal values), and chronosystem (changes over time). All of these five systems operate dynamically, influencing how individuals process and respond to stress (Bronfenbrenner, 1979; Mika-Lude et al., 2023).

In PSP settings, ecological systems theory helps clarify how stigma emerges, how silence is upheld, and how external pressures affect internal spaces. For example, a paramedic's reluctance to speak up about mental health may stem not only from their immediate work culture (microsystem), but also from institutional expectations (exosystem), societal ideas of heroism (macrosystem), and cumulative exposure over a career (chronosystem) (Koopmans et al., 2017; Rodrigues et al., 2023). Ecological systems theory emphasizes the importance of context in understanding behavior and outcomes, particularly in environments where individual well-being is shaped by complex structural forces. By contextualizing mental health outcomes within overlapping systems, this theory supports a more holistic understanding of both individual distress and the environmental forces that sustain it (Reynolds & Wagner, 2008; Wild et al, 2020).

Together, these three theories provide a framework that integrates personal experience, coping mechanisms, and systemic influences. Rather than isolating trauma as either an individual or clinical problem, the theories support an exploration of how psychological strain among PSP is shaped by the broader culture of their work, the expectations of their profession, and the systems they operate within. This theoretical foundation informs the literature review that follows in Chapter Two.

Methodology

This capstone answers the research questions through a literature-focused approach designed to better understand the psychological and systemic challenges experienced by PSP. The primary databases used were the academic libraries of City University of Seattle and Mount Royal University, with the majority of searches conducted through PsycInfo To ensure findings

were grounded in current practice, the search strategy prioritized peer-reviewed journal articles published within the last five years.

The process began with broad search terms such as *"first responder,"* "*first responder's PTSD," "suicide risk," "trauma in paramedics"* and *"mental health stigma in police officers."* These initial searches returned hundreds of thousands of results—*"first responders"* alone yielded 109,101 results from the City University of Seattle academic library. As themes began to emerge through manual scanning of article titles and abstracts, typically within the first three to five pages of results for relevance and feasibility, the search strategy became more refined. For example, a search for *"first responders and high-stakes decision-making"* narrowed the results to 11 in the PsycINFO database, and *"burnout in correctional staff"* returned 889 articles in the City University of Seattle database. Other refined terms such as *"moral injury in public safety personnel," "help-seeking barriers in first responders,"* and *"resilience and coping strategies in EMS"* typically produced between 200 and 2,500 results depending on the database searched. In addition to formal searches, some articles were also located following citations within already-reviewed studies—particularly when the reference sources appeared to support a developing theme or offered additional insight.

As the body of literature grew, a spreadsheet was developed to track article titles, keywords, and topical relevance. This tool allowed for thematic sorting and comparison across sources. Articles were categorized by emerging patterns such as trauma exposure, organizational culture, moral conflict, and public stigma. These themes later informed the conceptual structure of Chapter 2. This categorization process was not without challenges; themes often overlapped, and some studies resisted simple classification. Consultation with a faculty advisor helped clarify these early categorizations and supported streamlining of the overall structure of the literature

review. A secondary faculty reader later reviewed the full draft and offered feedback that supported the final revisions. Throughout this process, the review was informed not only by the quantity of research available but by the thematic patterns that recurred, many of which suggested critical areas of interest within the forthcoming literature review on PSP mental health.

Positionality Statement

My interest in PSP mental health began with a simple curiosity: what kind of person chooses a profession where trauma is not the exception, but the norm? Unlike historical periods where military service was compulsory, today's PSP voluntarily enter into high-risk, emotionally grueling work. I wanted to understand not just the psychological toll of this choice, but the identity behind it—who these individuals are, and what they carry.

As an emerging psychologist I sought out supervision under a clinician who specializes in PSP work. Though I could not treat this population directly due to my student status, I was able to observe a small number of sessions. What I witnessed reinforced what I had long suspected: this is a population that operates with extraordinary loyalty, stoicism, and pride, and a population who often suffer silently. It became evident that successful therapeutic work with this group required more than technique; it required some who "gets it," who understands the realities of the work, the unspoken emotional codes, and the cultural norms of this profession that shape how distress is expressed or hidden. When a therapist truly understands the realities of PSP, the client doesn't have to explain or translate their world, they can get to the actual therapeutic work, rather than spending sessions educating the person across from them.

While I do not come from a PSP background, I was raised with values that resonate strongly with this workplace/occupational culture and norms: loyalty, respect for hierarchy, and emotional resilience. I have often felt a connection to this population—even without personal

ties—because of those shared values. As a Caucasian, cisgender female raised in a multigenerational household shaped by post-war values, I was brought up in a family where respect for authority, structure, and emotional steadiness were quietly emphasized. While emotional suppression was never forbidden, I felt a strong undertone of composure, especially in moments of difficulty. I also witnessed firsthand the resilience and interdependence required to sustain a family business; my parents launched a trucking company in 1995, and I watched them navigate setbacks with teamwork and resolve. These experiences taught me the importance of staying grounded under pressure and of showing up for others even when it is hard—values that mirror the ethos of many PSP environments.

Furthermore, I have been told many times that I am someone people come to with the darkest parts of their stories. I do not flinch. I do not shut down. That steadiness is something I value, and I believe it is especially important when working with people who have witnessed the worst sides of humanity. I want to be someone they do not feel they have to protect, but who them can come to and be supported by.

As I moved through this project, I kept checking in with myself, questioning where my assumptions came from and making sure I wasn't simplifying issues that are deeply complex. I recognize that I came into this capstone with a confirmatory bias—a tendency to notice or value information that aligned with my early beliefs about PSP culture and identity. To help mitigate this, I made a point of reflecting critically on the themes that emerged and discussing them with peers to explore how others interpreted the same findings. I also checked in regularly with my practicum supervisor, whose clinical experience with this population helped me differentiate between patterns grounded in evidence and those shaped by my own experience. My hope is that this capstone chips away, even a little, at the misunderstanding and stigma surrounding PSPs.

More than anything, I hope it helps psychologists and future helpers to see this population more clearly, and that it lets those in the field know there are clinicians willing to try to understand, and who genuinely want to support them.

Definitions of Key Terms

Burnout: A state of emotional, physical, and mental exhaustion caused by excessive and prolonged stress, particularly in constrained workplace settings (Baker et al., 2023; Maslach & Jackson, 1981). Symptoms can include depersonalization and reduced sense of accomplishment.

Compassion Fatigue: Emotional exhaustion and a reduced ability to empathize, often resulting from continuous and chronic exposure to other's trauma (Cogan et al., 2024).

Cumulative Trauma: Psychological impact resulting from repeated exposure to traumatic events over time, rather than a single catastrophic incident (Casas & Benuto, 2022; Cogan et al., 2024).

Dehumanization: A cognitive process of viewing others (or being viewed) as less than human—mechanical, animalistic, or superhuman—which can intensify emotional exhaustion and distress (Fontesse et al., 2021; Mika-Lude et al., 2023).

Eusociality (in PSP): A theoretical concept framing PSP as highly cooperative individuals who prioritize the collective group over their self, which sometimes leads to internalized failure and suicidality (Ringer et al., 2021).

Family Spillover Effect: The emotional and relational impact that a PSP's occupational stress and trauma have on their spouse, children, and home environment.

Fearless Dominant Personality (FDP): A set of personality traits common among first responders involving emotional resilience, social dominance, and low anxiety, which may hinder help-seeking (Chandrashekar, 2022).

First Responders (AKA Public Safety Personnel): Professionals who are involved in emergency response and public safety, including police officers, paramedics, firefighters, emergency medical technicians (EMTs), dispatchers, correctional officers, and search and rescue teams (Wild et al., 2020). Not all are first on the scene, but each plays a critical role in crisis response and safety.

Help-Seeking Barriers: Factors that may prevent individuals from accessing psychological care, including fears about confidentiality, professional consequences, stigma, scheduling conflicts, and/or lack of organizational support (Haugen et al., 2017).

Mental Health Stigma: Negative societal attitudes and internalized beliefs about mental illness that discourage people from opening up about mental health struggles and seeking support (Burzee et al., 2022; Cogan et al., 2024; Haugen et al., 2017).

Moral Injury (MI): Psychological distress resulting from actions, or the lack of them, that violate one's moral or ethical code (Blumberg et al., 2018; Rodrigues et al., 2023).

Organizational Stress: Stress derived from systemic and structural factors in the workplace, such as rigid hierarchy, lack of leadership support, and poor peer relationships (Koopmans et al., 2017; Shane, 2010).

Public Safety Personnel (PSP): A broader term used in Canada to describe a wide range of emergency and enforcement professionals, including paramedics, correctional officers, firefighters, and more, who operate in high-pressure, often high-risk environments (Carleton et al., 2017). PSP may also be referred to as first responders.

Workplace Violence (WPV): Any physical, verbal, or sexual aggression encountered on the job. For PSP, these incidents can come from the public, clients, or even colleagues (Murray et al., 2019.

Outline of Capstone Chapters

This capstone is made up of three chapters, each one building on the last to offer a deeper examination into the mental health experiences of first responders. It is structured to take the reader through a review of the current literature which explores both the emotional and systemic factors at play in PSP mental health, and finally into a discussion of the potential implications for clinical practice and a final policy recommendation.

Chapter 2 is a literature review organized into five interconnected themes. First, it outlines the prevalence of mental health concerns within the PSP population, including concerns such as PTSD, depression, anxiety, substance abuse, and suicidality. From here, the focus shifts to the cumulative effects of trauma exposure and how phenomena such as moral injury, compassion fatigue, and burnout emerge, and are sustained over time. The next section investigates the organizational and cultural systems surrounding PSP. This is followed by a review of research that relates to identity and perception, including how traits like fearless dominance may play a part in PSP help-seeking behavior and emotional processing. Chapter 2 concludes by considering how occupational experiences may spill-over into the personal lives of PSP, and how this spill-over may impact relationships, parenting, and emotional connection.

Chapter 3 synthesizes the findings from Chapter 2 with the goal of identifying clinical considerations and applications. Areas of focus include clinical recommendations that take into consideration trauma-informed frameworks, and the creation of psychological safety in therapeutic settings. A policy recommendation brings attention to systemic barriers that may inhibit help-seeking among PSP. The intention is not just to analyze the literature, but to offer direction that is practical, relevant, and grounded in what this population actually needs.

Chapter 2: Literature Review

PSP, including police officers, paramedics, firefighters, emergency medical technicians (EMTs), dispatchers, correctional officers, and search and rescue teams are essential within a society that depends on them for crisis management and maintaining public safety. Stressors mostly occur in PSP who endure constant traumatic scenes, high pressure, and erratic schedules. However, frequent, and recurring contact with traumatizing experiences and high levels of pressure, combined with major organizational challenges, have led this population to be at an increased risk for mental health concerns and an obvious need for mental health assistance (Wild et al., 2020). Due to occupation-specific stressors, great interest has developed in terms of understanding the mental health of first responders. This chapter serves as a springboard to a scholarly exploration of the unique and nuanced mental health needs of PSP that are critical to psychologists desiring to serve this population.

