An Exploration of the Lived Experiences of Police Officers in Departments with Embedded Clinicians

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Abstract

The problem addressed in this study is the mental health stigma experienced by U.S. police officers that often prevents them from accessing mental health care, resulting in high rates of PTSD and suicide. One potential solution that has emerged to address this mental health stigma for officers is embedding clinicians directly in police departments to support officer wellness. There is a lack of research into the impacts of this type of program, so this study examines the perceptions and experiences of officers in departments with embedded clinicians to better understand how this program impacts mental health stigma for officers. Utilizing a framework of stigma theory and systems theory to understand how stigma is created and transferred in police departments, this study is an interpretive phenomenological analysis of eight interviews from police officers serving at departments with an embedded clinician. Questions were designed to elicit thick descriptions of the participants' perceptions and experiences with mental health stigma, the embedded clinician, and how this program impacts mental health stigma in their department and in their own perceptions of help seeking. Themes emerged indicating that structural stigma poses the greatest threat to the embedded clinician program having a positive impact, that stigma is gradually shifting as new generations of officers are entering the field, that the cultural competency of the clinician is key to having an impact on reducing the stigma for officers, and that the officers' own self-stigma is likely to be the most impacted by the clinician. Implications for clinicians include prioritizing cultural competency to build rapport with officers and to work with administrators to reduce structural barriers to care. Implications for police administrators include reducing structural barriers to accessing the program, and making sure that new officers access the clinician early in their career to continue shifting away from mental

health stigma. Future research should focus on deepening understanding of how an embedded clinician program can be most effective and decrease stigma.

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"There must be those among whom we can sit down and weep and still be counted as warriors."

-Adrienne Rich

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Chapter 1: Introduction

Society relies upon a mutually understood social contract that establishes the role of law enforcement officers to keep order in the community (Moll, 2007). As a result, police officers are tasked with everything from traffic enforcement to potential use of lethal force to keep citizens safe. Civilians often take the role of law enforcement for granted as if it is any other job, but officers are exposed to a constant flow of human suffering, violence, and critical incidents. These take a toll on their mental, physical, and emotional well-being (Drew & Williamson, 2024). This has culminated in a national mental health and wellness crisis for officers. Recent research by Violanti and Steege (2021) found that law enforcement officers are 54% more likely to die by suicide than the general population. According to the FBI, in 2025, 53 U.S. law enforcement officers were feloniously murdered in the line of duty (U.S. Department of Justice, 2026). According to First HELP, the leading national organization for collecting data on law enforcement officer suicides, there were 103 reported officer suicides in 2025 (First HELP, 2026). This contrast in felony murder of officers versus officer suicides suggests that the greatest danger to officers is not on-the-job calls, but rather the mental health crisis facing officers today. While the impact of the job on officers has been studied for the last several decades, it is really only in the last few years that the issue of supporting officer wellness has come front and center. Research into police officer mental health has identified what most impacts officers (Fuller et al., 2024), the diagnosis most likely to impact officers (Carleton et al., 2024), the increased suicide rate among police officers (Violanti & Steege, 2021), the role of maladaptive coping (Blumberg et al., 2024), and what the barriers are for officers seeking mental health support (Drew & Martin, 2021). More recent research has started exploring attempted solutions to the officer wellness crisis, including peer support (Milliard, 2020), clinical support (Arjmand et al., 2024b),

and other options (Bonner & Crowe, 2022). However, very little research has been completed on how these solutions overcome the identified barriers to officer wellness. Most significantly, the main barrier to officers seeking clinical support for mental health needs is the stigma in law enforcement around seeking help (Grupe, 2023; Soomro & Yanos, 2019). Research into solutions that effectively reduce mental health stigma for officers is desperately needed to inform policy, funding, and wellness programs to address the officer wellness situation in the U.S.

Statement of the Problem

The problem addressed in this study is the mental health stigma experienced by U.S. police officers that often prevents them from accessing mental health care, resulting in high rates of PTSD and suicide (Drew & Martin, 2021; Soomro & Yanos, 2019). Police officers have one of the most demanding and dangerous jobs in society, with their duties taking a toll on them physically, mentally, emotionally, and socially (Fuller et al., 2024; Galanis et al., 2021). Police officers are 54% more likely to die by suicide than the general population (Violanti & Steege, 2021). Despite well-documented and researched negative impacts of law enforcement work on officers, many officers refuse to seek help as a result of persistent, pervasive stigma among law enforcement agencies associated with having a mental health issue and/or seeking help. In fact, officers who are struggling with PTSD identify higher levels of stigma towards mental illness, preventing them from seeking care (Drew & Martin, 2021; Soomro & Yanos, 2019).

Awareness of the need for effective wellness support for officers' mental health has led to the development of wellness programs, the effectiveness of which is just beginning to be studied – including the presence of embedded clinicians in police departments (Crowe et al., 2022). While current research suggests that an embedded clinician may normalize mental health resources and help seeking (Uhl et al., 2023), further study is recommended to identify how

embedded clinicians may impact stigma in a police department's culture (Bonner & Crowe, 2022). Understanding what can be done to reduce mental health stigma for police officers can increase accessibility of support to this population, and is vital to reducing the effects of PTSD and the suicide rates in this professional community. Further study is encouraged to look at the perspectives of line officers on the impact of embedded clinicians on mental health stigma (Bonner & Crowe, 2022). This study explores how to begin more effectively filling the identified need for understanding how embedded clinicians may impact mental health stigma in a police department.

Purpose of the Study

The purpose of this qualitative phenomenological study was to explore the perceptions and lived experiences of police officers working in departments with an embedded clinician program regarding the reduction or elimination of the stigma to receive mental health care and influence help seeking among officers who need support. There is a need for an increased understanding of how an embedded clinician program might reduce the mental health stigma for officers as well as increasing the willingness of officers to seek help. Officers from police departments in Washington State that have an embedded clinician program were recruited to participate in a semi-structured interview about their lived experience with an embedded clinician program. These interviews were transcribed and analyzed for themes related to the program's impact on mental health stigma. To ensure an adequate sample size, eight officers were recruited for participation in this study. Zoom was utilized to conduct the interviews.

Introduction to Theoretical or Conceptual Framework

The guiding framework for this project is an integration of Erving Goffman's (1963) stigma theory with systems theory principles, primarily pulling from Bowen's ideas about

multigenerational emotional processes and differentiation (Kerr & Bowen, 1988), as well as Minuchin's ideas about structural family therapy, especially the roles played by subsystems and the formation of identity as it relates to one's environment (Minuchin, 2012). Goffman (1963) posited that stigma is a social construct where individuals are discredited due to a characteristic or attribute that is deemed socially unacceptable. As stigma is a social construct, it only exists due to, and within, systems. It makes sense to blend these two theories in examining the lived experiences of law enforcement officers that function within several layers of systems that generate and foster the stigma around mental health.

The parallels between how family systems operate and how police departments operate make a systems approach a good fit to explore the question of how an embedded clinician program might impact mental health stigma. Similar to family structures (Minuchin, 2012), departments have subsystems, require rules to operate, and need to be able to adapt based on internal and external pressures or they become dysfunctional. Bowen's (1985) ideas about multigenerational emotional process, and how different levels of differentiation between members of a department might generate anxiety, mirror exactly how patterns like "old school" ideas about mental health might be perpetuated in policies and expectations. The structural, individual, and peer stigmas faced by officers around mental health have been passed down for generations of officers, the repercussions of going outside of the system's expectations can be severe (Hofer & Savell, 2021; Ricciardelli et al., 2020). Blending concepts from these theories can lead to a well-rounded view of how stigma functions in a department, and can lend itself to a better understanding of how this can potentially be altered to reduce stigma.

With this integrated framework in mind, this study will explore the systemic impacts of mental health stigma on officers and how an embedded clinician can impact that stigma. The

articulated framework informed the decision to conduct this study as a qualitative phenomenological study to explore the lived experiences with stigma of the impacted subsystem of rank-and-file officers. Understanding that a department operates much like a family system (Kirschman, 2018), exploring how introducing an embedded clinician into a department system might alter the experience of officers around mental health stigma will provide a valuable perspective in understanding how this phenomenon can be impacted to promote officer well-being.

Introduction to Research Methodology and Design (Nature of the Study)

The goal of this qualitative phenomenological study is to increase the understanding of the lived experiences of police officers who work at a police department with an embedded mental health clinician, and how that program impacts the officers' experience with mental health stigma. Rooted in the philosophy of Heidegger and Hussel, phenomenology seeks to capture the essence of experience through examination of participants' perspectives (Moustakas, 1994). To understand the perception of officers' experiences with embedded clinicians and how they experience mental health stigma, 8 rank-and-file officers who work at departments that have an embedded clinician program were recruited and interviewed. Additional recruitment would have happened if data saturation had not been reached with the original eight interviews (Smith et al., 2022). Interviews were semi-structured for consistency, recorded, and each interview was transcribed. All interviews were coded and inductively analyzed for themes (Smith & Nizza, 2022) Once themes were identified, a description of the phenomenon was synthesized from the findings. Limitations, recommendations for further research, and implications of the findings were also included. These findings were reviewed by the participants (member checking) to ensure their experience was accurately captured and communicated (Moustakas, 1994).

Given that the purpose of the study is to gain insight into the impacts of an embedded clinician on the mental health stigma experienced by police officers, this methodology and design was the most effective approach. This research method allowed for exploring the lived experiences of officers related to changes in mental health stigma resulting from both the requirements of the job and the presence of an embedded clinician.

Research Questions

RQ1

What are the perceptions and lived experiences of police officers working in departments with embedded clinicians related to reducing or eliminating the stigma of mental health care?

RQ2

How did the embedded clinician program in the participants' departments contribute to the perception of mental health stigma among officers?

Significance of the Study

In 2015, President Obama's Task Force on 21st Century Policing released its final report outlining key priorities for U.S. law enforcement agencies regarding policy, procedure, and programming. Pillar Six of the report (President's Task Force on 21st Century Policing, 2015) addresses officer wellness and safety, stating that "the wellness and safety of law enforcement officers is critical not only to themselves, their colleagues, and their agencies but also to public safety" (p. 75). Pillar Six places the mental health of officers on equal footing with the use of ballistic vests. The report recognizes the toll of the profession, including high suicide rates and prevalence of mental health and substance use disorders among officers. In response, the report issues a call for development and support of resources for officers, including the normalization

of accessing resources such as mental health clinicians (President's Task Force on 21st Century Policing, 2015).

In recent years, research into officer wellness has focused on identifying stressors contributing to mental health concerns for officers (Jetelina et al., 2020), barriers to care (Richards et al., 2021), and attempted solutions (Crowe et al., 2022), but lacks clarity on whether these solutions effectively reduce barriers to help seeking – including mental health stigma (Bonner & Crowe, 2022). The current study will specifically address the under-researched area of how an embedded mental health clinician might decrease mental health stigma for officers, possibly encouraging help-seeking. In doing so, this study directly contributes to the literature on effective wellness programs in law enforcement. Research in this area can contribute to the knowledge base for policies and funding for embedded clinician programs in departments across the U.S.

Perhaps more importantly, research into how embedded clinicians can reduce mental health stigma for officers could influence help-seeking behaviors in this population. Increasing understanding around how these programs support officer wellness can contribute to their propagation, refinement, and the cultivation of best practice standards for in-house clinical programs. As the 21st Century Policing Task Force report (2015) emphasizes, healthy officers lead to healthier communities. The importance of developing research backed programs for officer wellness directly impacts not only the officers, but the communities they serve. In addressing this research gap, the current study has the potential to inform effective wellness practices, strengthen relationships between communities and officers, and provide guidance for evidence-based program development in U.S. law enforcement.

Definitions of Key Terms

Critical Incident

A critical incident is a significant event that overwhelms an individual's ability to cope, elicits a strong emotional response, and may impede a person's ability to function normally in significant life domains (Mitchell, 1983). A critical event may include exposure to trauma, death, serious injury, or threats to life and safety.

Embedded Clinician

An embedded clinician is a mental health professional who is integrated into an organization, such as a police department, to provide on-site mental health services, consultation, and support tailored to the needs of that department (Jetelina et al., 2020).

Officer Wellness

Officer wellness refers to the holistic well-being of law enforcement officers, including physical, emotional, psychological, social, and spiritual health (President's Task Force on 21st Century Policing, 2015).

Peer Support

Peer support in a law enforcement context refers to support provided by trained officers to their colleagues. Peer support includes emotional support, stress management, psychological first aid, and post-critical incident support or referrals (Papazoglou & Andersen, 2014).

Stigma (in the Context of Law Enforcement)

Stigma is what occurs when society labels an individual as deviant based on perceived differences from normal expectations, which contributes to social exclusion, discrimination, or internalized shame (Goffman, 1963). In a law enforcement context, this means that officers who

experience mental distress might be viewed as incompetent or unfit for duty, reinforcing a culture of silence around mental health needs (Drew & Martin, 2021).

Summary

The problem addressed in this study is the mental health stigma experienced by U.S. police officers often preventing them from accessing mental health care, resulting in high rates of PTSD, mental health and substance use disorders and suicide (Drew & Martin, 2021; President's Task Force on 21st Century Policing, 2015; Soomro & Yanos, 2019; Violanti & Steege, 2021). Officer wellness has come into focus in the last ten years in particular, since the release of the President's Task Force on 21st Century Policing (2015) report identifying officer wellness as a key component of modern policing. Research has primarily focused on identifying barriers to help-seeking in police officers, with mental health stigma identified as the main barrier (Drew & Martin, 2021). Some research has explored potential solutions, such as peer support, critical incident stress management, and chaplains, but there is a lack of research into how an embedded clinician might decrease mental health stigma for officers (Bonner & Crowe, 2022; Crowe et al., 2022). This study explores the lived experiences and perspectives of police officers who work in departments that have an embedded clinician to better understand how this type of officer wellness program might decrease mental health stigma for officers and influence help seeking among officers who need support. The next chapter of this dissertation will explore the existing literature on mental health stigma in law enforcement, contributing stressors to mental health concerns in this population, and existing literature on embedded clinicians to highlight the gap in research on this subject.

Chapter 2: Literature Review

The problem addressed in this study is the mental health stigma experienced by U.S. police officers often preventing them from accessing mental health care, resulting in high rates of PTSD and suicide (Drew & Martin, 2021; Soomro & Yanos, 2019). The purpose of this qualitative phenomenological study is to explore the perceptions and lived experiences of police officers working in departments with an embedded clinician program regarding the reduction or elimination of the stigma to receive mental health care and influence help seeking among officers who need support. To best understand the foundation of this study and the need for it, this section will review the existing literature on stigma in law enforcement culture, the mental health needs of this population, existing and attempted solutions, and what is needed to better understand the impacts of embedded clinicians in police departments. First, the theoretical framework will be reviewed, integrating stigma theory with systems theory for a better understanding of how this stigma forms and how it might be shifted in a department. Stigma in law enforcement will be examined next, followed by an examination on research into existing solutions to this problem, including current help-seeking behaviors in law enforcement officer, existing solutions, barriers to care, and the role of culturally competent clinicians.

The National University library was the primary source of research, with the Navigator Search being utilized to find relevant research. Search terms utilized included *law enforcement, mental health, police, stigma, mental health stigma, chaplains, moral injury, first responder, stigma theory, PTSD, suicide*, *military, embedded clinician, critical incident,* and various combinations of these terms. Most searches were limited to peer reviewed, full text articles published in the last five years. Also included were books on these topics. Some searches with wider date ranges were included to identify seminal works on this topic.

Theoretical Framework

To best understand how stigma develops and is perpetuated in the context of law enforcement organizations, a blending of stigma theory and family systems theory is utilized for this study. Stigma theory provides insight into how stigma develops and functions, while systems theory offers insight into how stigma is maintained and transmitted in systems like a police department (Ricciardelli et al., 2020). Developing an understanding of how these two theories connect facilitates a framework for examining how the phenomenon of mental health stigma might be altered in the law enforcement system.

Stigma Theory

Stigma theory, developed by Erving Goffman (1963), posits that stigma is a social construct where individuals are discredited due to a characteristic or attribute that is deemed socially unacceptable. If the stigma is concealable, as much as possible, a person might present as "passing" to avoid the consequences of stigma; this does create potentially stressful consequences if the stigmatized condition is revealed (Martinez & Hinshaw, 2016). Internalized, self-stigma can grow out of the structural stigma experienced by an individual (Goffman, 1963). Whether an individual identifies as having mental illness (MI) or not can greatly impact help-seeking behavior (Fox & Earnshaw, 2023). Individuals who self-label as someone with MI may experience positive and/or negative consequences, including opening themselves up to the impacts of stigma rather than choosing to pass as not having MI. The Fox and Earnshaw (2023) study found that those who are most likely to not self-label are individuals that are male, younger, and single. Even if they were identified as having mental health symptoms based on the administered inventories in the study, those individuals that did not label themselves as having MI seems to indicate a rejection of the negative stereotypes they may have internalized around

this issue. Additionally, according to the Bureau of Labor Statistics (2021), 82.9% of law enforcement in the U.S. is made up of males. This suggests that if males are more likely to avoid identifying with a mental illness diagnosis due to internalized or external stigma, then law enforcement officers in particular may be prone to this stigma- and its impacts on help seeking behavior.

Structural stigma is defined in Gyamfi (2024) as a social arrangement rooted in “power differences embedded in religious, cultural, and political systems that enable and justify public stigmatizing behaviors towards marginalized persons, skewing their life changes and denying them of existing social services…” (p. 901). The structural stigmas established at the socio-cultural level led to internalized stigma and anticipatory stigma, altering the behavior of the stigmatized individuals and contributing to poor self-esteem and health impacts (Gyamfi, 2024). Reducing stigma perpetuated by structural stigma requires changes in subsystems, starting at the individual level and including families, schools, workplaces, and larger systems such as media and governing bodies (Gyamfi, 2024). This level of stigma shows up most strongly for law enforcement officers in department policies around mental health, such as requiring an automatic fit-for-duty evaluation if someone discloses a mental health struggle, or in attitudes that those who take leave for mental health reasons are just “abusing the system” (Bikos, 2020).

Systems Theory

Systems theory presents ideas on how behaviors and patterns are transmitted or changed, which may lend itself to an understanding of how stigma forms, is perpetuated, and can be altered. Bowen’s theory of intergenerational emotional process, differentiation, and how anxiety functions in a family system are useful ideas in understanding how certain patterns can be perpetuated in a system (Kerr & Bowen, 1988). Multigenerational emotional process posits that

families produce members who are differentiated on a continuum, and each member will tend to be attracted to others who are a similar differentiation. This tends to perpetuate patterns, and change (up or down) occurs slowly, through a series of events and processes, and on occasion, events or processes converge that generate rapid change (Kerr & Bowen, 1988). Two primary sources of stress can generate change: first, psychological pressure that is self-imposed, such as wondering if they fit in with a group or being concerned about what is expected of them. The second source is pressure people exert on each other to think, feel, or act in a certain way (Kerr & Bowen, 1988). The more differentiated an individual, the more they are able to navigate these pressures and life events with minimal anxiety (or dysfunction); poorly differentiated individuals will be more impacted by this stress and more likely to experience symptoms in response (Kerr & Bowen, 1988). Bowen wrote about the application of his ideas in a workplace system (Bowen, 1985), stating that

> emotional issues in administrative organizations have the same basic patterns as emotional issues in the family, that it is accurate to think of varying levels of differentiation in work situations as it is in the family, and that the principles toward the differentiation of self in work situations can be as effective as they are in the family. (p. 464)

This idea suggests that attitudes about mental health in a law enforcement department can contribute to dysfunction and structural stigma around mental health for officers. Depending on each person's level of self-stigma, susceptibility to peer stigma, and the force of structural stigma, law enforcement officers will experience mental health stigma in varying degrees in their department.

Salvador Minuchin's ideas in his theory of structural family therapy also contribute to a helpful understanding of how stigma can be perpetuated or changed. Minuchin wrote that "man's experience is determined by his interaction with his environment" (Minuchin, 2012, p. 2). Patterns are developed in social context, but also impact internal processes. Individual identity is based on one's sense of belonging to different groups (Minuchin, 2012). Systems are made up of subsystems, and these interact in different ways through transactional patterns, which in turn regulate behavior (Minuchin, 2012). These patterns maintain themselves through feedback loops, and can handle a certain amount of stress, but resists change beyond a certain threshold. The system will self-correct when this threshold is crossed. Systems need to be adaptable to change when necessary based on internal and external factors (Minuchin, 2012). Boundaries are the rules defining who participates and how in subsystems. These are meant to protect differentiation of the subsystem from other forces, and boundaries must be clear for proper functioning (Minuchin, 2012). Law enforcement agencies are inherently structured with layers of subsystems that regularly interact: administration, rank-and-file officers, and other subsets withing these subsystems, such as specialty units like SWAT, traffic enforcement, or detectives. Depending on how rigid the boundaries are between subsystems, these interact in different ways that impact behavior and mental health of officers. Morale among the rank-and-file subsystem is frequently impacted by decisions of the administration subsystem. Attitudes about mental health among the rank-and-file subsystem can also be impacted by the administration subsystem's attitude about mental health- and yet it is difficult to find agreement on what this means in a larger system like a law enforcement agency.