Understanding the Mental Health Landscape

Before examining the many factors that shape the psychological well-being of first responders, it's necessary to take a step back and examine the broader mental health trends and epidemiology within this population. Large-scale studies and systematic reviews provide critical insights into the scope and severity of mental health issues, offering a baseline understanding of just how pervasive conditions like PTSD (Carleton et al., 2017), depression (Wild et al., 2020), substance abuse (Beauchamp et al., 2022; Rotunda et al., 2024), and suicidal ideation (Koopmans et al., 2017; Stanley et al., 2017) are within this population. These epidemiological findings not only highlight elevated risks but also set the stage for a deeper exploration of what contributes to such outcomes and where existing supports continue to fall short.

In a large scale quantitative Canadian study, Carleton et al. (2017) examined the symptoms of various mental disorders among 5,813 PSP using validated screening measures. Accordingly, 44.1% of participants screened positive for at least one mental disorder where a prevalence was substantially higher than in the general population at 10.1%. Post-traumatic stress disorder (PTSD), major depressive disorder (MDD), generalized anxiety disorder (GAD), social anxiety disorder (SAD), panic disorder (PD), and alcohol use disorder (AUD) were the most common diagnoses, listed here in order of descending prevalence as identified by Carleton et al. (2018). The highest prevalence of mental health problems was found among correctional workers, RCMP officers, and paramedics, professions characterized by repeated exposure to high-stress and potentially traumatic incidents. This may help explain why their rates surpass those of other PSP whose roles involve less direct or sustained exposure to human suffering or violence. These findings paint a picture of the psychological toll that often accompanies frontline service, reflecting the high prevalence of mental health concerns among PSP. While prevalence data alone cannot confirm the presence of systemic shortcomings, the consistency of these rates—particularly among correctional workers, RCMP officers, and paramedics— raises important questions about the adequacy of existing mental health supports, the accessibility of preventative interventions, and broader organizational cultures that may discourage early help-seeking. These issues are discussed more fully in this chapter. However, the accuracy of the prevalence rates come into question as many authors relied on self-reported data of participants' diagnoses instead of the authors, themselves, performing clinical diagnostic interviews, raising concerns about the accuracy of the diagnoses and possible response biases.

A systematic review by Stanley et al. (2017) identified 63 quantitative studies focused on suicidal ideation and attempts among first responders. It was estimated that police were at a

significantly increased risk of suicide, with up to an eightfold risk when compared to their retired counterparts; almost half of the firefighters reported ideation and 15.5% attempted suicide. The rates of suicide among EMTs and paramedics were also poorly documented (Stanley et al., 2017); however, Stanely et al. (2017) identified a rate of 10.4% for serious suicidal ideation in a group of Norwegian ambulance personnel. Other contributing factors include chronic trauma exposure, erratic shift schedules, mental health stigma, and access to firearms.

While Stanley et al. (2017) synthesized a multitude of different studies on suicidality in PSP, there were some clear methodological inconsistencies that limited how comprehensive the findings could be. First, most of the studies included were cross-sectional or retrospective, making it difficult to understand how suicidal thoughts or behaviors change over time or what might be causing them. Second, there was a large variation in how suicidality was both defined and measured. For example, some studies used validated tools, while others relied on single questions or unstandardized surveys. Third, many of the samples came from single departments or samples that were convenient, meaning that the findings may not have applied to all first responders. Further, some studies also did not adjust for key demographic differences or account for factors like the "healthy worker effect," (Stanely et al., 2017, p.27)—a type of bias that occurs when working populations appear healthier than the general population. Such differences and factors could skew comparisons to the general population (Pearce, Checkoway & Kriebel, 2007). Lastly, this review only focused on quantitative data which left out the personal, lived experiences of PSP; additional qualitative research could have been utilized to give the findings increased depth and meaning.

Nevertheless, Carleton et al. (2017) and Stanley et al. (2017) offer a potential illustration of the psychological strain carried by PSP that highlights both the high prevalence of potentially

diagnosable mental health conditions and the increased risk of suicidal thoughts and behaviors across this population. Building on this foundation and establishing that a problem exists among PSP, the next section turns toward the underlying reasons for such elevated risk of developing such mental health concerns, focusing on the chronic exposure to trauma and the structural stressors that shape the lived experience of PSP work.

Elevated Mental Health Risks Among PSP

As mentioned earlier, PSP are consistently exposed to traumatic incidents that serve as significant risks factors for stress-related psychopathology and health complications. According to Wild et al. (2020), this population's reoccurring exposure to critical incidents, combined with organizational conditions which lead to stress and burnout, including irregular shift patterns and limited informal support, predisposes them to conditions, as recounted in the earlier epidemiological studies mentioned above, such as PTSD and MDD. In addition to ongoing occupational hazards and exposure to traumatic incidents, and the brutal reality of human suffering, individuals within this line of work can be constantly exposed to public scrutiny which further exacerbate their stress levels, leaving this population further vulnerable to mental health issues (Koopmans et al., 2017; Reynolds & Wagner, 2008).

While national data in Canada highlights the extent of psychological distress in PSP (Carleton et al., 2017), international findings underscore that this trend is not geographically isolated. A cross-sectional study conducted in Saudi Arabia by Alshahrani et al. (2022) examined over 1,300 PSP and found that 55.2% reported symptoms of depression, 51.2% experienced anxiety, 56.8% struggled with insomnia, and 47.9% exhibited moderate to severe symptoms of post-traumatic stress. The researchers used a series of validated self report screening tools, including the PHQ-9 for depression, GAD-7 for anxiety, ISI for insomnia, and IES-R for post-

traumatic stress, to assess symptom severity across both responders and a general population control group. These prevalence rates were significantly higher than those found in the general population, suggesting that the occupational stressors inherent to first responder work, such as exposure to trauma, unpredictable hours, and organizational constraints, pose serious mental health risks that persist across cultural and healthcare systems.

What makes Alshahrani et al.'s (2022) contribution particularly salient is not only the magnitude of distress reported, but the fact that such elevated symptomatology was observed in a distinct ethnocultural setting, where stigma around mental illness and public emotional disclosure may be even more pronounced than in Canada. Despite this, prevalence rates were comparably high, suggesting that core features of first responder work, such as chronic exposure to crisis, suppressed emotional response, and limited systemic support, may override ethnocultural variance in how psychological symptoms manifest. These findings offer a crucial lens; the profession itself imposes a structural and emotional burden that transcends borders.

That said, some caution is warranted when interpreting these results. Alshahrani et al.'s (2022) study employed a cross-sectional design, which limits the ability to determine whether these symptoms were persistent or circumstantial. Additionally, reliance on self-report measures may have introduced bias, particularly in a cultural context where mental health stigma could lead to underreporting or selective responding. The first responder group itself was not disaggregated by role (e.g., EMTs vs. police officers), which blurs possible differences in exposure and vulnerability. However, these limitations do not negate the core finding that more than half of the PSP screened reported clinically relevant mental health concerns. If anything, the likelihood of underreporting only deepens concern about what remains unseen or untreated in this population.

Further, Alshahrani et al. (2022) highlighted how elevated symptoms are not always accompanied by formal diagnoses or active treatment-seeking. Much like Carleton et al. (2017), who noted widespread self-reported distress in Canadian PSP, Alshahrani et al. (2022) described a population where symptoms are visible, yet formal mental health engagement may remain limited. Together, these studies suggest a disconnect between the scale of suffering experienced by PSP and the systems in place to address it, a pattern that calls in to question the adequacy of both national and occupational responses to first responder well-being.

The evidence outlined in this section highlights just how persistent and multifaceted psychological strain can be for first responders. Repeated exposure to trauma, combined with structural stressors like shift work, organizational pressures, and lack of informal support, leaves this group especially vulnerable to burnout and mental health challenges over time (Koopmans et al., 2017; Reynolds & Wagner, 2008; Wild et al., 2020). Studies such as Alshahrani et al. (2022) demonstrate that these elevated risks are not anomalous, nor are they culturally bound—they are occupationally driven and globally recognized. What emerges across these studies is not just a high prevalence of symptoms, but a system that appears ill-equipped to manage the kind of cumulative psychological exposure that reshapes mental health over time, often in ways that traditional diagnostic frameworks may overlook. As the weight of this exposure accumulates, another concerning pattern emerges: a turn toward maladaptive coping strategies. In particular, the use of substances such as alcohol becomes not just a form of relief, but a secondary risk factor. The next section explores the intersection between mental health and substance abuse in this population and considers how these struggles further complicate the risks already at play.

Substance Abuse in First Responder Populations

In addition to other mental health concerns, addiction and substance use disorders (SUDs) are also very common and serious conditions among first responder populations (Beauchamp et al., 2022; Rotunda et al., 2024). As discussed earlier, PSP often suffer from extreme work-related stress, potentially leading to mental health issues such as PTSD, depression, and anxiety (Carleton et al., 2017; Wild et al., 2020). Subsequently, substance abuse, in particular alcoholism, is very common in such high-stress occupations as a way of coping with the intensity of the work (Rotunda et al., 2024). Rotunda et al. (2024) analyzed the correlation between alcohol misuse and mental health conditions, including PTSD, depression, anxiety, and suicidal thoughts, in Northwest Florida firefighters. The investigators carried out a cross-sectional survey of 546 firefighters with an array of well-validated measures, such as the AUDIT (Alcohol Use Disorders Identification Test, for alcohol misuse), the PCL-5 (PTSD Checklist for DSM-5, for post-traumatic stress symptoms), the PHQ-9 (Patient Health Questionnaire-9, for depression), the GAD-7 (Generalized Anxiety Disorder-7, for anxiety), and the SBQ-R (Suicidal Behaviors Questionnaire-Revised, for suicidal ideation and risk), to identify the presence of alcohol abuse as well as mental health symptoms. Rotunda et al. (2024) found that: 38.8% of participants had high risk alcohol use, and nearly 9% were alcohol dependent. Mental health disorders were also prevalent, with 24.6% of firefighters experiencing moderate to severe depression, 4.4% experiencing moderate to severe anxiety, and 18.9% meeting criteria for PTSD. Rotunda et al. (2024) further found that 21.1% of participants had experienced suicidal ideation in the past year, and 13.6% were at risk for suicide. The study's statistical analysis revealed that alcohol abuse was linked significantly with higher levels of depression, PTSD, anxiety, and suicide risk.

While Rotunda et al.'s (2024) study's large sample size applies generally to a Northwest Florida population of firefighters, there were a number of limitations worth noting. One of the main limitations was how the study was cross-sectional in nature; Rotunda et al. (2024) could not draw causal conclusions and could only indicate correlations as opposed to causation between alcohol abuse and mental illness. Furthermore, their reliance on self-reported data could have been biased and potentially have been influenced by the social desirability of the respondents or their inaccurate recall of previous activities. The predominantly male sample also limited possibility for the study to account for gender differences in substance abuse and mental illness. Another limitation was the exclusive focus on alcohol abuse, to the exclusion of other drugs such as opioids or cannabis, which seem to be increasing in significance in the broader context of substance abuse (Wilson et al., 2021).