Connecting Stigma Theory and Systems Theory

Since stigma is a social construct (Goffman, 1963) it only exists due to, and within, systems. It makes sense to blend these two theories in taking a look at the stigma faced by law enforcement officers that function within several layers of systems that generate and enforce the stigma around mental health for officers. The parallels between how family systems operate and how police departments operate make a systems approach a good fit. Departments have subsystems, require rules to operate, and need to be able to adapt based on internal and external pressures- or they become dysfunctional. Bowen's ideas about multigenerational emotional process, and how different levels of differentiation between members of a department might generate anxiety, mirror exactly how patterns like "old school" ideas about mental health might be perpetuated in policies and expectations. The structural, individual, and peer stigmas faced by officers around mental health have been passed down for generations of officers, and the repercussions of going outside of the system's expectations can be severe (Bikos, 2020). Blending an understanding of these theories can lead to a well-rounded view of how stigma functions in a department, and can lend itself to a better understanding of how this can potentially be altered to reduce stigma.

Trauma and Law Enforcement

Trauma exposure is one of the main contributing factors for officers who develop PTSD, a primary concern that carriers stigma for officers (Drew & Martin, 2021). Understanding the sources of trauma exposure is vital in an exploration of the lived experiences of police officers around mental health stigma. The inevitable, pervasive nature of trauma exposure in law enforcement work supports the potential value of embedded clinician programs in police departments. To understand the impacts of trauma exposure on police officers, a definition and

discussion of the general impacts of trauma as well as the specific ways officers are impacted by trauma is necessary. For the purposes of this paper, the definition of trauma from the Substance Abuse and Mental Health Services Administration (SAMHSA) (2024) will suffice:

> …individual trauma [is] an event or circumstance resulting in: physical harm, emotional harm, and/or life-threatening harm. Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. (paragraph 1)

This definition allows for the reality that a range of events can cause trauma responses, including exposure to violence, having one's life directly threatened, or the secondary exposures to trauma from exposure to other's stories of these events happening to them. This definition also acknowledges the varied, complex range of symptoms that can occur to individuals exposed to trauma.

The DSM-V-TR (American Psychiatric Association, 2022) outlines the symptoms of post-traumatic stress disorder (PTSD) into four primary clusters: intrusion, avoidance, negative alterations in cognitions and/or mood, and alterations in reactivity and arousal. Qualifying traumatic events, per the DSM (APA, 2022), include exposure to actual or threatened death, serious injury, or sexual violence. Trauma exposures may include a direct threat to one's own life or safety, witnessing the impacts of these events on others, or sustained exposure to such events (for example, collecting evidence at a crime scene or interviewing victims). Often, officers are regularly exposed to traumatic events in all of these capacities, and approximately

21%-32% of police officers meet clinical criteria for a diagnosis of PTSD at some point during the course of their career (Zegel et al., 2023).

Acute trauma and cumulative trauma

Critical incident exposure is a regular part of law enforcement work, meaning that officers are sent to incidents that present a danger to safety or life, and that overwhelm the officer's ability to cope in one or more life domains (Mitchell, 1983). A recent study of Danish police examined what kinds of incidents seem to impact officers the most, and identified which categories of calls (danger or threat, accidents, and deaths and distressing crimes) were the most impacting types of critical incidents (Møller et al., 2023). This study collected accounts of incidents from participants, and of 2,960 incidents reported, the researchers discovered that "routine" calls, such as traffic accidents and dealing with mental health calls also stuck with officers, suggesting that not only critical incidents stack up and cause stress reactions, but the day-to-day routine calls officers respond to may also contribute to the build-up of trauma exposure. The most recent studies examining frequency of critical incident exposure suggest that the average officer will encounter around 188 critical incidents over the course of a career (Chopko et al., 2015; Weiss et al., 2010). A 2001 study (Patterson, 2001) found that the average exposure to critical incidents was about three incidents over every six months of service. Based on the current review of the literature, more current research would be beneficial to understanding the rates of critical incidents and impacts on officers.

Secondary and vicarious trauma exposure—that is, exposure to victims and witness stories in the course of their duties—also contributes to the development of mental health symptoms in officers (Velasco et al., 2024). Secondary trauma exposure contributes to the shifting paradigms of how officers see other people, themselves, and the world around them

(Hofer et al., 2021). Secondary trauma symptoms include intrusion, avoidance, negative cognitions or mood, and increased reactivity and arousal, similar to PTSD symptoms (Ogińska-Bulik & Bąk, 2022). The secondary trauma impacts on officer cognitions may be due to intrusive rumination about the stories they hear or witness, especially if the officer's personality tends towards more pessimism, or if the officer themselves have experienced traumatic incidents (Ogińska-Bulik et al., 2023).

While acute exposures to trauma may produce acute stress reactions or post-traumatic stress symptoms, recent research strongly supports that the sustained, high level of exposures to critical incidents primarily contribute to the development of these symptoms in police officers (Brewin et al., 2022; Hansen et al., 2025). Hansen et al. (2025) conducted a two-year study with 2,823 Danish police officers to examine the role of critical incidents in developing PTSD. A baseline survey for PTSD symptoms was administered, with additional surveys at the 3month, 6-month, and 12-month points post-exposure to critical incidents, and results were compared between groups of officers with high exposure to critical incidents, moderate exposure, and no exposure. At baseline, participants who screened positive for PTSD were not included in the study so that the baseline group of participants had no clinical levels of PTSD. Results indicated that the groups with high and moderate levels of critical incident exposures had consistently higher rates of PTSD symptoms than the non-exposed group, and all exposed groups had higher levels of PTSD symptoms at the 24-month mark. These findings strongly support the hypothesis that high levels of critical incident exposure in police officers contributes to the development of PTSD.

Brewin et al. (2022) examined the occurrence of complex PTSD (CPTSD) versus PTSD in police officers, and possible contributing factors to the development of either diagnosis.

Complex PTSD is a disorder that arises in response to prolonged, repeated exposure to traumatic stress (Brewin et al., 2022), though the DSM-V does not differentiate between CPTSD and PTSD at this time. The International Statistical Classification of Diseases, 11th edition, (ICD-11; World Health Organization, 2019) does differentiate between the two diagnosis. The Brewin et al. (2022) study examined the rates of CPTSD vs. PTSD and contributing factors in a sample of 12,248 commissioned officers in the UK. The researchers administered a series of surveys to delineate between PTSD and CPTSD in the sample, and to understand what factors contributed to each diagnosis. The study found a combined PTSD and CPTSD prevalence of 20.6%. Contributing factors to these diagnosis included not just high, sustained exposure to trauma and violence, but also the presence of shame due to humiliation (mostly reported by males) and/or sexual harassment (mostly reported by females) (Brewin et al., 2022). This suggests that police culture and organizational stress, including peer stigma towards mental health, may also contribute to these symptoms developing, pushing officers to the allostatic load that causes early retirement, mental or physical health difficulties related to the job, and contributes to officers deciding to leave the job (Drew et al., 2024).

Long-term impacts of trauma exposure

A link has been established between the diagnosis of PTSD and the use of excessive or undue force by police officers (DeVylder et al., 2019). A sample of 137 US police officers participated in this study, and they completed four inventories: the PCL-5, the ACE inventory, the Workplace Exposures to Difficult Situations (assessing for a range of dangerous situations officers might encounter) and a novel measure (the Unusual Situations Involving Use of Force) that assessed for self-reported personal involvement in excessive uses of force or abusive police practices. Bivariate analysis was utilized to test for associations between PTSD and childhood

trauma and workplace trauma, as well as associations with the police abuse variable. Notably, this study also found that a high Adverse Childhood Experiences (ACE) score was associated with PTSD and engagement in abusive policing practices, which highlights that officers often enter their careers with underlying life experiences that contribute to trauma responses. Abusive policing practices were also correlated to officers in workplaces with higher levels of stress and trauma exposure (DeVylder et al., 2019), highlighting the role that organizational stress potentially plays in the development or aggravation of PTSD for officers. The study did not establish any predictive relationships between excessive use of force and PTSD, but it does suggest that further research into how PTSD and excessive use of force interacts for police officers would benefit from additional studies.

Encounters with trauma creates changes in how officers perceive and interact with the public (Hofer et al., 2021). In line with how the brain changes when exposed to trauma, officers create a new default response to situations based on past traumatic experiences with calls and people (Hofer et al., 2021; van der Kolk, 2014). Hofer et al. (2021) found that the changes described by officers in their perception of people, situations, and environments stemmed not just from critical incidents, but also from secondary trauma exposures- which many officers in the study described as taking a heavier toll than the critical incident exposure.

When dealing with PTSD symptoms, it is not unusual for maladaptive coping strategies to emerge, particularly the use of alcohol. Alcohol use has been connected to increased PTSD severity and to avoidance symptoms of PTSD in particular, and higher PTSD symptom severity is connected to greater probability of lifetime alcohol-related problems (Smith et al., 2020). Family history of substance use increases the risk for officers experiencing peritraumatic stress during critical incident exposure, increasing the risk for PTSD symptoms developing for the

officer (Smith et al., 2020). Blumberg et al. (2024) found that approximately 70% of officers do not access positive, adaptive coping skills, and those who implement primarily pleasure-seeking coping skills tend to be more susceptible to problematic alcohol use, as well as suicidality and higher rate of anxiety and depression symptoms. Over time, alcohol use can compound and create a feedback loop for PTSD symptoms.

Stigma in Law Enforcement

To understand the experiences of stigma for law enforcement officers, an examination of the various sources of stigma is necessary. Additionally, understanding the extent of how stigma impacts help-seeking in officers supports the value of a solution such as an embedded clinician, particularly if that solution can reduce stigma for officers. Stigma in law enforcement culture stems from several identifiable sources: police culture itself, structural/organizational stigma, peer stigma, public stigma, and self-stigma, all of which can pose a barrier to officers seeking care (Richards et al., 2021). Core tenets of police culture may generate this stigma, such as the values around self-reliance, distrust of outsiders, expectations of being “tough” and stoic (Soomro & Yanos, 2019). These values are built into the very fabric of most police departments, setting the stage for clear delineation between those who are inside the “right” group, and those who are deemed deviant from those expectations. Fear of repercussions around not falling into line can keep officers from seeking help when they need it most. If they do seek help, it can be difficult to open up to a provider so that help is actually effective. Anxiety around the process, and around their department superiors finding out, can sabotage the process. Stigma is pervasive and deeply rooted for many officers, and it costs some of them their lives.

Structural Stigma

Structural stigma- that is, stigma that is perpetuated by an agency's policies, attitudes, and actions around mental health concerns (Hofer & Savell, 2021)- perpetuates, and may originate, this main barrier to officers seeking care. A Canadian study on public safety personnel, primarily law enforcement, revealed that agencies' attitudes about mental health perpetuates this issue, including leading new members to view mental health support as creating a burden on the system, discouraging help-seeking, and discouraging awareness of members' own mental health needs (Ricciardelli et al., 2020). Bikos (2020) found specifically that policies that punished officers for taking time off to heal through requirements such as fit-for-duty evaluations or forcing them to choose between employment and wellness contribute to this level of stigma and prevent help-seeking. Line level officers are most likely to report fear of repercussions should they report a mental health concern (76%), and more than half of senior management level officers report the same fear. This suggests that structural stigma within a public safety organization is a key factor in perpetuating mental health stigma among police officers. Lack of clear, transparent mental health policies and processes in a department heavily contributes to structural stigma and the fear experienced by officers when they need mental health support (Hofer & Savell, 2021). This creates a default assumption that nothing positive will come from seeking support, and contributes to many officers avoiding help until it's too late.

Peer stigma

Peer stigma has been identified as a significant concern among police officers (Jaafar et al., 2024). Emotional invalidation and lack of support from peers and supervisors is not only a contributing factor to stress for officers, but also to the stigma in police culture around mental health concerns. In organizations that view those out on mental health leave as a burden on the

system, this peer stigma may play an even more significant role in impacting officers' decisions to seek help or not (Ricciardelli et al., 2020). Officers do not want to be viewed by their coworkers as creating an undue burden on staffing levels. An additional dynamic of peer stigma has to do with the exposures police officers get on the job to members of the public who are having a mental health crisis. It is known to officers how they themselves and their coworkers talk about people in mental health crisis, and fear of being identified in the same way by peers can create an additional stigma barrier to seeking care (Newell et al., 2022). A study by Padilla (2023) found that for the sample participants, 57% of them identified fear of peers, supervisors, or subordinates finding out they are seeking mental health help was the biggest barrier they faced in seeking care. The same study found that for organizations facilitating mental health services for their officers, the language of the services mattered. For example, "mental health services" may be less well-received than terms like "classes" or "check-ins," suggesting that peer and organizational culture dictates the stigma attached to how these services are conceptualized and communicated about (Padilla, 2023).

Public stigma

Public stigma towards law enforcement officers can generate an additional source of considerations for officers around seeking mental health support. A study by Wheeler et al. (2021) found that when members of the public have a high sense of self-stigma around mental health, those individuals also projected a stigma around the same for law enforcement officers. In this study, 162 participants completed surveys about their own self-stigma around mental health, and then completed a survey asking similar questions adapted to apply to law enforcement officers who seek mental health support. Statistical analysis found that higher self-stigma among civilians around mental health predicted higher levels of stigma towards law enforcement

officers that seek mental health support. This may generate additional pressure for law enforcement officers to present an image of being "fine," unaffected by their work and not needing support. If there is a use of force that goes public, having a mental health issue adds an additional layer of stress for involved officers- especially if that information is leaked to the public. The emergence of social media, paired with the increased social scrutiny of police officers, presents unique stressors on modern officers around public perception. With the risk of being constantly recorded and going viral, officers face additional pressure in their duties, especially as younger officers shape their identity in an age of being viewed as part of the problem instead of the solution (Singletary, 2024). This additional pressure may fuel stigma around mental health for officers, as they are "on display" more often and must appear invulnerable and strong regardless of circumstances.

Self-stigma

Self-stigma is a key factor that prevents officers from seeking help. This may be due to the perception of what their peers think about seeking help, which causes officers to internalize that stigma. It may be that the *perception* of these attitudes, rather than the *reality* of what others really believe, generates this internalized self-stigma (Grupe, 2023). It is notable that this study included civilian police employees, and this group also reported this internalized stigma. Self-stigma in law enforcement officers and support employees merits further research.

Stigma as a barrier to care

The layers of mental health stigma law enforcement officers face- structural, peer, public, and self-stigma- notably impacts whether officers decide to seek help or not (Drew & Martin, 2021; Richards et al., 2021; Soomro & Yanos, 2019). With the elevated rate of suicide among officers (Violanti & Steege, 2021), this is an urgent barrier for officers that needs to be

addressed. Research into the effectiveness of interventions on the structural, peer, public, and self-stigma levels is needed to understand how to change this for officers, and can contribute to the development of effective wellness programs in law enforcement agencies.

Law Enforcement Stressors

Police officers encounter a variety of stressors that influence their mental health and inform their experiences with mental health concerns, which is necessary to understand when addressing mental health stigma in officers. The multiple sources of stressors for officers also highlights the need for a solution such as embedded clinicians in police departments. These stressors range from home life to calls for service to organizational stressors, all of which are documented contributors to clinical concerns in law enforcement officers. No two officers have the same combination of stressors, so understanding the various stressors is key for administrators, policy developers, and clinicians in developing effective wellness programs.

Moral Injury

A significant aspect of police work that contributes to officer mental health concerns is moral injury. Moral injury occurs when an individual is forced to witness, perpetrate, or cannot stop an action that violates the individual's deeply held moral values (Papazoglou, et al., 2020). Mooren et al., (2024) conducted a study that found that while moral injury is often co-occurring with PTSD, moral injury is its own phenomena and requires assessment for presentation within police clients by those treating this population. Moral injury may or may not be part of PTSD causes for individual officers, so individually tailored assessment and treatment is necessary. Mordeno et al., (2022) found that officers who are able to adapt meaning and situational beliefs they hold when exposed to a moral injury are able to buffer against the development of mental health symptoms; failure to make adaptive meaning out of these situations exacerbates

symptoms, especially related to PTSD and depression. Officers working in special units, such as internet crime against children (ICAC) or sexual assault/special victims units, face all of the same barriers as the rest of their coworkers in seeking care, but also face unique, additional moral injury. These additional injury layers include feeling like they are unable to talk to peer support about their work due to the nature of it, and in unique symptoms such as impacts on their parenting and marriages, including sexual dysfunction stemming from their work (Mitchell et al., 2022; Redmond et al., 2023). This may close off significant sources of support to officers in special units with significant moral injury exposures, contributing to the development of mental health symptoms.

Organizational Stress

Organizational stress plays a significant role in the development of mental health concerns in police staff. In recent years, amidst post-COVID changes and social unrest, departments have faced high levels of burnout and mental health concerns among officers and support staff. Social stressors, department policies, and impacts on family were all identified as contributing stressors for both sworn and unsworn police staff (Fix & Powell, 2024). A comparative study of over 2000 sworn and unsworn Australian police personnel revealed that unsworn police personnel have even higher levels of depression and distress than sworn personnel, despite the lower exposure to critical incident trauma; levels of PTSD were elevated in both groups; unsworn personnel had comparable levels of anxiety, alcohol use, and burnout to sworn personnel (Varker et al., 2023). Both groups experienced operational and organizational stress, suggesting that department wellness programs need to include unsworn staff to truly have an effective wellness culture.

An additional aspect of organizational stress that may put pressure on officers' wellness is the dynamics between department members: peers, supervisors, and administration. Jaafar et al. (2024) examined the connection between emotional validation and mental health outcomes for police officers. Looking at emotional validation from supervisors, colleagues, and the public, the study found that perceived emotional invalidation all three sources negatively impact mental health outcomes. This suggests a few things: first, that organizational culture does matter when it comes to mental and emotional wellness of officers; second, that emotional invalidation might contribute to mental health stigma in police organizations; third, that emotional validation can moderate between occupational stressors and the development of PTSD or other mental health conditions, suggesting that a healthy peer support program can play a powerful role in officer wellness.

Another organizational stress source is policies and procedures that breed distrust between subsystems of rank and file and the administration. Distrust of an organization, particularly if that organization has negative or stigmatizing attitudes and policies around officers seeking mental health support, leads to under-reporting of symptoms and prevents officers from seeking support (Marshall et al., 2021). This study highlights the impacts of structural stigma on officer help-seeking. The social norms of an organization significantly impact officers' willingness and likelihood of accessing available mental health resources. A study on the impacts of mindfulness on health outcomes in police found that positive social norms and acceptance in an organization made it more likely that officers would access that particular tool (Krick & Felfe, 2020). The attitude of organizational leadership around mental wellness, from the chief down to the sergeants, can play a significant role in how officers experience stigma around help seeking.

Trauma exposure is connected to mental health concerns in police officers, but organizational stigma compounds this exposure and contributes to the development of clinical levels of PTSD, depression, anxiety, or other mental health concerns. Craddock & Telesco (2022) found that not only does long-term exposure to critical incidents and traumas on the job contribute to negative outcomes for police officers, but this is worse in officers who perceive that seeking help would not be supported by their agency or would have negative impacts on their career. Thus, organizational stress is strongly connected to the impacts of critical incident trauma.

Interaction of Personal Life and Occupational Trauma

Trauma in the field is often complicated by officer's personal life stressors. Pierce and Eldridge (2024) examined police officers in Alaska to examine if exposure to personal and duty related traumas are connected to PTSD and depression symptoms. The study found that exposure to duty-related or personal traumas alone were not connected to PTSD or depression; rather, the combination of personal and duty-related trauma exposures were significantly associated with PTSD and depression symptoms, with the severity of symptoms increasing with higher number of exposures. The impacts of police work also impacts an officer's family, and can generate stressors in an officer's personal life that contribute to the development of mental health concerns. A literature review conducted by Sharp et al., (2022) found that intimate partners and children of responders can experience relationship strain, stress, and mental health diagnosis tied to their loved one's profession. This research suggests that to support officer mental health, departments should offer wellness resources that support family members, not just the officers.