In contrast to Rotunda et al.'s (2024) cross-sectional analysis, Beauchamp et al. (2022) used a cross-sectional design with a between-groups comparison to examine substance use disorders among PSP during COVID-19. The researchers compared two groups: PSP who had begun mental health treatment before the pandemic and those who started treatment after the pandemic began. Statistical analysis was used in the research to explore the effect of the timing of treatment on substance use and mental health outcomes. Beauchamp et al. (2022) discovered that nearly 40% of PSP screened positive for potential substance use disorder, a statistic that was later confirmed by Rotunda et al.'s (2024) findings. Interestingly, the timing of treatment, either before or after the pandemic, did not appear to have a significant impact on the likelihood of substance use disorder. This result suggested how extrinsic stressors, like the COVID-19 pandemic, might have not had as direct an effect on substance use as expected. The research did, however, find that heightened depression, anxiety, and suicidality were linked to increased

substance abuse (Beauchamp et al., 2022). By comparing the pre-pandemic and post-pandemic cohorts, Beauchamp e al. (2022) offered helpful insight into how external stressors, the pandemic included, might not have influenced substance use in first responders. However, their study too had limitations. Like Rotunda et al.'s (2024) study, it was cross-sectional and therefore could not determine cause-and-effect relationships. More specifically, Beauchamp et al.'s (2022) sample consisted of only those PSP who volunteered for mental health treatment and may not be representative of all PSP because of this potential self-selection bias; results may not reflect the experiences of those PSP who do not seek help.

Rotunda et al. (2024) and Beauchamp et al. (2022) both highlight the significant issue of substance abuse and its association with mental health challenges within the PSP population. Rotunda et al. (2024) found strong associations between alcohol abuse and mental health symptoms including PTSD, depression, and anxiety. In addition, Beauchamp et al. (2022) demonstrated substance use to be prevalent among PSP with mental health issues also elevating risk for substance abuse. These studies point to more than just comorbidity between mental health and substance abuse; they potentially illustrate how substance abuse becomes embedded within the occupational culture of PSP as both a coping mechanism and, at times, a silent norm.

Alcohol misuse, in particular may emerge as a culturally sanctioned outlet for managing distress, especially when emotional expression is constrained by professional expectations (Beauchamp et al., 2022; Carleton et al., 2017; Rotunda et al., 2024). These findings suggest that substance use is not simply a byproduct of trauma exposure, but a response to trauma as well. Without intervention that assists PSP in coping with the individual distress and that sustains these habits, alcohol abuse and potentially substance abuse is likely to remain an under-addressed, high-impact mental health issue in this field. These findings also raise concern about the

heightened suicide risk in this population; both Rotunda et al. (2024) and Beauchamp et al. (2022) found that substance use was strongly associated with increased symptoms of depression, anxiety, and suicidality, factors that compound one another in ways that elevate overall suicide risk among first responders. This issue demands closer attention given how frequently mental illness, substance use, and suicidality intersect in the lives of PSP (Rotunda et al., 2024; Stanley et al., 2017).

Suicide in PSP

As the systematic review by Stanley et al. (2017) underscored, PSP are also at risk for suicide. Other evidence also demonstrates that PSP have considerably higher rates of suicidal ideation and behaviors (Koopmans et al., 2017; Stanley et al., 2016). Stanley et al. (2017) and Koopmans et al. (2017) identified that stigma, underreporting, and misclassification may prevent the true extent of this issue from being understood. Regardless, both sets of researchers conclude that there is a profound vulnerability to suicide within this population.

A meta-analysis and systematic review by Petrie et al. (2018) drew specific attention to the vulnerability of ambulance personnel to mental health problems, and more specifically PTSD. Petrie et al. (2018) used a rigorous methodological strategy where studies were screened based on meta-analysis and systematic reviews of observational studies in epidemiology (MOOSE) guidelines, where the quality of the study was assessed using the NIH Quality Assessment Tool; only those studies that used validated measures to study symptoms of PTSD, depression, anxiety, or general psychological distress among currently employed ambulance personnel were included in the review. From 27 studies in 15 countries, representing over 30,000 ambulance workers, the authors calculated a pooled PTSD prevalence of 11%, significantly above that of the general population. The studies reported depression and anxiety at 15% each, as

well as general psychological distress at 27%, suggesting a more general psychiatric symptom burden beyond PTSD. Meta-regression analysis demonstrated that duration of data collection influenced PTSD prevalence, being lower in more recent studies possibly due to improvements in workplace mental health initiatives. Nevertheless, high levels of psychological morbidity in all the studies demonstrate that the combined impact of catastrophic exposure to trauma, organizational stressors, and mere availability of means to lethal weapons places ambulance personnel at immense risk of mental ill-health, including suicidality. This risk may be further heightened by their direct and routine access to lethal means in the line of duty, such as medication or equipment used in emergency care, underscoring the urgent need for tailored mental health support for this group (Petrie et al., 2018).

Further, Carleton et al. (2017) found that paramedics and dispatchers were significantly more likely to report suicidal thoughts and behaviors compared to police officers and firefighters. As previously discussed, these findings were based on occupational comparisons within their large-scale national survey of Canadian PSP, using validated self-report measures. In reviewing these studies, it was recognized that not only does this population require more mental health support, but tailored support specific to the type of first responder accessing treatment.

Taken together, the findings discussed throughout this section on suicide in first responder populations make clear that suicide risk is not simply a function of individual pathology, but the result of ongoing exposure to trauma within occupational systems that reward emotional suppression and discourage help-seeking (Koopmans et al., 2017). While PTSD, depression, and substance use are prominent contributors, they are rarely stand-alone explanations for why PSP reach a crisis point. The literature suggests that the cumulative effects of moral burden, cultural silence within PSP environments, and repeated exposure to crisis create

a climate in which suicidal ideation becomes less an exception and more a predictable consequence for some (Ringer et al., 2021; Stanley et al., 2017). These findings challenge us to consider suicide prevention in this field not just as a clinical priority, but as a structural one. This perspective opens the door to a deeper examination of how trauma builds over time.

The Long-Term Emotional and Psychological Toll of Cumulative Trauma

When the general public discusses trauma, they imagine some disastrous one-time incident; for first responders, its not just about the one incident, it is the accretion of the exposure to trauma over the years that starts to take its toll. The psychological and emotional burden builds up incrementally, making it difficult to talk about and monitor the impact of trauma. This next section explores how that kind of cumulative and long-term trauma exposure might manifest in the lives of first responders, not just as daily stress, but also as moral injury, compassion fatigue, and burnout. These notions represent what happens when individuals are consistently exposed to situations that demand sustained emotional, psychological, and physical effort.

Understanding Moral Injury in PSP

PSP are often celebrated for their resilience, but that resilience comes at a cost, which is one that is not always visible. Moral injury (MI) has been introduced in recent years as a type of pain that does not show up in traditional trauma frameworks (Koenig & Al Zaben, 2021). Blumberg et al. (2018) state that moral injury (MI) refers to the pain one undergoes as a result of seeing, committing, or having the possibility to intervene in an act that goes against deeply held principles. Unlike PTSD which arises from fear, MI stems from immorality (i.e., the absence of morality, and guilt), all of which come with a burden of shame and disassociation from one's values (Barnes et al., 2019; Rodrigues et al., 2023). Frequent exposure to potentially moral injurious events (PMIEs) make MI an important issue to be investigated among PSP. For those in

first response professions, PMIEs can include systemic failures, corruption, or lack of resources needed to perform their duties (Blumberg et al., 2018). Such events can result in feelings of guilt, shame, and inner conflict (Barnes et al., 2019; Rodrigues et al., 2023).

Rodrigues et al. (2023) conducted a qualitative inquiry into MI among Canadian PSP through semi-structured interviews with 38 participants in Ontario. This study employed thematic analysis within a constructivist framework to identify how PSP navigate moral conflicts in practice. Most of the participants mentioned distress when professional duties came in conflict with their personal ethics; this was largely heightened by systemic failures, decisions made by leadership, and resource constraints. These findings underline how specific moral dilemmas inherent in public safety occupations and institutional factors may potentially predispose PSP to MI.

Rodrigues et al. (2023) also stated how PMIEs arise in various seemingly contradictory situations, including care being provided to violent perpetrators, implementation of policies that may prolong suffering, or perhaps even inaction against witnesses of misconduct by professional peers. The results of such situations may result in emotional numbing, professional withdrawal, or a loss of confidence (Rodrigues et al., 2023). This internalization of moral distress was strengthened by organizational cultures promoting efficiency over the well-being of PSPs. The moral tension described here—between personal ethics and constrained work environments—not only deepens moral injury but also sets the stage for burnout, which will be explored in more detail later. Moral tension often emerges in systems where trauma is met with limited and constrained autonomy, support, or flexibility (Baker et al., 2023). Although Rodrigues et al. (2023) gave valuable insights into MI among PSP populations, limitations include recall bias and a lack of intersectional analysis regarding gender, race, and disability.

Ringer et al. (2021) also examined the impact of MI on PSP in terms of it's impact on suicide risk, particularly examining cognitive distortions related to self-esteem. Their work was theoretical, not based on new interviews or surveys, and they introduced a novel framework worth discussing. Drawing on the concept of eusociality, which refers to species that function around group survival through cooperation and self-sacrifice, Ringer et al. (2021) proposed that PSP, first responders and military personnel often operate on that same instinct. Their theory suggested that such individuals are wired, either through personality, training, or even biology, to put others first. Ringer et al. (2021) argued that the problem arises when experiencing a MI disrupts that instinct. If a person starts to believe that they've failed their group, or that they're no longer useful to it (due to emotional numbing, professional withdrawal, and loss of confidence) the instinct to protect others can turn on itself. Ringer et al. (2021) argued that in those moments, suicide can start to be viewed as a viable way to carry out, while logical but not necessarily rational, self-sacrifice.

What's important to keep in mind here is that Ringer et al.'s (2021) work does not offer empirical proof. Again, it was a proposed framework and an idea that was meant to start a scholarly conversation and guide future research re-positioning MI out of the realm of psychological symptoms and placing it in a much broader context, including culture, evolution, identity, and purpose. Still, without empirical testing, it remains just an untested framework. Ringer et al. (2021) acknowledge this and yet make an interesting case for further study, especially around how MI and a loss of belonging combine to increase risk in high-stakes professions.

Taken together, Rodrigues et al.'s (2023) grounded interviews and Ringer et al.'s (2021) conceptual model conceptualize MI for PSP not just as a psychological issue, but as a moral and

cultural one as well. This is not just about trauma in the traditional sense. It is about what happens when people can no longer live in alignment with the reasons they pursued their profession (and perhaps their calling) in the first place. Any effort to support PSP has to meaningfully understand this dilemma. Treating symptoms is important, but so is making space for people to re-establish meaning, to reconnect with their values, and to grieve the ways the systems they serve sometimes fall short. What the studies indicate is how moral injury does not simply stem from ethical dilemmas; it reshapes how PSP understand themselves within their work. It fractures the alignment between their values and their actions, often in ways that are invisible to those around them (Ringer et al., 2021; Rodrigues et al,. 2023). Left unaddressed, this dissonance erodes meaning and purpose, compounding the effects of trauma beneath the surface. In a profession built around resilience, these silent ruptures can be some of the hardest to name and the hardest to heal. When unresolved, MI may begin to disrupt one's ability to stay connected and present with others, setting the stage for compassion fatigue. The numbing, withdrawal, and disillusionment that follows can start to show up not just in moments of distress, but in the ordinary demands of care, leaving responders stretched thin in ways that aren't always visible (Cogan et al., 2024; Rodrigues et al., 2023).