Shift Work

Shift work stressors may also contribute to, or exacerbate, mental health concerns in officers. A common struggle for many police officers is sleep disturbance, due to either the impacts of shift work or sleep disruption tied to trauma exposure. A study by Plant et al., (2024) examined the connection between sleep disturbance and suicidality in police officers, as well as the impacts that emotional support may play in suicidality. Sleep disturbance was found to be connected to suicidality. These sleep disruptions may impede the officer's ability to process stress and trauma exposures, disrupt emotional regulation, negatively impact their relationships (thus damaging their emotional support relationships), and contribute to suicidality. If the officers who reported struggling with sleep disruption and suicidality also perceived that their department had a stigma around mental health support, they were also less likely to seek out support. This would suggest that departments need to not only offer well-rounded wellness programs for officers, but also that decreasing barriers to mental health care may mitigate the impact of suicidality for officers. Addressing policies and procedures that relate to mental wellness would also be a necessary step around addressing this barrier to care.

Existing Solutions

In examining the experiences of police officers with a specific type of intervention- in the case of this study, embedded clinicians- understanding how existing solutions have impacted mental health stigma is important. In particular, examining the literature on embedded clinicians in military units can lend insight into how this solution might impact mental health stigma for law enforcement officers.

Help-Seeking Behaviors in Law Enforcement Officers

Understanding the current help seeking behaviors and patterns in law enforcement officers is key to understanding where solutions are needed to support this population. Understanding what prompts officers to seek help, what factors are important for officers deciding to seek help, and what solutions are currently in place to support officers seeking care are all vital to best serve this population.

Familiarity with mental health support may lessen barriers to help-seeking. Officers who have sought help previously are more likely to access a wellness option such as employee assistance programs (EAP), chaplaincy, or peer support (Whittington & Basham, 2024). The same study that identified familiarity as a prompt to access wellness resources also identified confidentiality as a key factor in officers' willingness to seek help. While clinicians, chaplains and peer support all have varying built-in confidentiality protections, officers need to be confident in the confidentiality of their organization's wellness offerings (Whittington & Basham, 2024). The implication for an embedded clinician program is important: for officers to trust the program and utilize it, confidentiality is paramount to success. Embedded clinicians certainly benefit from the officers being familiar with them, which may encourage officers to access this type of resource.

There may be several nexus points that prompt officers to seek care. A study involving 20 members of the Canadian RCMP (Burns & Buchanan, 2020) found that critical incident stress debriefs may be a connection point to mental health services for some officers. This study found that personal concerns might prompt officers to seek care more than work-related concerns, as 89% of their participants sought mental health care for personal life events, while 53% of the participants' mental health care contacts were for work events. Furthermore, positive social

contacts like a supervisor encouraging them to seek care, as well as positive interactions with mental health providers, often served as a nexus to the officers seeking care. This suggests that while structural, peer, and self-stigma are all significant barriers for seeking care, familiarity or connecting with a familiar mental health professional might break through these levels of stigma and help an officer connect with services.

Mental Health Training

Officers given training in mental health, such as CISM/CISD or psychological first aid, demonstrated an increase in willingness to access professional support for mental health needs (Carleton et al., 2020), though participants without mental health training were also aware of professional support options. Officers with and without mental health training were willing to access personal support, such as a spouse or friend, highlighting the importance of healthy social supports for officers. Additionally, this suggests that making sure good resources are available to families of officers so that their social support systems are also healthy plays a key role in officers seeking support.

Chaplains

Chaplains are a commonly accepted and familiar resource for mental health support with groups such as military and first responders (Laysen et al., 2023). In military settings, and increasingly in first responder settings, chaplains are often a first line for counseling and mental health services, especially due to the lower stigma around talking with a chaplain as opposed to a mental health provider (Kazman et al., 2022; Phelps et al., 2023). Chaplain duties and functions often overlap with mental health providers in military settings, with both providing bio-psycho-social-spiritual care to members. This is particularly true in addressing moral injury and other

factors that may contribute to PTSD (Cooper et al., 2023). With a similar dynamic in police settings (Ramchand et al., 2019), an integrative approach that includes embedded chaplains and mental health providers may be a pathway to altering the stigma around seeking mental health support with the law enforcement population. Chaplains ought to be part of a larger wellness program that includes mental health providers, serving as a nexus to mental health treatment (Phelps et al., 2023). Familiarity, as highlighted previously, serves both the chaplain and the mental health clinician in serving this population.

Peer Support

Despite the fact that peer perspective is a source of mental health stigma for officers, peer support can be a powerful intervention to decrease stigma around mental health help seeking. Peer support is a popular and common option for support in law enforcement agencies (Ramchand et al., 2019; Uhl et al., 2023). A peer support program within a police department is a small group of officers given basic training in interventions such as critical incident stress management or psychological first aid and can then provide emotional support to their fellow officers (Whittington & Basham, 2024). However, peer support personnel are not trained clinicians, and peer support has limits to how effective it can be. Limited confidentiality protections, limits of training peer support receives, and the perception of how trustworthy the peer support team members are all influence how effective peer support teams are (Milliard, 2020). Peer support is most effective in conjunction with clinical support, especially as a mental health provider can provide additional levels of confidentiality. Uhl et al. (2023) advocates for an integrated model that combines peer support with clinical support and services. A study by Daniel and Treece (2022) confirmed that the input of peers and social supports prompted most officers to seek care, suggesting that peer support can play a powerful role in reducing stigma

around care-seeking. It would be important for any embedded clinician to develop a strong relationship with the peer support team at a department, and the trust between peer support and the clinician could serve as a nexus to helping officers overcome the layers of stigma to ask for help.

Barriers to Help-Seeking

Help-seeking in officers may be met with external barriers, including long wait times for treatment, perceived lack of control in treatment, and struggling to find a provider who is culturally competent (Arjmand et al., 2024b). Additional barriers to seeking care include concerns about confidentiality, lack of cultural competence in the provider, lack of awareness of available resources, and distrust of both their agency and outside providers (Testa et al., 2023). Any department embedded clinician program must take steps to actively address these concerns, starting with confidentiality protections and ensuring the right provider is filling this role. Communication around confidentiality, cultural competence, and ensuring that the provider becomes familiar with members of the department to increase trust are likely key to successful embedded clinician programs.

Embedded Clinicians in Military Units

The evolution of understanding PTSD has always been closely tied to the military, and references to the impacts of trauma exposure are long documented even in ancient literature, such as the Iliad (Crocq & Crocq, 2000).The symptoms were often stigmatized as cowardice, and those who suffered from these symptoms were written off as having poor constitutions or as being too emotional- hence the historical label of “hysteria” (Horswill & Carleton, 2022) in relation to these symptoms. Starting in the Civil War with the label of “soldier’s heart,” an emphasis on symptoms being primarily physical rather than psychological emerged (Monson et

al., 2007). In 1880, doctors labeled the cluster of symptoms that included difficulty sleeping, cardiovascular distress, arousal, fatigue, and tremors as "traumatic neurosis," than as "neurasthenia" (Crocq & Crocq, 2000). This coincided with a recognition that these symptoms emerged in response to psychological trauma exposure, but the diagnosis was still heavily stigmatized as a result of economic fears that those who have these symptoms would create a drain on the medical and economic system (Horswill & Carleton, 2022). By World War I, these symptoms were labeled as "shell shock" and an understanding that these reactions were not just physiological in nature, but also psychological, was emerging (Saigh & Bremner, 1999). Further study through World War II led to the first official diagnostic criterion in the first DSM, though it was referred to as "gross stress reaction" (Saigh & Bremner, 1999). Subsequent studies involving Korean War veterans and later studies with Vietnam veterans contributed to the development of criteria to standardize diagnosis of these symptoms, with the DSM-III finally establishing criteria for what is now known as posttraumatic stress disorder (Saigh & Bremner, 1999).

Embedded clinicians is an emerging idea in law enforcement, but has existed for the last few decades in the military, with each branch implementing their own style of this program (Hryshko-Mullen et al., 2022). The Army had this type of program as far back as World War I, sending psychiatrists to the front lines to support soldiers with "shell shock" (what we now know as PTSD) (Hryshko-Mullen et al., 2022). Embedded clinicians are members of the unit to which they are assigned, and might deploy and/orlive on the ship or base with their unit, and may even enter combat with the unit at times, all the while providing mental health support to the unit members (Hryshko-Mullen et al., 2022; Lippy et al., 2022). Military members face many of the same barriers to care that law enforcement officers do, particularly mental health stigma and the

fear of being found unfit for duty (Zumwalde et al., 2023). Peer, self, and public stigma all contribute to reduced help-seeking in military members (Campbell et al., 2023; Zumwalde et al., 2023). Similar to structural stigma in law enforcement, structural mental health stigma is deeply rooted in Department of Defense policies, procedures, and cultural norms (Campbell et al., 2023). Martinez et al. (2023) interviewed 26 embedded clinicians with the U.S. Air Force and found that having to overcome mental health stigma was a significant barrier in their work with airmen. Conversely, and offering hope for the current study, these providers also reported that the embedded nature of their job seemed to reduce mental health stigma. Citing not just their presence, the clinicians identified building relationships and showing up to offer support at events outside of the office seemed to help airmen become more comfortable coming to the embedded clinician for support (Martinez et al., 2023).

Embedded clinical programs in military units appear different from traditional clinic setting care provided to military members (Lippy et al., 2022). Apart from offering mental health support to service members, embedded clinicians in a military unit offer other services, such as consultation to leadership, education on mental health topics, performance enhancement, and spending time with the unit in daily activities- all to support the mission readiness of the unit and its members (Lippy et al., 2022). This position requires a specific set of skills beyond just clinical capabilities, including knowledge of military culture specific to the unit the clinician is embedded in, comfort working independently, being adaptable to shifting work schedules, ability to build rapport with both leadership and rank-and-file service members, and the ability to navigate tricky ethical situations that may arise (Barron et al., 2022; Lippy et al., 2022). To cultivate these skills and ensure quality care, ongoing training in these skills is key to building competency and trust with the unit members (Barron et al., 2022; Hryshko-Mullen et al., 2022;

Ogle et al., 2019). Ethical considerations specific to this type of clinical context include navigating multiple dual relationships, straddling the line between obligation to mission readiness and protecting the confidentiality of service members, record keeping concerns, and how to handle directives from command leadership that may be in conflict with standards of care (Hryshko-Mullen et al., 2022). Ogle et al. (2019) drew a direct comparison between embedded clinicians in military units and mental health providers who might be embedded in a police department, reflecting the similar challenges and competencies required to successfully practice in a context that varies greatly from a clinic office setting.