Understanding Compassion Fatigue in PSP

Compassion fatigue, which consists of emotional exhaustion and a reduction in the capacity for empathy, is considered a major concern for PSP (Cogan et al., 2024). Continuous exposure to trauma and suffering in high-stress environments has typically resulted in emotional numbness, burnout, and long-term psychological distress for the workers (Cogan et al., 2024). Cogan et al. (2024) explored this and utilized a qualitative approach where they conducted in-depth semi-structured interviews with 54 PSP employed in various capacities. They contrasted

the data using both inductive thematic analysis and interpretive phenomenological analysis (IPA), which allowed them to explore not only common patterns but also idiosyncratic meaning-making about trauma. The study identified occupational stressors such as shift work, workload, and exposure to repeated traumatic events as contributing to trauma. While PSP liked their work because of the sense of purpose and camaraderie, such positive factors were not able to overcome the enduring effect of exposure to trauma.

While Cogan et al.'s (2024) two-method design enriched understanding of compassion fatigue among PSP, the large sample made it harder to elucidate the nuance that such detailed exploration provides and is typical of IPA. In addition, there was the risk that the sensitive nature of the topic, coupled with self-reporting, could have led to some of the participants leaving out parts of their experience. Regardless, Cogan et al.'s (2024) study yielded valuable data on how stigma and lack of psychological safety in the workplace could result in trauma going unaddressed, with burnout and compassion fatigue accumulating over time. In this way, compassion fatigue could be seen as both a response to cumulative trauma and a step towards deeper emotional exhaustion, with burnout being its more entrenched and pervasive result (Baker et al., 2023; Cogan et al., 2024).

Casas and Benuto (2023) tell the stories of PSP and detail the disillusionment that often followed from the result of cumulative trauma. In contrast to interviews, their data came from 30 anonymous trauma narratives that PSP voluntarily submitted to an online support website. This storytelling format gave participants the space to express their thoughts in their own words and at their own pace, allowing for honest, emotionally raw reflections. Casas and Benuto (2023) then conducted both linguistic and thematic analyses of the narratives, examining structure, tone,

coping strategies, and references to trauma to better understand how PSP process and communicate their experiences of formal treatment settings.

Casas and Benuto (2023) noted that many PSP entered the field with high aspirations, only to experience psychological distress and emotional exhaustion over time. These patterns were consistent with those later reported by Cogan et al. (2024), who found symptoms of heightened PTSD, depression, anxiety, and emotional numbing. Maladaptive coping mechanisms included substance abuse, social withdrawal, and suppression of emotions among PSP (Casas & Benuto, 2022). Although this study did not directly measure compassion fatigue, it pointed out the symptomology and manifestation of it. However, the limitations of anonymity amongst respondents and a lack of demographic details reduced the generalizability of these findings. Both studies highlighted that the onset of compassion fatigue represented a complex, cumulative psychological consequence in need of professional attention.

The studies reviewed here suggest that compassion fatigue is not only an individual phenomenon but a cultural one, habituated by the emotional expectations placed on first responders. It is not the trauma alone that wears PSP down, but the sense that they have no room to discuss it, and no space to step back (Casas & Benuto, 2022; Cogan et al., 2024). This suppression, over a period of time, becomes a form of disconnection from the work, from others, and indeed from oneself. It is in this subdued, cumulative detachment that the seeds of deeper exhaustion are planted. Over time, unless compassion fatigue can be identified and addressed, it can evolve into a more entrenched psychological concern. The gradual deterioration of empathy and increased emotional exhaustion that are hallmark features of compassion fatigue most often set the stage for burnout, especially in settings where high demands meet low support (Baker et

al., 2023; Cogan et al., 2024). The next section explores how those pressures accumulate and how burnout emerges as both a personal and organizational consequence.

Understanding Burnout in PSP

Burnout, as described by Maslach et al. (1981), is the chronic, psychological response of stress from improperly managed work by the organizations that employ PSP. Burnout results in three elements: emotional exhaustion, depersonalization, and a decline in personal achievements. These same symptoms in PSP manifest in forms that influence both personal, health, and professional engagement.

Baker et al. (2023) conducted a cross-sectional study using self-reported data from 357 United States police officers'. The police officers were categorized into three groups to examine how burnout is experienced differently depending on one's role: command staff, detectives, and patrol officers. The researchers employed standardized instruments like the Maslach Burnout Inventory, Human Services Survey and the Police Stress Questionnaire-Organizational to assess levels of burnout and organizational stressors. Following this, they used bootstrapped correlation tests to measure how each of these stressors was correlated with burnout for each group. Baker et al. (2023) reported that the highest level of burnout were recorded among front line officers due to exposure to several traumatic events over a period of time, high-pressure decision-making, and restricted freedom to exercise judgement. They outlined the following symptoms: persistent fatigue, emotional depletion, irritability, and increased cynicism toward the public and colleagues, along with depersonalization leading to hostility towards people, decreased job satisfaction and diminished professional effectiveness.

Baker et al. (2023) also found that burnout is manifested differently according to hierarchy. On the one hand, command staff were most troubled by administrative work and

policy changes, while detectives, on the other hand, had frustrations with the court system along with poor coworker relationships as other specific triggering factors. Despite general organizational stressors such as bureaucratic inefficiencies, favoritism, staffing shortages, and institutional non-support, PSP report these stressors to be major contributors to burnout regardless of rank (Baker et al., 2023). While the research provides valuable contributions, there are some important limitations. The population was not demographically diverse, with 95% of subjects identifying as white; while this may reflect the racial composition of many policing organizations, it nonetheless limited the researcher's ability to explore how burnout may be experienced across different racial or cultural identities of PSP. Additionally, group sizes were unequal, particularly among detectives, which could influence the applicability of the results. Furthermore, similar to most cross-sectional designs, the design was also limited in making causal inference.

While the study by Baker et al. (2023) reflected just how grim burnout may be for first responders, it also demands closer explanation of why this kind of psychological exhaustion developed and how it is maintained. Burnout does not just arise overnight, it seems to develop in work environments that make it hard to manage repeated trauma. These environments seemed to be shaped by a mix of systemic and cultural pressures specific to PSP. All of these involve strict hierarchical structure (Baker et al., 2023; Koopmans et al., 2017), a culture of non-vulnerability (Burzee et al., 2022; Casas & Benuto, 2022; Cogan et al., 2024), and more recently, the weight of being in the public eye (Koopmans et al., 2017; Mika-Lude et al., 2023). These various aspects of the PSP culture leave little room for recovery or care and thus further complicate the challenge of supporting PSP to maintain their well being. This lack of psychological space not only

accelerates burnout but also perpetuates the effects of unresolved moral injury and compassion fatigue (Baker et al., 2023; Cogan et al., 2024; Rodrigues et al., 2023).

In summary, moral injury, compassion fatigue, and burnout do not seem to exist in isolation. They interact, intersecting with one another, and gradually wear down even the most resilient individuals. What begins as a single moral wound can unsettle a responder's sense of purpose (Rodrigues et al., 2023). When this is followed by relentless exposure to suffering, without space to process or rest, it becomes harder to sustain empathy (Cogan et al., 2024) and eventually, harder to stay engaged at all (Baker et al., 2023). The cumulative toll isn't always dramatic, but it may be incremental and deep over time. It speaks to the quiet unraveling of psychological well-being that can happen in the very professions society leans on for strength.

Environmental and Cultural Contributors to Psychological Distress

Having explored the emotional impact of cumulative trauma, it becomes just as important to examine the broader context within which this trauma occurs. PSP are not only exposed to high-impact incidents, they operate within systems that often normalize, perpetuate, or even exacerbate psychological strain (Koopmans et al., 2017). Traumatic events may be an unavoidable part of the work, but the culture and structure surrounding that work shape how trauma is experienced, processed, and supported (Casas & Benuto, 2022). This section investigates beyond the traumatic incidents themselves and turns attention toward institutional and cultural factors, including workplace dynamics, organizational stress, and stigma that influence mental health and either exacerbates or ameliorates how PSP cope with trauma in their unique workplace.

Workplace Trauma as an Environmental Contributor to Psychological Distress

Given the complexity of trauma within first responder populations, a deep understanding is critical for psychologists aiming to provide effective support to this population. Studies by Casas and Benuto (2022) and Cogan et al. (2024) add to an in-depth knowledge base with regard to first responders, suggesting that the approach should not only be trauma-informed but sensitive to environmental and workplace-specific challenges for psychological resilience.

As discussed, Casas and Benuto (2022) provided a qualitative analysis using thematic analysis and linguistic tools of 30 anonymously completed trauma accounts from first responders. Their analysis was employed to identify recurring patterns and themes within the narratives of PSP. This allowed for thick descriptions that were rich in first-person information, highlighting the deep environmental impact that work trauma has on mental health. The importance of this study was the depth of the first responder narratives which depicted repeated exposures to various types of traumas, such as pediatric deaths, motor vehicle accidents, and suicides, contributing to psychological distress that included depression, anxiety, PTSD, and intrusive thoughts. Casas and Benuto's (2022) study, focused on genuine narratives, provided ecological validity and a more fulsome exploration of mental health challenges facing this population. However, while the naturalistic setting and first-person accounts added depth and authenticity, the study's reliance on self-selected online submissions also introduced potential bias. The narratives may have only reflected those more willing or ready to disclose, possibly excluding the perspectives of individuals who were more severely impacted but less inclined to share their experiences.

Cogan et al. (2024) furthered their understanding by using a mixed-methods approach which consisted of semi-structured interviews of 54 PSP that they analyzed using interpretive

phenomenological analysis. This research revealed the cumulative effect of occupational trauma. More specifically, the research explored how daily exposures to traumatic events, such as witnessing fatalities, responding to mental health crises, and delivering traumatic news, built up over time to cause what participants described as “micro-traumas” (Cogan et al., 2023, pg. 6). Symptoms reported included flashbacks, nightmares, and emotional exhaustion; these symptoms not only undermined personal well-being but affected performance. The findings of this study highlight the need for interventions tailored to deal with cumulative and multiple traumas due to their pervasive effects on mental health.

However, the study by Cogan et al. (2024) had limitations in terms of participant diversity and presented some methodological challenges. While few police officers and PSP of colour were included in their sample, potentially limiting the breadth of perspectives, the reality has been that many PSP organizations in Canada remain predominantly white and male (Carleton et al.,2017). As such, Cogan et al.’s (2024) sample may reflect the demographic makeup of these institutions, even if it provided limited insight into how race or intersectionality shape trauma and resilience. Additionally, although participants reported symptoms consistent with PTSD, the study did not include any formal screening measures, which also limited the researcher’s ability to assess the clinical significance of the symptoms described.

Such findings call for psychologists to rethink their reliance on current therapeutic models and consider the broader ecology in which PSP operate. High frequency and intensity of trauma exposure in this population necessitates interventions that address individual symptoms and focus on environmental and organizational conditions that contribute to psychological distress, such as stigma and lack of psychological safety. Moreover, knowledge of cultural

nuances shaping the perceptions of PSP about mental health becomes important to enhance therapeutic rapport and effectiveness, allowing interventions to be appropriate and effective.

Administrative Workplace as an Environmental Contributor to Psychological Distress

Stress in the first responder profession is not only a result of trauma exposure; it is also environmentally produced within the administrative workplace itself. Organizational structure and workplace dynamics often have an equally significant, but lesser-talked-about, influence on psychological distress (Koopmans et al,. 2017; Murray et al., 2020; Shane, 2010). The environments that PSP operate within, which can include authoritarian management, overwhelming administrative tasks, or lack of support, can quietly but powerfully chip away at psychological well-being over time (Baker et al., 2023; Maslach & Jackson, 1981). Understanding this facet of the work is critical, especially for psychologists who work with this population.

In their narrative review, Koopmans et al. (2017) reviewed 40 studies that explored suicide risk and mental health concerns in Emergency Response Services (ERS). While their review was mostly founded on police data and relied heavily on secondary sources, it did point to major trends, particularly in Canadian settings. Koopmans et al. (2017) emphasized how paramilitary structures, strict hierarchies, and organizational silence towards mental health issues resulted in chronic psychological distress. Although the methodology underreported EMS and firefighters, it illustrated that workplace culture internally had influence on how mental health risks manifest.

While Koopmans et al. (2017) reveal how systemic structure and silence shape mental strain, Murray et al. (2020) bring a more direct lens focused on the traumatic reality of workplace violence and the organizational responses that follow. Murray et al. (2020) emphasized EMS

workers and their experience with workplace violence (WPV). In this context, WPV was defined as acts of verbal, physical, or sexual aggression directed toward EMS personnel by patients, family members, or members of the public during the course of their duties (Murray et al., 2020, p. 492). By conducting a systematic review of 104 studies, they found that as many as 93% of EMS personnel were exposed to some type of verbal, physical, or even sexual violence while at work. What was surprising, though, was how often these types of incidents were not reported or were not taken seriously by the organization. It was a matter of being just a part of their job (Feiner, 1995) for most EMS providers, and they thought that reporting would not make it change. The lack of systematic follow-up and the absence of clearly defined policies and mental health supports are environmental stressors that contribute to psychological distress (Murray et al., 2020). While WPV definitions varied within the studies Murray et al.'s (2020) message was apparent: indifference in the organization adds another dimension to the burden experienced by PSP who already work in a very demanding profession.

More recently, Baker et al. (2023) expanded on these ideas by examining variations in organizationally rooted psychological stress by rank in police forces. They used a cross-sectional survey design and measures like the MBI-HSS and PSQ-Org, and bootstrapped correlations to strengthen their findings. What they found was that not all officers stress equally. Administrative overload and ongoing policy changes were cited as stressors by command staff. Conflict with peers and judicial system delays were endorsed by detectives as creating stress. Unpredictable leadership and short staffing were noted by patrol officers as their greatest stressors. While Baker et al.'s (2023) study was limited to a fairly homogenous and geographically contained sample, it underscored the need for interventions to be tailored to the unique pressures of rank within the police force.

Shane (2010) also studied organizational stress from a performative perspective. In his 461-officer study of two urban U.S. departments, Shane (2010) discovered that administrative and managerial dysfunction, including poor leadership, lack of transparency, and adversarial internal accountability systems were more predictive of reduced performance than operational stressors like court time or exposure to trauma. Using the Police Stress Questionnaire (PSQ) and performance data, Shane's (2010) research demonstrated how internal organizational dynamics are potent environmental contributors to psychological distress and how well officers perform on the job. Shane's (2010) study only considered patrol officers and not rural departments or higher-level officers, but their findings strongly suggest organizational stressors matter.

Finally, Casas and Benuto (2022), whose methodology was previously described earlier in this chapter, identified themes of organizational failure after trauma as stressors, including poor debriefings, no follow-up, and PSP feeling unsupported. Because accounts were anonymous and self-selected, it is challenging to generalize the results. Despite this, Casas and Benuto (2022) addressed the reality that many PSP felt angry towards their institutions when they were in most need of assistance. Independent of professional diagnoses of trauma, these reports show how institutional neglect can contribute to psychological distress and can potentially complicate existing issues for PSP.

Together, these studies demonstrated that organizational systems and workplace culture were tied to PSP stress. Harsh hierarchies, inattentive command, poorly defined expectations, and weak support systems don't merely make the job harder to perform - these are environmental contributors to psychological distress. While operational stress can be an issue, internal systemic stresses of equal or greater magnitude must also be addressed. Organizational realities seem to create the backdrop against which other challenges, like help-seeking behavior and openness

about mental health, take place. With this in mind, it becomes necessary to examine more closely how mental health stigma shows up in first responder culture, and how it interacts with these structural pressures to influence whether individuals seek or receive the support they need.

Mental Health Stigma as a Cultural Contributor to Psychological Distress

This chapter has established that PSP are not only faced with exposure to repeated traumatic incidents; they are also exposed to constant organizational stressors, including the common theme of persistent mental health stigma. The stigma attached to mental health within PSP culture poses a problem unto itself, and also impacts help-seeking attitudes and behaviors, thus prevents individuals from getting necessary psychological help (Bruzee et al., 2022; Chapman et al., 2014; Cogan et al., 2024; Davenport, 2012; Haugen et al., 2017). As outlined earlier, mental health disorders are prevalent within this population; however, many PSP tend to hide their symptoms because of fears surrounding their job and job opportunities (Carleton et al., 2017). The stigma that surrounds the mental health of PSP acts as a cultural barrier to psychological well-being while at the same time allowing undermining narratives around mental health to thrive. Stigma thus keep individuals without support and makes them vulnerable to chronic mental health conditions.

Cogan et al. (2024) provided insight into the experiences of PSP and their views on stigma as being akin to a “cultural taboo” (p.9). Their qualitative study revealed that PSP experience significant pressure to maintain a “stiff upper lip” (p.9) demeanor, discouraging expressions of vulnerability. In this context, admission of mental health difficulties was often viewed as indicative of weakness, professional incompetence, or even unfitness for duty. This led to the development of a “macho” (p.9) culture in which any admission of mental health challenges may be deemed a risk to judgment, ostracism, and even career hazard. Participants in

Cogan et al.'s (2024) study also expressed fears of being reported to regulatory bodies or losing their professional registrations, further heightening their reluctance. This was in line with the meta-analysis conducted by Haugen et al. (2017), which illuminated how fear of breaches in confidentiality and negative career impacts were among the most highly endorsed stigma-related barriers that prevent help seeking.

Haugen et al. (2017) quantified the stigma that PSP faced by aggregating findings from 14 studies assessing the prevalence and impact of mental health stigma and barriers to care among this population. The studies selected were based on a strict set of predefined inclusion criteria that ensured at least one variable related to barriers or stigma associated with mental health care was mentioned. The Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies (QATOCCSS) was utilized by the authors as a methodological framework that considered sample size, research design, and measurement reliability. Consensus, or if necessary, the involvement of a third reviewer, resolved disagreements in the selection process as a way of ensuring methodological rigour.

The main results of Haugen et al.'s (2017) review demonstrated that about 33.1% of PSP experienced stigma, while 9.3% reported other additional barriers to care. Major identified barriers were the inability to schedule appointments, acquiring time off from work, and issues reaching service facilities. This study identified that much similarity existed across all types of PSP like police, medics, and firefighters. However, most were enveloped by a military-like culture that depended on self-reliance. The PSP culture's narrative on resilience translated to the suppression of any vulnerability, even at a cost of their mental health. Most importantly, Haugen et al. (2017) illustrated the need for psychologists to ensure PSP were afforded comfortable and confidential places to disclose their concerns without fear of judgement or professional risk.

While these studies provide important insights, there were still some gaps. Haugen et al. (2017) noted that their findings were dominated by studies that originated in the United States, with a paucity of non-Western cultures represented. This narrow focus limited the generalizability of the findings and created a need for more culturally diverse research into how stigma contributes to psychological distress in PSP populations outside of the United States. More research was also needed to examine the relationship between stigma and diagnosis, such as PTSD or substance use disorders. PSP with conditions such as alcohol use (Davenport, 2012) or PTSD (Chapman et al., 2014) were noted to endorse stigma and barriers to care. However, more research was needed to understand how stigma uniquely affects individuals with these specific diagnoses, so that interventions can be tailored to their experiences.

While Haugen et al. (2017) offered a foundational look at stigma's reach across the profession, Burzee et al. (2022) deepened the conversation by quantifying how stigma was felt among peers and internalized by individuals. Burzee et al. (2022) contributed to the empirical literature on stigma by re-surveying the Police Officer Stigma Scale (POSS), a psychometric tool originally developed to assess attitudes and beliefs related to mental health stigma within police culture. Their research aimed to more precisely define how stigma has been measured in PSP and to identify which specific elements of the scale affect mental health attitude and behavior within this group. With 135 participants from Central Florida consisting of police officers, firefighters, and emergency dispatchers, their research utilized factor analysis to quantify the structure of the POSS and its reliability. The scale was able to generate a high internal consistency ($\alpha = .84$), which suggested that the instrument was effective in quantifying appropriate dimensions of stigma.

Based on their analysis, Burzee et al. (2022) developed a two-factor model of mental health stigma in first responders: (1) coworker mistreatment with mental illness; and (2) fear of disclosing a mental disorder. The first factor, which accounted for 59% of the variance, was indicative of attitudes about how others with mental illness are treated in the workplace, ranging from subtle exclusion to open discrimination. Internalized concerns by PSP with mental disorders about disclosure and consequence accounted for a 13.5% variance. These fears included career loss, loss of regard from the rest of one's colleagues, or being deemed unfit to serve.

There were limitations to Burzee et al.'s (2022) study despite its important findings on factors that contributed to PSP disclosing their mental health concerns and the stigma that surrounds it. The sample community, as mentioned earlier, was regionally centered in Central Florida, and all had experienced mental health awareness training, which was not always reflective of the broader first responder community, particularly those less exposed to mental health discourse. Also, like a lot of work in this research space, Burzee et al. (2022) utilized self-report information, limiting generalizability. Burzee et al. (2022) also indicated that additional cross-cultural work would be required because the results could not be directly applied to populations outside of the United States; they specifically mentioned the potential for a difference between American and Canadian PSP. In addition, the extent to which stigma may be influenced at the organizational or institutional level of leadership was not investigated by the research. These are areas that subsequent studies may be able to provide deeper insights.

Despite these limitations, Burzee et al.'s (2022) work is important because their revised POSS used was psychometrically validated for use in Canadian PSP populations and refined to focus more directly on stigma that interferes with help-seeking behavior. This made for a better

measure for assessing stigma in first responder populations and a more accurate platform on which to build targeted interventions. Their findings also added validity to the idea that stigma occurs on a multitude of interpersonal levels: by the way one treats others; and intra-personally, by fear of oneself being treated differently. This suggests that stigma reduction strategies must address not only individual attitudes but also workplace culture.

Generally, stigma remains a deeply entrenched barrier to seeking mental health treatment among first responders. It is underpinned by cultural norms, peer beliefs, and institutional policies that position seeking help as vulnerable and subsequently unsafe. Although recent research, most notably by scholars like Haugen et al. (2017), Cogan et al., (2024), and Burzee et al. (2022), has shed light on the various forms and impacts of shame, more work is needed to translate this knowledge into effective, sustained change for PSPs and their workplace culture at large. This includes closing gaps in cultural representation, exploring organizational determinants of wellbeing for PSPs, and evaluating the practical effectiveness of stigma-reduction interventions. Unless and until the culture shifts to a place where psychological health is necessary to doing one's professional work, stigma will continue to isolate those who work with others at great personal cost.