Outcome studies examining the impacts of embedded mental health clinicians in military units is scarce. Russell et al. (2014) surveyed 1,132 California Army National Guard soldiers about their behavioral health needs and treatment. From 12 different units, soldiers who had been deployed or were part of units that had perceived higher behavioral health needs were recruited and completed a range of surveys to assess behavioral health symptoms, perceived mental health stigma and barriers to care, unit climate (cohesion, collective efficacy, organizational support, morale), behavioral health care utilization, and close relationship distress. Results indicated that participants in units with an embedded clinician were more likely to report accessing mental health care. Symptoms in units with an embedded clinician were reported as being lower than in units without the embedded clinician program. While no direct evidence was found to support a positive effect of an embedded provider, the program did seem to lower barriers to care and to reduce stigma for soldiers in units with a provider. Limitations to the study included lack of randomized sampling, underpowered sampling to detect effects due to a number of outcomes demonstrated nonindependence, and the study was cross-sectional only, limiting results to correlation rather than causation. Beyond the Russell et al. (2014) study, very little outcome

research exists on this type of program. In fact, all the studies referenced here specifically call for further research into the efficacy and outcomes related to embedded clinician programs in military units (Barron et al., 2022; Hryshko-Mullen et al., 2022; Lippy et al., 2022 Ogle et al., 2019; Zumwalde et al., 2023). Similar to the gap in research around embedded clinicians in law enforcement agencies, embedded military clinician programs would benefit from expanded research into outcomes to support the continued funding and support of embedded programs.

Embedded Programs in Law Enforcement Agencies

Embedded mental health providers in law enforcement agencies are a proactive option for mental health care and officer wellness (Ramchand et al., 2019). These clinicians offer a range of services, from an EAP short-term type model to being able to offer long-term services, trainings, critical incident support, and peer support collaboration. Officers want to know when they see a mental health provider, that person will be able to understand their perspective, how their work impacts them, and not be afraid of the stories being shared in therapy (Arjmand et al., 2024b). Culturally competent therapists are versed in the norms and values of responder culture, including how this population is different from civilians, how responders think, emote, cope, and the unique presentation of symptoms in this population (Arjmand et al., 2024a). Specialized training, occupational exposure, and consultation are important ways for providers to develop this competence.

Ideally, wellness programs in police departments are a combination of proactive and reactionary intervention approaches, to include peer support and CISM, and clinical interventions for intervention care, provided by culturally competent therapists. These interventions include EMDR, motivational interviewing, mindfulness practices, and CBT (Rodriguez et al., 2024). As Whittington & Basham (2024) found, previous help seeking lessens

the barrier for officers choosing to seek support, suggesting that familiarity with the clinician might play an important part in these programs. Ride-alongs, attendance at trainings and briefings, and general immersion in law enforcement culture can all contribute to cultural competency for clinicians wanting to do embedded work.

Limitations of Current Research

While the studies cited in this literature consist of sound research, there were some common limitations that future studies should seek to remedy. According to the most recent FBI data available for 2019 (U.S. Department of Justice, Federal Bureau of Investigations, 2020), local and state level law enforcement agencies were comprised of 87.2% male commissioned officers and 12.8% female commissioned officers (no data is available that reflects non-binary officers). RespondCapture (2024), a company focused on recruiting first responders for agencies in the United States, reports that in 2024, the percentage of racial or ethnic minority officers increased from 27% in 2019 to 31%. Most of the studies included here cite a sample pool made up primarily of white males. While this is reflective of the general makeup of U.S. law enforcement agencies, the studies do cite lack of diversity as a limitation. The study cited in this present literature review with the largest sample pool is Drew & Martin (2021), with a national sample of 7,963 police officers from the United States. However, they report that while assuming that their large sample pool is likely reflective of the demographics of U.S. law enforcement, they did not collect ethnic, gender, or age demographic data and thus cannot definitively be sure that their participant pool accurately reflects these demographics. The most significant criticism of the studies included here is simply the gap in the literature that exists around what effectively reduces mental health stigma for law enforcement officers. Bonner & Crowe (2022) and Crowe et al. (2022) both reviewed current trends in officer wellness, and specifically called for further

research into how embedded clinician programs impact mental health stigma. Long term, outcome studies for the variety of solutions examined in this literature review would also lend further insight into wellness programs and their effectiveness. Future studies in this area ought to be mindful of and seek to mirror that in their sample pool to further solidify findings and recommendations.

Summary

Police departments, like families, experience the passing down of patterns and habits that impact its members across generations of officers. Officers already face numerous challenges on the job that can contribute to mental health concerns, such as high trauma exposures, organizational stress, and external stressors that they still have to navigate (Craddock & Telesco, 2022). Mental health stigma for officers comes from several different levels- including structural (Bikos, 2020; Ricciardelli et al., 2020), peer (Jaafar et al., 2024), public (Wheeler et al., 2021), and self-stigma (Grupe, 2023). This stigma often prevents officers from seeking help when they need it most (Drew & Martin, 2021). A variety of programs have been developed to help navigate mental health challenges for officers, including EAP, embedded chaplains, peer support, CISM/CISD, and other avenues of support (Carleton et al.,2024) Officers endorse a number of barriers to accessing support, including availability of services, fear of repercussions (Padilla, 2023), lack of confidentiality (Whittington & Basham, 2024), and struggling to find a culturally competent provider (Arjmand, O’Donnell, Sadler et al., 2024). Finding ways to normalize mental health support, including embedded clinicians, may be a viable option to reduce stigma and encourage help-seeking (Uhl et al., 2023). The goal of this study is to examine the impact of embedded clinicians on stigma in police departments, which has been widely called for in the existing research. This literature review highlights that there is a lack of research

on the impact of embedded clinicians on mental health stigma for officers, and this study seeks to start filling that gap. The follow chapter will outline the procedures for this study to effectively begin examining the impact of embedded clinicians in police departments.

Chapter 3: Research Method

The problem to be addressed in this study is the mental health stigma experienced by U.S. police officers that often prevents them from accessing mental health care, resulting in high rates of PTSD and suicide (Drew & Martin, 2021; Soomro & Yanos, 2019). The purpose of this qualitative phenomenological study is to explore the perceptions and lived experiences of police officers working in departments with an embedded clinician program regarding the reduction or elimination of the stigma related to receiving mental health care and what influences help seeking among officers who need support. This study centers around two research questions:

What are the perceptions and lived experiences of police officers working in departments with embedded clinicians related to reducing or eliminating the stigma of mental health care?

How did the embedded clinician program in the participants' departments contribute to the perception of mental health stigma among officers?

This chapter outlines how data was collected to answer these questions through a phenomenological qualitative study. First, an examination of why this methodology is the most appropriate approach to answering the research questions outlines the rationale for choosing this method. An outline of the population and sampling method follows. This section also includes a description of the materials utilized for the study, the study procedures, and the data analysis strategies. Additionally, identifiable limitations, assumptions, and delimitations of the study are described. Finally, the ethical assurances for this study, including IRB approval, steps taken to protect participant confidentiality, and the researcher's role in the study are outlined.

Research Methodology and Design

This study utilized a qualitative phenomenological methodology (specifically, an interpretive phenomenological approach) to explore police officers' lived experiences and

perceptions of mental health stigma and how an embedded clinician program impacts stigma in their departments. Numerous quantitative studies have been conducted to understand the pervasiveness of stigma as a barrier to care for police officers (Bikos, 2020; Drew & Martin, 2021; Soomro & Yanos, 2019), but little has been done to understand how this stigma might be reduced by specific intervention types, including embedded clinician programs (Bonner & Crowe, 2022). To begin filling this research gap, this study is focused specifically on understanding the lived experiences and perceptions of officers in departments with an embedded clinician to allow for an effective in-depth exploration of this phenomenon (Moustakas, 1994; Smith et al., 2022). Rank and file police officers were interviewed to gather information about their lived experiences and perspectives on this issue. Interviews were semi-structured for consistency, recorded, and each interview was transcribed (Smith & Nizza, 2022). Once themes were identified, a description of the phenomenon was synthesized from the findings and analyzed for themes to better understand the participants' experience and how the embedded clinician might impact those experiences. These findings were reviewed by the participants (member checking) to ensure their reported experience was accurately captured, documented and described (Moustakas, 1994).

Interpretive phenomenological analysis was the best approach to this problem when compared to other qualitative approaches. Ethnography, requiring the researcher to directly observe the activity being studied (Moustakas, 1994), is not a practical approach to answering the research questions at hand. A case study would not be broad enough to create a depth of understanding needed regarding the officers' perceptions and lived experiences to answer the research questions (Yin, 2013). Evaluation of a specific type of program would not provide the insight needed to answer the research questions (Kushner, 2017). The goal of this study is to

understand a specific phenomenon, not to create a theory based on the data, so grounded theory research was not an applicable method for this study (Moustakas, 1994). A narrative approach was also insufficient to answer the research questions, as a narrative approach would communicate the experience of the research subjects but not necessarily provide broader insight or understanding into the phenomenon of stigma for officers (Smith et al., 2022). Quantitative approaches would not be appropriate to answer the research questions as these approaches do not provide insight into the participant's experience of the phenomenon (Neubauer et al., 2019).

Population and Sample

The population sampled was police officers in Washington state. In 2024, Washington state had 11,070 commissioned police officers; 9,733 male commissioned officers and 1,337 commissioned female officers (Washington Association of Police Chiefs and Sheriffs, 2025). The research questions in this study were designed to increase understanding of mental health stigma in police departments, making the commissioned law enforcement staff population the ideal focus for this study. The researcher is located in Washington State and knows of a number of departments in Washington that have embedded clinician programs, making the specific population of commissioned officers in Washington a reasonable population from which to draw the sample. To obtain a sample from this population, departments identified as having an embedded clinician program were contacted to establish permission to recruit from the rank-and-file officers. Officers from these departments volunteered to be interviewed about their perceptions and lived experiences around mental health stigma, and how the embedded clinician program impacts that stigma. Inclusion criteria were police officers who have been on the job for at least five years, are at least 26 years old (the minimum age in Washington State to become a police officer is 21, and with an inclusion criteria of at least five years on the job, the minimum

age inclusion criteria is 26), and are familiar with their department's embedded clinician program. Flyers soliciting for interviews were distributed at departments that agree to participate.

While selecting a sample size is not an exact science in qualitative studies (Sebele-Mpofu, 2021; Smith et al., 2022), approximately 8 to 10 participants is generally considered an acceptable sample size to reach saturation (Smith & Nizza, 2022). Eight officers were recruited from identified departments (those with embedded clinicians) and interviewed. Saturation was reached by eight interviews, though the researcher was open to further recruitment had this not been the case. Purposive sampling was utilized to verify that participants met the inclusion criteria to ensure richness of data (Sebele-Mpofu, 2021). Purposive sampling also helped the participant sample more closely reflect the makeup of law enforcement in the state, at minimum with gender representation. Given the homogeneity of the sample (all rank-and-file officers with experience in departments with an embedded clinician), eight participants provided sufficient depth of information about the research questions and led to data saturation.

Instrumentation

Two instruments were used for this study. First, a brief demographics survey (Appendix A) was completed to ensure that potential participants meet the inclusion criteria. To those who met criteria, the researcher reached out to schedule an interview. Those who did not meet criteria were thanked for their willingness to participate, but no further interview was pursued. The second instrument used in this study was a set of semi-structured interview questions developed by the researcher (Appendix B). Semi-structured interviews are the most commonly utilized form of inquiry for phenomenological studies, as they allow for an in-depth exploration of participants' perspectives and experiences (Smith et al., 2022). The interview was designed to provide an in-depth understanding of participants' perceptions and lived experiences, and to

elicit rich data to answer the research questions. The interview questions were aligned with the research questions.

Study Procedures

This study centered around seeking to understand the lived experiences and perceptions of police officers working in departments that have an embedded clinician program and the impact that program might have on mental health stigma for those officers. To collect this information, an interpretive phenomenological approach was utilized. After receiving approval from the National University IRB, study participants were recruited from police departments in Washington State with an embedded clinician. A flyer was sent to identified departments that agreed to participate, and an initial demographic screening questionnaire was utilized to screen for qualified participants. The flyer included a link or QR code that accessed the demographic survey to start the participation process. Demographic survey questions are found in Appendix A. Inclusion criteria are police officers in Washington that have been on the job for at least 5 years, are at least 26 years old, and who are familiar with their department's embedded clinician program. Participants who meet these inclusion criteria were contacted for interviews, and informed consent was obtained from them. Eight participants were recruited, and while saturation was reached at eight interviews, the researcher was open to further recruitment if this had not occurred (Smith & Nizza, 2022). Interviews were conducted using Zoom and recorded. Utilizing Zoom's transcription feature, a transcript of the interview as produced and then reviewed by the researcher for accuracy against the recording. Interviews were semi-structured to elicit a rich understanding of participant's perspectives and experiences (Smith et al., 2021). See Appendix B for the list of interview questions.

Once interviews and transcriptions were complete, the interviews were coded and analyzed for themes. Following the process outlined by Smith et al. (2022), transcripts were read initially and initial researcher reactions or thoughts recorded. The next step was exploratory noting, getting familiar with the transcript and commenting about observations on the content and meaning to the participant to start drawing out meaning. The third step was constructing experiential statements, statements that succinctly communicate emerging themes and are built upon the notes made on the transcripts (Smith et al., 2022). Once each interview had gone through this analysis, the next step was to map out these themes and statements to find connections between the interviews. Microsoft Excel was utilized to code the interviews and map out themes. Analysis of these statements across interviews produced the themes and sub-themes that emerged in response to the research questions (Smith & Nizza, 2022).

To establish trustworthiness, Lincoln & Guba (1985) outline steps to be taken throughout the phenomenological study process. To ensure credibility, member checking was utilized to verify that the transcripts reflect the participant's perspectives and experiences (McKim, 2023). Each participant received a copy of their interview transcript and was given the opportunity to provide feedback to the researcher to ensure accuracy of the transcribed interview, which decreases the risk of researcher bias. It was assumed that if a participant did not respond to the researcher with amendments, they considered the transcript to be sound. To ensure dependability, the researcher maintained an audit trail and clear records at each research step. To ensure confirmability, peer review was utilized (Ahmed, 2024), primarily through the review of the dissertation committee members. To ensure transferability, thick descriptions of the research context and methodology will be provided so that readers may judge the transferability of the study for themselves (Ahmed, 2024).

Data Analysis

To answer the research questions, interpretive phenomenological data analysis was utilized (Smith & Nizza, 2022). Because interviews were conducted using Zoom, the interview was recorded and the embedded transcription feature utilized to capture the interview. To ensure accuracy, the Zoom recording and transcription were reviewed and the transcription entered into Excel for easy line-by-line analysis. Column A contains the transcribed interview; column B contains the researcher's initial impressions and thoughts; column C contains the exploratory notes; column D contains the experiential statements (Smith & Nizza, 2022). Exploratory notes were broken down into descriptive, linguistic, and conceptual notes and color coded to delineate each category (Smith & Nizza, 2022). Each interview transcript went through this process. To cluster statements by each experiential statement, column E was utilized to sort statements into the appropriate experiential statement category. Each of the eight interviews had its own spreadsheet in Excel. An additional separate spreadsheet contains the statements and clusters for all experiential statements for cross-case analysis.

To ensure the trustworthiness of the data, the researcher utilized several tools. Member checking was utilized to verify that the transcripts reflect the participants' perspectives and experiences (McKim, 2023). Each participant received a copy of their interview transcript and was given the opportunity to provide feedback to the researcher to ensure accuracy of the content from the transcribed interview, which decreases the risk of researcher bias. Dependability is supported through the researcher's audit trail and clear records of each research step. To ensure confirmability, peer review was utilized (Ahmed, 2024), primarily through the review of the dissertation committee members. For transferability, thick descriptions of the research context

and methodology were provided so that readers may judge the transferability of the study for themselves (Ahmed, 2024).

To maintain confidentiality and ethical assurances, each participant was asked to review an informed consent that disclosed the pros and cons of participation, as well as information on how their confidentiality was protected. The consent information was reviewed at the beginning of each interview and consent was demonstrated by the participant acknowledging understanding and by their decision to continue with study participation. Each participant was assigned an identifier (such as P1, P2, etc.) and no names are utilized in the research write-up. Demographic information was compiled but not identified by participant name. Additionally, all data was stored on a computer that is password protected and accessible only to the researcher.

Assumptions

An assumption in research is a belief that is taken for granted by the researcher and which is accepted as true without concrete proof but is necessary for the study (Ellis & Levy, 2009). For this study, it was assumed that the participants were honest about their experiences and perceptions of the mental health stigma in their department and how the embedded clinician program has impacted that stigma. An additional assumption was that the participants have at least some awareness of mental health stigma, how it might be present in their occupational system, and how it may impact them. It was also an assumption that the participants were being honest about meeting the inclusion criteria for the study.

Limitations

A limitation is an uncontrolled threat to the internal validity of a study (Ellis & Levy, 2009). Limitations to this study included the possibility that the participant demographics may not represent the demographic makeup of the larger population being studied, thus potentially

limiting the generalizability of the findings. To mitigate this limitation, potential participants completed a brief demographic survey so that the researcher may attempt to reflect the demographic makeup of the population being studied through selectively inviting potential participants to interview.

A potential limitation stems from the researcher's work as an embedded clinician in a number of police departments. This may produce the perception of a bias that this kind of program does have a positive impact on reducing mental health stigma for officers. While the researcher had intended to not recruit from departments they serve, these departments had members that expressed interest in being interviewed. To protect against bias and exploitation of a power dynamic, no participants from the researcher's affiliated departments are past or present clients of the researcher. To mitigate this bias, the researcher kept a journal of thoughts and personal reflections on the interviews, utilized member checking to ensure the participants' perspectives were accurately and clearly articulated, and peer review by the dissertation committee was utilized to reduce the researcher bias on the analysis.

Delimitations

Delimitations are the boundaries implemented by the researcher to establish and maintain the scope and feasibility of the study (Ellis & Levy, 2009). Delimitations for this study were selected to maintain the scope of the study, in line with the theoretical framework, problem and purpose statements, and to effectively answer the research questions. Recruitment was limited to Washington State police officers at departments with an embedded clinician to narrow in on a qualified sample population. The participant inclusion criteria were established with the goal of recruiting participants who have worked in the law enforcement field long enough to have experienced or observed mental health stigma in their department, witnessed the establishment of

an embedded clinician program, and have experienced or observed any impacts that program had on the stigma in their department. In Washington, departments with embedded clinicians have primarily started those programs within the last five years, which informed the minimum amount of time a participant needs to be on the job to qualify for the study.

An additional delimitation of the study was the choice to interview 8 to10 participants for saturation. This number of participants is generally accepted as a saturation point in qualitative research (Smith & Nizza, 2022) and offers a depth of understanding of the participants' perspectives and experiences. Overall, the geographical limit, inclusion criteria, and small sample size were selected to provide a clear, concise amount of data to address the articulated issues in the problem and purpose statements and provide rich insight into officers' experiences with an embedded clinician and mental health stigma.

Ethical Assurances

The first ethical assurance for this study is that recruitment and data collection did not take place prior to the National University IRB approval being granted. To ensure protection and ethical treatment of all participants, this study was designed to comply with the standards established by the Belmont Report (respect of persons, beneficence, and justice) (U.S. Department of Health, Education, and Welfare, 1979). To comply with respect of persons, informed consent was provided and obtained from all participants prior to their interviews. The informed consent was written in plain English for accessibility and clearly outlined the risks and benefits of participation in the study. This included ensuring all participants are aware they do not have to answer any question(s) they are not comfortable answering, that they may withdraw from the study at any time, and that they are aware of the steps taken to protect their confidentiality. To comply with the principle of beneficence, the following risks and benefits

were weighed: sharing about their experiences with stigma and an embedded clinician could be therapeutic as the participants share their story, but it may also raise distress. In the case of distress, the interview could be paused, and resources could be provided if necessary for the participant. To minimize risk of harm, the interview was conducted in a private Zoom interview, and all data was securely stored. At the conclusion of each interview, the researcher offered a quick debrief to the participant to ensure a smooth transition post-interview. To comply with the principle of justice, the inclusion criteria were designed to identify participants whose lived experience and perspectives can be explored to answer the research questions but not exploit this population. For this reason, participants from any departments in which they serve as an embedded clinician were not past or current clients of the researcher, and additional assurances were given that their department would not be notified of their participation in the study to protect confidentiality and protect against exploitation. Results from the study were used to the best of the researcher's ability to benefit the population of focus, and member checking was utilized as a protection against misrepresenting or exploiting the participants' stories.

Police officers as a population are often concerned with confidentiality around mental health issues (Whittington & Basham, 2024), so ensuring participants of the steps taken to protect their identity was a priority. All identifying information, such as names or department names, were scrubbed from the data and replaced with an identifier such as "P1" or "P1 Department." As all data collection and analysis was digital, documents and recordings were kept on a secure computer with a password. This information was included in the informed consent, and helped mitigate the risk of harm (or perception of risk) for the participants.