Cumulatively, the traumatic interruptions, organizational pressures, and long-standing stigma that pervade PSP culture illustrate that psychological distress does not occur in a vacuum. These events are a part of a greater professional culture that discourages openness and facilitates silence. But even this spectrum is inadequate. The first responders' sense of self—and whether or not they opt to accept assistance—are also shaped by broader cultural forces and public narratives (Chandrashekar, 2022; Haugen et al., 2017; Koopmans et al., 2017; Mika-Lude et al., 2023; Ringer et al., 2021). In order to fully understand the mental health concerns of this

population, it is important to look at how these concerns are situated within external views, social expectations, the greater public debate, and how these factors intersect with the professional and personal identities of PSP.

Identity, Culture, and Public Perception

A deeper comprehension of first responder mental health also requires looking beyond internal systems and organizational culture to the broader social narratives that construct identity. Public opinion, cultural expectation, and media representation all play a part in how PSP are viewed, and how they view themselves (Chandrashekar, 2022; Haugen et al., 2017; Koopmans et al., 2017; Mika-Lude et al., 2023; Ringer et al., 2021). These external forces may reinforce stigma, predisposing PSP to moral injury, complications receiving help, and potentially causing feelings of isolation or affective disconnection. This section explores how identity, culture, and public stories converge with working life, and how these forces impact the mental health of first responders.

Public Scrutiny of PSP Through Dehumanization Narratives

Understanding the psychological impact of public scrutiny on PSP has become increasingly important for psychologists working with this population, particularly in light of the zeitgeist and heightened attention following events such as the murder of George Floyd and the rise of social movements calling out police bias and institutional harm (Fine et al., 2024). These shifts in public awareness have intensified media coverage and criticism, placing added emotional and moral pressure on first responders, especially those in policing roles (Fine et al., 2024; Koopmans et al., 2017; Mika-Lude et al., 2023). The literature reviewed places much emphasis on how societal/ media narratives dehumanize first responders, and shifting societal expectations add significantly to burnout, stress, and even suicidality among PSP (Fontesse et al.,

2021; Koopmans et al., 2017; Mika-Lude et al., 2023). Such emphasis becomes a form of public scrutiny on PSP in general and understanding this influence can aid in generating a holistic and current view of their mental health.

Dehumanization, in psychological terms, refers to the denial of some aspect of human qualities, emotions, and individuality to a group (Haslam et al., 2008). It can take many forms: animalistic dehumanization, where the subject is compared to an animal (e.g., the use of the term "pigs" for police); mechanic dehumanization, where subjects are treated as emotionless and likened to machines; and deistic dehumanization, where subjects are regarded as superhuman e.g., "hero" narratives which disregard vulnerabilities (Fontesse et al., 2021). These forms of dehumanization carry psychological implications, especially among PSP, who are nonetheless continuously judged by the public to act unrealistically. When PSP first understand how they are perceived as disposable or unemotional, emotional detachment occurs. This detachment results in a loss of self-worth that accelerates the process of burnout and the deterioration of mental health, which ultimately creates more stress (Mike-Lude et al., 2023).

Mika-Lude et al. (2023) conducted an empirical analysis which included 211 participants and a cross-national analysis of meta-dehumanization occurring among first responders. Results from this study were able to identify a significant relationship between perceived dehumanization and emotional exhaustion using hierarchical regression analysis and Pearson correlation coefficients. Their results revealed how the police and EMS personnel, first-line of defence populations, were highly predisposed to burnout from negative public perception. Mika-Lude et al. (2023) further emphasized the cultural dimension by underlining that Canadian PSP reported higher meta-dehumanization and burnout compared to the United States sample.

Mika-Lude et al.'s (2023) findings hint at deeper structural differences that may help explain the disparity in mental health burdens across national contexts. For example, media representation can play a role in shaping how PSP are publicly perceived, when portrayals are overwhelmingly negative or reductive, which may reinforce feelings of being misunderstood or vilified, contributing to self-dehumanization and eventually emotional exhaustion (Mika-Lude et al., 2023). Public trust also seems to matter when trust in emergency services is low; PSP may perceive their work to be undervalued or constantly under suspicion, which can erode morale and heighten stress (Koopmans et al., 2017). Lastly, the availability of social support, both within organizations and in broader community settings, can either buffer or intensify the effects of stress and scrutiny (Koopmans et al., 2017; Mika-Lude et al., 2023). These factors together help clarify why ranks within PSP may report more severe psychological outcomes than others, despite being within the same profession.

Though Mika-Lude et al.'s (2023) study has notable strengths, the study is not without its limitations. Again, self-report data can be prone to a number of biases, including social desirability and subjective perception errors. Mika-Lude et al.'s (2023) study also could not determine causality because of its correlational design. Additionally, the quantitative nature of this study limited its understanding of the personal experiences of dehumanization. A mixed methods design could have yielded more insights.

Koopmans et al.'s (2017) study examined the notion of public scrutiny of PSP by conducting a narrative literature review of suicide in PSP in Canada and internationally. The review synthesized 40 studies, with particular emphasis on how stigma related to mental health continued to shape the experience of PSP professionals. One key finding was how the underlying paramilitary workplace culture in many emergency services reinforced the belief that emotional

resilience is non-negotiable, which in turn discouraged PSP from seeking support for their mental health. Moreover, Koopman et al. (2017) found that public scrutiny increased psychological distress because the media often portrayed PSP as either heroes or villains. Such polarized portrayals of PSP created unrealistic expectations, and thus increased pressure on individuals to suppress emotions while trying to maintain a composed public image.

Together, Mika-Lude et al. (2023) and Koopmans et al. (2017) offer more than just parallel findings. They potentially illustrate how public scrutiny, in its many forms, shapes the way PSP relate to themselves, their work, and the people they serve. Mika-Lude et al. (2023) demonstrated how perceptions of being dehumanized can wear away at emotional resilience and contribute to burnout, while Koopmans et al. (2017) situated those effects within a cultural landscape that demands stoicism and punishes vulnerability. What emerges from both studies is a pattern in which PSP are caught between public expectation and personal cost. If left unaddressed, internalization of public scrutiny occurs, and it can be increasingly difficult to disentangle this from the mental health challenges these individuals face.

Personality Characteristics and Their Relationship to PSP Culture

PSP often have a distinctive set of characteristics that define their ways of thinking, feeling, and acting, thus influencing their mental health and access to care. Haugen et al. (2017) suggest that the scarcity of conceptual and identity frameworks pertaining to PSP often means that military frameworks and identities are applied to topics like stigma and mental health. This is not to say that such an approach has no merit. However, the application inherently cannot go very far because such approaches hold the risk of oversimplifying the unique experiences of PSP. Nevertheless, key parallels, such as pre-employment mental health screenings, predominantly male demographics, and a shared emphasis on self-reliance, are illuminating because they reflect

structural and cultural factors that may shape both who enters the profession and how stigma about mental health has been internalized within it (Haugen et al., 2017). This may explain who may be interested in pursuing this profession: typically, a person of considerable mental health strength and flexibility, who fits in comfortably in highly stressful situations. PSP differ from military personnel in several important ways. Their work is more civilian-focused, involves continuous exposure to trauma within their own local communities, and typically offers geographical stability. The nature of the threats they face, along with the legal and societal scrutiny to which they are subjected, also sets them apart. For these reasons, relying solely on military frameworks may risk oversimplifying the unique realities of first responder experiences.

Chandrashekar (2022) extended this discussion by proposing and theorizing the existence of the fearless dominant personality (FDP) and how it applies to many first responders. This personality includes traits such as emotional resilience, low anxiety, and social dominance that are quite useful in handling situations that are dangerous and unpredictable. These traits imply the ideal type of person oriented towards the role of a first responder (i.e., individuals who are both biologically and psychologically prepared to face trauma with equanimity). At the same time, Chandrashekar (2022) pointed to the negative features of the FDP, particularly their contribution to emotional detachment and reluctance to seeking mental health support. Chandrashekar's (2022) personality theory on PSP argues that the stigma from PSP culture first responder communities is reinforced by the idealization of strength and fearlessness, further discouraging vulnerability and help-seeking behaviors. The psychological impact of functional disconnection patterns (FDP) gets more layered when you factor in moral disengagement— a tendency of people to justify questionable behavior as a way of easing emotional discomfort (Bandura, 1999; Chandrashekar, 2022). This makes it all the more important for psychologists to

really get a feel for the behavior patterns common in first responders—not just as isolated traits, but as ones that are shaped and sometimes amplified by their work environment. Interventions, then, need to strike a balance: drawing on what's flexible and resilient in the individual, while also addressing the obstacles they might unknowingly reinforce.

Chandrashekar (2022) puts forward an interesting analysis that points to certain personality patterns that might show up more often in public safety personnel (PSP). These traits, when viewed in the broader PSP culture, could be both shaped by and shaping that environment. That said, the argument would be strengthened by research that tests these ideas in practice—especially research that looks at how things like organizational culture and peer dynamics either support or push back against these traits. Recent work on FDP also points to the need for follow-up studies that take place in different contexts—across regions, roles, and settings—to really see if these claims hold up.

Relatedly, Ringer et al. (2021) introduce the concept of eusociality as the theoretical framework of personality informing suicide risk in first responders. Eusocial behaviors are those that put the collective welfare over personal welfare, such as self-sacrifice for the greater good of a communal living situation, a common component of the role of being first responder (Hayes & Stanford, 2013; Joiner et al., 2016). Ringer et al.'s (2021) framework identified, for the first time, the psychological drivers that underpin entering this profession, emphasizing a strong sense of duty and altruism. However, Ringer et al. (2021) also identified potential risks associated with these traits, such as moral injury, and thwarted belongingness, which can exacerbate mental health challenges. While this framework is compelling, it also has not been empirically validated.

In sum, the working identity of PSP is shaped not only by internal traits like emotional steadiness and a strong sense of duty, but also by the cultural values, institutional structures, and

public expectations that reinforce those traits. The FDP model (Chandrashekar, 2022) and the concept of eusociality (Ringer et al., 2021) highlight how the same characteristics that make someone effective in crisis can also increase their risk of emotional suppression, moral injury, and reluctance to seeking support. These patterns are not individual. They point to a broader professional culture where expressing vulnerability is often viewed as a sign of weakness. In order to fully understand the mental health risks that come with this line of work, it is important to consider how personality traits, occupational identity, and workplace culture interact. This overlap influences how first responders relate to their roles, and it offers valuable insight for psychologists aiming to provide care that feels relevant, respectful, and grounded in the reality of their experiences.

Chapter Summary

Psychologists working with PSP need to understand and appreciate the distinctive challenges in mental health and intersectionality with culture within the profession. PSP are often exposed to trauma and violence in the course of duty, putting them in stressful situations, coupled with organizational stress factors that place them at greater risk for PTSD, depression, as well as suicidal ideation, burnout and compassion fatigue (Wild et al., 2020). As mentioned earlier, Carleton et al. (2017) found that 44.5% of PSP of Canada demonstrated a positive screen for at least one mental disorder compared to 10.1% of the general population, signalling a call for an urgent need to intervene. A high rate of suicide and suicidal ideation existed among PSP but cannot be accurately estimated due to stigma and gross underreporting (Koopmans et al., 2017; Stanley et al., 2016). Of particular note is vulnerability to cumulative trauma and access to lethal means, especially among paramedics and dispatchers (Petrie et al., 2022). Psychologists should acknowledge how structural barriers might prevent help-seeking among first responders, related

to confidentiality and possible career impacts deeply rooted in stigma, stemming from both PSP and their workplace culture (Haugen et al., 2017).

Organizational stress also plays an important role. Hierarchical structures, long hours, workplace violence, and lack of support exacerbate emotional exhaustion and subsequent burnout (Murray et al., 2019). Studies show that systemic issues, such as poor leadership and bureaucratic inefficiencies, may be more damaging than trauma exposure itself (Shane, 2010). Drawing from this understanding about these occupational adversities allows psychologists to build trust and hope within their clients and most importantly demonstrates to PSP their abilities to empathize with their unique circumstances. Moral injury (Blumberg et al., 2018) and the FDP described by Chandrashekar (2022) have also contributed to the understanding with PSP as emotionally detached. When all of these concerns are combined with the stigma emerging from PSP culture, it becomes exceedingly hard for PSP to show any sign of weakness, affecting their willingness to seek help. Furthermore, the elements of public scrutiny and dehumanization add notions of isolation and resentment among PSP (Mika-Lude et al., 2023).

There is a call for psychologists to consider “cultural competence” and “trauma informed” paradigms that address stigma, organizational stressors, and cumulative trauma exposure. Frameworks for therapeutic interventions with PSP should consider the importance of building rapport, acknowledge systemic barriers, and integrate peer support to significantly improve therapeutic outcomes. Being cognizant of these different factors will allow psychologists to not only be responsive to first responders, but will also enable them to build resilience and achieve holistic mental health for this population.

Chapter 3: Discussion and Applied Practices

This chapter begins by outlining clinical insights for psychologists working directly with PSP with knowledge that considers the lived context of this unique workforce. After that, the focus shifts to a wider lens examining how systemic structures like policy, organizational culture, and high-level decisions influence mental health outcomes for PSP. Recommendations are laid out, drawn from recurring ideas that came up again and again in the review of the research in the previous chapter. There is also a short section that flags limitations within the reviewed literature and a few areas where more research is still needed. The final part of the chapter is more personal. It steps back to reflect on what the process of writing this capstone has taught me. This chapter is not about offering all the answers, but it contributes to broader dialogue on how best to understand and support PSP, individuals working in high-stress, public-facing roles.

Clinical Implications and Practice Principles

Collaboration with PSP in a therapeutic environment requires more than foundational clinical knowledge. It requires context, knowledge, cultural sensitivity to the PSP environment, and adaptability to collaborate with cumulative, layered, and entrenched trauma in organizational systems and identity. Drawing on the literature review findings, this section offers clinical principles that are helpful for psychologists working with PSP in individual therapy. While these recommendations are not based on direct clinical experience, they are rooted in current empirical research and theoretical frameworks reviewed in the previous chapter. They are offered as considerations to inform practitioners working with PSP in trauma-informed, context sensitive, and ethically sensitive contexts. Emphasis is placed on pragmatic, responsible, and organizationally appropriate care for PSP within their environment and culture, prioritizing trauma-informed, ecological, and stress-coping principles.

Clinical Recommendation #1: Expect Indirect Entry and Work with the Presenting Concern

PSP rarely present for therapy to process trauma in a self-motivated way (J. Mendoza, personal communication, June 25, 2025). Instead, many present more frequently because a partner, friend, or supervisor brought some change to their attention. This kind of indirect entry point, for example, “My wife says I’ve been drinking too much,” or “Things at home aren’t great lately,” is more than just common; it offers insight into how emotional strain is often recognized in relationships before it is acknowledged internally. What might look like hesitation to engage might often be better understood as an organizationally shaped way specific to PSP culture of entering therapy (Rodrigues et al., 2023). For the majority of PSP, it is cues from the outside world in terms of how others perceive them, changes in relationships, or worry from someone who cares about them that initiates help-seeking, not self-awareness of pain from within (Jones et al., 2019; J. Mendoza, personal communication, June 25, 2025).

When a PSP client comes to therapy for the first time, their presenting concern does have to be listened to and acknowledged. The issue they complain about by name (i.e., drinking, relationship issues, or issues at work) deserves full and extensive consideration. While doing this, it is useful to stay politely curious about what else might be going on. Rather than moving straight into charged emotional questions, it could be more effective for psychologists to leave space for the client to uncover at their own pace. Open and open-ended questions like, “What do you think your partner has been seeing lately?” or “Have things started to feel different at work or home?” may encourage reflection without putting the client on the defensive. These types of invitations have the potential to make it easier for individuals to label and name what they are feeling in their own terms. This is reflective of the foundation of the transactional theory of stress and coping (Lazarus & Folkman, 1984) wherein assessment of coping with stress in relation to

the environment is a priority. It also resonates with some of the key tenets of trauma-informed care (TIC) (Kim et al., 2021), including the need to place emphasis on safety first, maintaining a collaborative approach, and avoiding forcing disclosures until therapeutic relationships can support them.

Clinical Recommendation #2: Recognize and Explore Moral Injury and Identity Disruption

Moral injury appears to be a common but often neglected problem in clinical practice with PSP (Lentz et al., 2021). It often arises when a person is placed in a situation or asked to make a decision that goes against their own ethical or moral code—for example, following an order that feels wrong, enforcing a policy they believe is harmful, or staying silent during an institutional breakdown (Ringer et al., 2021; Rodrigues et al., 2023). Although these experiences may not constitute criteria for PTSD, they may lead to enduring shame, guilt, and identity disturbances that ought to be addressed.

It is with these patterns in mind that it may be clinically useful to remain mindful of subtle signs of moral injury when treating PSP. Clients may not immediately define their distress in moral terms, but that they say things like “I don’t feel like myself anymore,” or “I used to be proud of what I do,” which may suggest deep internal conflict. Rather than attempting to rephrase these disclosures on the spot, psychologists may better serve their clients by providing space to discover their meaning slowly and together. Delicate questioning along the lines of “What would have felt right for you in that moment?” or “Has this work changed your understanding of yourself,” may ignite reflection and awareness. This is a recommendation informed by principles of TIC, in this instance, ones that encourage collaboration, safety, and empowerment (Kim et al., 2021). It is also informed by the transactional theory of stress and coping (Lazarus & Folkman, 1984), which emphasizes the subjective appraisal function in

determining the emotional impact of stressful experience. Sometimes, as therapy begins to unfold, this work begins to support post-traumatic growth where clients can clarify their values, and start to think differently about what they've lived through. They may notice how it has changed them, what still matters to them now, and what they still want to carry forward (Horswill et al., 2021; Wild et al., 2020). Right beside moral injury, another pattern that frequently shows up in PSP narratives is burnout, a more chronic, accumulative form of distress that can quietly shape how individuals feel about their work, their role, and even themselves (Cogan et al., 2024).

Clinical Recommendation #3: Identify Burnout as a Systemic and Psychological Concern

Burnout is a common concern with PSP clients, though it is also seldom acknowledged (Baker et al., 2023; Casas & Benuto, 2022; Cogan et al., 2024). It is not only fatigue, but profound loss of mission, attachment, and emotional presence. In the literature, burnout tends to exist simultaneously with compassion fatigue, moral injury, and detachment from colleagues or even the public (Baker et al., 2023; Cogan et al., 2024). Clients may be saying "checking out," "numb," or, "counting down the days until retirement," without realizing they may be describing burnout. Exploring burnout in therapy may require careful inquiry into the emotional texture of the work itself, particularly in how the client feels constrained from performing the work. Questioning the client's emotional connection to their role and attending to shifts in their motivation may be more revealing than simply screening for symptomology. Questions like "How do you feel about coming to work today," or "When did the job stop feeling like something you cared about?" may help PSP clients begin to access their own burnout stories. This approach acknowledges that burnout should not bee seen as a personal weakness. More

often, it is something that grows out of long-term exposure to broken systems, cultural expectations, and ongoing organizational strain.

The ecological systems model (Bronfenbrenner, 1979) is useful in this case as it places the client's experience within the broader context of their environment. Burnout is not only influenced by individual coping mechanisms but also by management, organizational culture, and public narratives (Baker et al., 2023; Bruzee et al., 2022; Cogan et al., 2024). Counseling can support clients by helping them grasp the manner in which these systemic layers converge and what is under their locus of control (Wang et al., 2014). While burnout may manifest internally as detachment, exhaustion, or cynicism, its effects will not necessarily remain so. For many PSP, these stressors extend into the home and impact mood, communication, and emotional availability with family members (Cogan et al., 2024; Pennington et al., 2022).

Clinical Recommendation #4: Address the Spillover into Family Life

The impact of work stress on PSP families is often overlooked. In many cases, PSP clients visit therapy only after one partner has expressed concern (Jones et al., 2019; J. Mendoza, personal communication, June 25, 2025). Home is where compounded stress initially begins to directly affect mood, conduct, and emotional availability. This trickle-down effect could lead to conflict, distancing, and prolonged relational tension (Cogan et al., 2024; Pennington et al., 2022).

In therapy, attending to the client's relational context does not mean diverting focus from their individual needs. It does suggest, however, recognizing that the client's problems often exist in a larger context. Asking questions such as, "What version of you comes home?" or "How has your stress changed your place in the family?" may help PSP clients see the unintended effects of coping. Where possible, psychologists can provide psychoeducation about stress and

trauma relational spillover and gently present opportunities to reconnect or repair for both PSP and potentially their families as well.

These conversations also adhere to ecological theory (Bronfenbrenner, 1979), namely the interplay between the microsystem (family) and macrosystem (cultural norms of emotional expression). TIC here, means embracing the client's need to protect their loved ones but in a gentle manner of uncovering the unseen cost of emotional withdrawal (Kim et al., 2021). Of course, none of this work, whether addressing moral injury, burnout, or relational strain, can unfold meaningfully without a foundation of psychological safety. The ability to reflect, process, or even name distress often depends on whether clients feel safe enough to do so in the first place (Brandes, 2016).

Clinical Recommendation #5: Build a Therapeutic Alliance that Centers Psychological Safety and Trauma-Informed Principles

Many PSP clients are fearful of mental health professionals or psychologists due to negative past experiences, concern about criticism, or worry about professional consequences (Burzee et al., 2022; Haugen et al., 2017). They may challenge the psychologist initially, be unemotional, or delay disclosures until they are absolutely sure that the setting is indeed safe. Rather than interpreting this hesitation as resistance, therapists can interpret it as adaptive. Through slowing down, not being intrusive with questions, and being consistent and nonjudgemental in their presence, clinicians can gradually build the relational trust required for deeper emotional exploration. This likely entails being able to tolerate silence, maintain boundaries, and be sensitive to the cultural rationale for emotional regulation.

TIC emphasizes exactly these conditions: safety, trustworthiness, choice, and collaboration (Kim et al., 2021). When clients discover that therapy is a space where they don't

have to explain themselves and expect retaliation, actual improvements are more possible. Creating that kind of space requires not only psychological safety, but also sensitivity to the culture of PSP and their profession. PSP clients are not homogenous; variables such as gender, race, and sexual orientation affect the way individuals perceive both their role and their access to care. Clinicians should also be aware of how power systems and marginalization intersect with occupational identity, and how these dynamics may influence trust, disclosure, and perceived safety in therapy (Wild et al., 2020).

While therapy offers one pathway for responding to the psychological toll carried by PSP, it cannot be the only one. Many of the issues that show up in the therapy room – burnout, moral injury, emotional withdrawal – don't begin or end there. They are shaped by organizational culture, broader systems, and the stories PSP tell themselves (or are told) about what it means to be strong. With that in mind, the focus now shifts to system-level change. The following section offers a concrete policy recommendation, one grounded in the same research themes that shaped the clinical principles above. The goal is to think practically about how to support early help-seeking, reduce stigma, and create the kinds of environments where growth becomes possible.

Policy Recommendation: Enhancing PSP Mental Health Through Voluntary Family Involvement

Policy Context

While family dynamics do not occupy a central position in the literature reviewed in Chapter 2, several interrelated themes (i.e., stigma, emotional suppression, burnout, compassion fatigue, moral injury, and delayed help-seeking) repeatedly highlight the broader context in which psychological strain evolves for PSP. These themes emphasize that distress is not confined to the individual but is modulated by institutional processes, cultural norms, and relational

networks. The cumulative effect of these influences is to lead to silence, withdrawal, and isolation that can make it difficult for PSP to discern or seek assistance for their mental health.

As noted in the previous section on clinical recommendations, PSP are more likely to be pushed into therapy by pressure or concern from someone close to them than to seek it out independently (Jones et al., 2019). This suggests that even when mental health struggles are kept internal, they often show up first in close relationships, especially within families. Partners and relatives may notice shifts in mood, communication, or emotional presence before the PSP fully recognizes the depth of their own distress (Jones et al., 2019; Pennington et al., 2022). Although family members frequently provide informal support, they are rarely given the knowledge or tools to respond in ways that feel informed or effective.

PSP mental health care, therefore, cannot be reduced to an individual-level approach. A more holistic intervention model recognizes that well-being is co-created in the relationships and networks surrounding an individual. Offering family members voluntary, accessible, and non-invasive ways of learning to support their PSP is one method of engaging these larger systems in a respectful and informed manner. The following policy proposal builds on that understanding.

Policy Proposal

This capstone's proposal suggests a 3-phase, voluntary model designed to acknowledge and support the role that families can take part in with respect to supporting PSP. The goal is not to engage family members in treatment or to place new demands on them, but to offer psychoeducation and relational skills that can help them make sense of and cope with the emotional challenges of PSP work.

Onboarding Orientation. At commencement of recruitment and then service, PSP and their families are able to opt for an orientation session co-facilitated by a peer support lead and mental health practitioner. The session reviews:

- Normal emotional responses to PSP work
- Early warning signs of withdrawal, burnout, and stress
- Communication and boundary-setting strategies for PSP and partners
- Available supports for both PSP and their family members

Materials would also be made available online for access by those not present.

Regular Voluntary Info Nights. Throughout a PSP's career, their organization would offer quarterly or biannual psychoeducational evenings for PSP and their families. Sessions could take place either in person or through an online format, depending on what works best for participants. They would offer information and discussion on a few key topics:

- How burnout, moral injury, and emotional regulation show up in PSP's lives
- Navigating the effects of shift work and accumulated operational stress
- Developing healthy relational habits in the context of chronic stress

Attendance and participation would be completely voluntary. The tone would remain approachable and grounded, with the goal of encouraging shared understanding, not treatment or diagnosis.

Anonymous Online Resource Hub. The organization would also provide an open-access online space that doesn't require a password. It would include:

- Short videos and practical handouts for family members and loved ones
- Information on identifying early indicators of stress-related concerns
- Scripts and suggestions for initiating difficult conversations

- Tips for setting boundaries and maintaining connection

These resources would be available to anyone, at anytime, without disclosure or registration.

Rationale and Theoretical Alignment

This program proposal is rooted in the same principles that underlay the clinical recommendations in this capstone. From a trauma-informed care perspective (Kim et al., 2021), it prioritizes safety, agency, and access, offering optional support in a way that does not judge or coerce. From an ecological systems theory perspective (Bronfenbrenner, 1979), it recognizes that mental health is affected not only by the individual but by their relationships and immediate environments. Family is where stress typically reveals itself first, and where initial conversations can begin.

The program also aligns with the literature on stigma and help-seeking barriers in PSP culture. If PSP clients are more likely to access therapy at the request of a person close to them, then equipping that "someone" with context and language can create new, more robust support. Finally, this work allows space for post-traumatic growth, not through coercive disclosure, but through the creation of relational conditions in which emotional honesty becomes progressively possible over time (Horswill et al., 2021; Wild et al., 2020).

Feasibility and Ethical Considerations

This policy does not mandate family involvement or place unrealistic demands on PSP or their families. It is considerate of the fact that not all PSP have close family ties, and not all family members want or are able to be involved. Its strength lies in its flexibility and capacity development where each component is low-barrier, anonymous if required, and adaptable to different sizes and types of organizations. It also falls within ethical boundaries by not engaging in dual roles or expectations of family caregiving that are inappropriate. It is not the intent to pull

family members into clinical work but to provide them with tools that can help them make sense of what they are seeing and living through. It honors the fact that family members carry some of the emotional weight of this work, though they're not the ones wearing the uniform.

Proposal Summary

This program proposal and the suggestions that follow are pieces of a broader transformation in how we think about PSP mental health, not as an individual problem to be carried alone, but as something inherently relational and organizational. By offering low-key, voluntary supports to families, organizations can play an important role in normalizing emotional dialogue and earlier intervention in care. These supports will not solve everything, but they may be able to soften the edges of the silence and make it slightly more possible for growth, repair, and reflection to take place.

Limitations and Future Directions

Like most projects, this capstone has a few limitations; some are tied to the resources it draws from, and others are related to how the study itself was shaped. While the literature offers helpful insight into the mental health challenges PSP face, there are places where the data feels too broad, somewhat disjointed, or not deep enough to fully grasp the complexity of this population. A key limitation of the existing literature is the fragmentation of studied populations. The term "first responder" or "PSP" includes many different professions—police officers, paramedics, firefighters, correctional officers, dispatchers—yet most of the research doesn't separate them in a meaningful way. Some studies focus on one group, while others blend them all together. This makes it hard to identify role-specific patterns of trauma, stress, or resilience. What a paramedic goes through may look very different than the pressures faced by a

correctional officer or dispatcher, and interventions that don't reflect those differences risk the potential of responding accurately to the needs of PSP.

Another challenge is how much of the research relies on cross-sectional studies and self-reported data. While these methods are common and often necessary, they make it difficult to know how mental health shifts over time or the causes of these shifts. A lot of the data also comes from Western countries, mostly Canada and the United States, which raises questions about how applicable these findings are in other cultural settings. And even within these Western countries, often a lack of diversity is found in the research literature in terms of representation of diverse races, genders, sexualities, and ranks; each of these factors contribute to how trauma and stigma are experienced.

This capstone shares some of those same limitations. Because it is based on a literature review, it relies entirely on existing data. This means that patterns and themes identified here are shaped by what has already been studied, and possibly by what hasn't. Without direct engagement with PSP themselves, there are parts of the story that cannot be captured: the tone in someone's voice; the tension behind the words; the personal meanings that often get missed in surveys or summary statistics. It also means that intersectional experiences, especially how culture and power affect mental health, are only evident when they are made visible in the research, and that does not always happen.

Looking ahead, more research is needed. Longitudinal studies that follow PSP across years of service, major career transitions, or even into retirement would help show how trauma accumulates and what supports (or fails) over time. There is also a real need for research that focuses on specific subgroups—not just by type, but also by ethnocultural and marginalized

identities. Questions about how gender, race, sexual orientation, or rank shape the experience of stigma, burnout, or moral injury deserve more attention than they have received so far.

Finally, more work needs to be done around the family context. This capstone touched on how distress often shows up at home before it is recognized at work or in the self. Spouses, partners, and children often carry their own version of the weight, and they have perspectives that matter. Future studies that center their voices could offer a fuller picture of how PSP mental health plays out in real life and how healing might, at least in part, begin in those relational spaces. These limitations do not undo the value of what has already been learned, but they do point to what is still needed. The hope is that this capstone contributes to that ongoing effort, and that the questions raised here continue to spark curiosity, clarity, and care in those working to support PSP in real and lasting ways.

Personal Reflection and Professional Learning

This capstone has given me so much more than I expected. I came into the process thinking that, by the end, I would have a solid grasp on how to work with PSP— I'd know the PSP culture, understand the pain points, and be ready to step into this space as someone who "gets it." What I realized along the way is that I've only scratched the surface. There is no arrival point when it comes to cultural competence or clinical readiness to respond to PSP. Working with any distinct population, whether it is PSP, Indigenous communities, or another group requires an ongoing commitment to listening, adapting, and learning from the person in front of you. There is no one-time download of knowledge that sets you up forever. If I want to be effective, I have to keep learning, and more importantly, keep showing up with humility.

That message became especially clear as I learned more about how PSP navigate silence, emotional control, and trust in the therapy room. I already had a sense that many PSP may tend

to hold their cards close and may be wary of psychologists. The literature confirmed this supposition. But what deepened for me was the understanding that this withholding is not resistance—it's a part of their culture. It is strategy. It is a kind of safety. That insight changed the way I think about how to approach conversations with PSP in therapy. In my clinical recommendations, I made a point of including open-ended questions not to extract disclosures, but to gently invite reflection. The aim isn't to force insight, but to meet people where they are and give them the space to open up in their own time. I had one firefighter client during practicum who shared a lot, right away—more than I expected. But even then, I had a gut feeling that there were parts of the story that didn't quite add up. Looking back, I wonder if his disclosures were less about seeking help and more about testing me: Would I flinch? Would I judge him? Would I try to correct the narrative? I didn't. I just listened. And I think that, in its own way, is what mattered. It reminded me that trust isn't always built through what is said; sometimes it is built through how we receive what has been offered.

Throughout the process, one thing that never changed was my desire to become a therapist that PSP don't have to translate their world to; I no longer believe that a research project can get me all the way there. I used to think that after reading enough, studying enough, or writing a capstone paper like this, I'd be in the best position possible to start working with this population. What I understand now is that this is just the beginning. Understanding PSP culture isn't a checkbox. It's a practice—one that requires, time, consistency, and relationships.

This project also happened during one of the hardest years of my life. I don't think I expected that my own resilience would be tested while writing about the resilience of others, but life had other plans. There were moments this year that felt like one trauma after another, and picking myself back up to work on this capstone was one of the most difficult things I've ever

done. Strangely, though, I think that made me connect to the material in a deeper way. I don't mean to compare myself to PSP because my struggles don't mirror the kind of threats or losses that they see daily; but, I do know what it feels like to show up while hurting. I know what it's like to keep moving forward when you are completely drained. And that gave me a deeper respect for how this population carries their pain. What also stood out, though, was the cost of carrying it alone. If there's anything I've learned from my own experience this year, it is that vulnerability— the kind we're often taught to hide—can be one of the greatest strengths we have. I want to share this realization with PSP. Even if vulnerability feels foreign or uncomfortable at first, I want to be someone who can offer a space where that kind of strength is possible.

When I think about what truly matters in working with PSP, it is not expertise or technique that comes to mind first; it is presence. It is being genuine. It is being someone who doesn't flinch at the worst of it and who won't try to package another's pain into something neat or palatable. I know that doesn't coming from training alone. It comes from who you are in the room. I don't have empirical evidence to back this up, but I believe this is a population that has a sharp radar for inauthenticity. They've seen a lot. They've dealt with a lot. And I think they can spot someone faking it from a mile away. So if there's a non-negotiable for me as a future clinician, it is this: show up honestly, stay open, and don't pretend to have all the answers. Hold space with integrity. Don't be afraid of their stories. Don't be afraid of silence. That's the foundation. That's where the work begins.

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