The researcher was responsible for developing the methodology, implementing the study, and conducting the interviews as well as the analysis of data. The researcher interpreted the data

and wrote up the findings. The researcher focused this study on an area with which they are familiar and in which they are working, addressing trauma in this population, and also conducting embedded clinical work in a number of police departments. To mitigate the potential researcher bias this creates, a number of safeguards were utilized. It is possible that their work will create assumptions that may impact the interpretation of the results. To mitigate this bias, the researcher kept a journal of thoughts and personal reflections on the interviews, utilized member checking to ensure the participants' perspectives were accurately and clearly articulated, and peer review by the dissertation committee was utilized to reduce the researcher bias during data analysis.

Summary

This study utilized interpretive phenomenological analysis to explore police officers' lived experiences and perceptions of mental health stigma and how an embedded clinician program impacts stigma in their departments. A participant sample of eight rank and file police officers in Washington State was recruited and interviewed. Interview transcripts underwent an interpretive phenomenological analysis (Smith & Nizza, 2022) to unearth insights that address the research questions. To ensure trustworthiness, the researcher utilized member checking, peer review, created an audit trail of all research decisions, and included rich descriptions of the research process for transferability (Lincoln & Guba, 1985). Limitations of the study likely center around the sample size, which may impact generalizability. Assumptions about the study include that participants would honest about meeting the inclusion criteria and in their responses, and the potential bias that the researcher has around the impact of embedded clinician programs from their own experience doing that work. To mitigate the potential bias in the data analysis, member checking, peer review, and a reflexive journal process was utilized. All data collection

and analysis was conducted in line with the IRB requirements and ethical practices to protect participants' well-being and protect their confidentiality, and data collection did not begin until official IRB approval had been granted. After the analysis process was complete and themes were established that answer the research questions, findings were reported in the next chapter.

Chapter 4: Findings

The problem addressed in this study was the mental health stigma experienced by U.S. police officers that often prevents them from accessing mental health care, resulting in high rates of PTSD and suicide (Drew & Martin, 2021; Soomro & Yanos, 2019). The purpose of this qualitative phenomenological study was to explore the perceptions and lived experiences of police officers working in departments with an embedded clinician program with a focus on assessing any reduction or elimination of the stigma to receive mental health care and influence help seeking among officers who need support. This study consisted of eight interviews with rank-and-file officers to explore their perceptions of mental health stigma in their departments, and how having access to an embedded clinician might impact that stigma for officers. The interviews were analyzed for themes related to two research questions centered on this type of program.

Trustworthiness of the Data

To ensure the trustworthiness of the data, the researcher utilized several tools. To establish credibility, member checking was utilized to verify that the transcripts reflected the participants' perspectives and experiences (McKim, 2023). Each participant received a copy of their interview transcript and were given the opportunity to provide feedback to the researcher to ensure accuracy of the content from the transcribed interview, which helps to decrease the risk of researcher bias. They were told that they could review their transcript and request amendments, and that if the researcher did not hear back from them, it would be assumed that they felt the transcript accurately reflected their perspective. No participants requested any amendment to their interview transcript.

Dependability is supported through the researcher's audit trail and clear records of each research step. For a sample selection of the audit trail, please see Appendix D. To ensure confirmability, peer review was utilized (Ahmed, 2024), primarily through the review of the dissertation committee members. For transferability, thick descriptions of the research context and methodology were provided so that readers may judge the transferability of the study for themselves (Ahmed, 2024).

Results

This study was designed to explore police officer's perceptions of mental health stigma in their departments, and how an embedded clinician program might impact that stigma. Eight officers from agencies in Washington State were recruited to participate in semi-structured interviews to answer two questions: 1. What are the perceptions and lived experiences of police officers working in departments with embedded clinicians related to reducing or eliminating the stigma of mental health care? and 2. How did the embedded clinician program in the participants' departments contribute to the perception of mental health stigma among officers?

All interviews were conducted over Zoom and recorded. The transcription feature of Zoom was also utilized, and the official transcription of the interview was done by entering the transcripts into Excel and compared against the recordings for accuracy. The length of time of interviews ranged from 11 minutes and 28 seconds to 35 minutes and 21 seconds. Police officers tend to be direct and not mince words, so the average length of interviews being around a 20-minute timeframe was not a surprise. Once the transcript was complete, a copy of their interview was sent to each participant for member checking purposes. Once all eight interviews were completed, a comprehensive analysis was conducted to reveal common themes to answer the research questions.

Demographics

Volunteers for this study were recruited from Washington State law enforcement agencies that have an embedded clinician program. Of the 11,070 Washington State law enforcement officers in 2024, approximately 88% are male and 12% are female (Washington Association of Police Chiefs and Sheriffs, 2025). For this study, volunteers were 63% male and 34% female. Of the participants, 75% were Caucasian and 25% self-identified as coming from a minority community. Median time on the job was 12.75 years, and median age was 42 years old. All officers were below the rank of sergeant at the time of the interview.

Table 1

Participant Demographics

Participant	Age	Gender	Years as an Officer	Ethnicity
P1	39	Female	12	Hispanic
P2	42	Male	5	Caucasian
P3	54	Male	12	Caucasian
P4	42	Female	18	Caucasian
P5	46	Male	19	Caucasian
P6	44	Male	18	Pacific Islander
P7	38	Male	10	Caucasian
P8	32	Female	8	Caucasian

Most of the participants had spent a significant amount of time in the career, and all but two of the participants have served in multiple departments. This wide range of experience led to rich descriptions of the officers' experience with mental health stigma, and the longer tenure of

most of the participants also generated a thick description of some of the long-term changes officers have experienced around mental health stigma.

Research Question 1

What are the perceptions and lived experiences of police officers working in departments with embedded clinicians related to reducing or eliminating the stigma of mental health care?

The purpose of research question 1 was to gain insight into how officers experience mental health stigma in their department, and what levels of stigma may pose barriers to officers in their department seeking mental health support. Of the eight officers interviewed, five had worked at more than one department, including one officer who also had experience working at a fire department and another who also had worked for the Washington State Department of Corrections. This provided insight into experiences with the cultures of multiple departments. The prevailing theme for this question was that structural stigma - the policies and attitudes put in place by department leadership - plays a significant role in the stigma experienced by officers. An additional theme that emerged in response to this question is that generational shifts are playing a role in shifting mental health stigma, assisted by exposure to an embedded clinician program.

Theme 1: Structural stigma resulting from policies and administration's attitude can impede or support the impact of the embedded clinician.

Participants had strong views about how administration perspectives and attitudes impact stigma. Participant 4 described the administration's implementation of an embedded clinician as being more for optics, seeking praise from the community or officers for being progressive, but not actually supporting the officers who needed it. In their view, seeking treatment crippled their

opportunity for advancement, which stood in sharp contrast to their department leadership's claims of wanting to support officer wellness through an embedded clinician program. They described it as "becoming kind of like a scarlet letter without wearing the letter, but it's there. It is very much there." If a department's administration doesn't support utilization of mental health resources in a non-punitive way, that structural barrier to care will override the embedded clinician's ability to reduce stigma related to help seeking and to make a difference for officer wellness. Participant 4 went on to say that

> the only reason I talk about [mental health] is because I know there's nothing I can say anymore that's going to change the trajectory of where my career is…where if my career hadn't been so derailed, I probably still wouldn't. I wouldn't be as open.

They went on to explain that if their career already hadn't been damaged by seeking mental health support, they likely wouldn't talk to the embedded clinician at all.

Several participants expressed concern about the weaponization of the embedded clinician program against officers. Participant 7 shared that their union had to address the weaponization of the clinician program by their administration:

> It only takes one administrative person with a bad attitude to put the kibosh on everything...I know there have been administrators who have tried to use [the clinician] as a tool against people in an HR sense, and it's like, uh-uh. No, you don't get to do that.

Even at the sergeant level, if supervisors at that level of administration have a negative opinion of mental health support, it can perpetuate the stigma for officers, as one participant described: "I do know there are certain sergeants that are adamantly against [the program], and think that it is a giant form of weakness." Participant 2 reflected that during a debrief of a critical incident, "I was like, 'that really scared me,' and it was immediately dismissed by a supervisor. They said

‘hey, we’re here for tactics, if you want help, that’s something else to talk about.’” This dismissive attitude by the participant’s sergeant prompted him to seek help outside of the department, rather than accessing the in-house clinician for fear of repercussions stemming from the sergeant’s attitude. Participants consistently reported that administration’s support or lack of support significantly factors into the embedded clinician’s effectiveness and the utilization of the program.

In contrast, administration can also make decisions that support the reduction of mental health stigma. For officers serving in departments with administrations that are supportive, it was reflected that the department leadership seemed to encourage use of the clinician’s services. Participant 8 reflected that

> …you lead by example. And so if you have leadership that is open to having mental health talked about having those potentially kind of tough conversations with people, people are going to be more open, more accepting to that. I think leading by example is a big thing, so having that positive opinion by leadership is huge.

Leadership at Participant 8’s department did this through openly discussing if they themselves had utilized the services, and making sure that policies around confidentiality were clearly outlined and respected. Participant 1 reported that at their previous department, the administration implemented a policy that required officers touch base with the clinician after certain types of calls. While helpful, the participant did reflect that the policy would benefit from a balance of standardization and flexibility to make sure that officers are accessing the appropriate support. For example, a standard that critical incident exposure prompts a peer support check in, but peer support can then choose to prompt a check-in with the embedded clinician based on how the officer is doing at the point of the peer support contact. The

consensus among participants was that the administration demonstrating support for mental health resources for officers and having administration lead by example set a positive tone for reducing mental health stigma in the department.

Theme 2: Generational shifts in stigma are gradual but noticeable.

A common thread among the interview participants was the idea that while many of them started in law enforcement during a time of "old school" attitude about mental health- i.e., "suck it up buttercup, it's not that bad," they also noted a gradual shift in the next generation of officers coming into the field. With the implementation of embedded clinician programs at their departments, participants reflected two key points: first, that new officers are being exposed to that resource earlier in their career, so it is more normalized in the culture for those officers. Second, that the older generation may not be accessing the resource themselves, but they do encourage the new officers to become familiar with the program and the embedded clinician. Participant 5 reflected that

> …we're doing a much better job at trying to get the young ones comfortable with it sooner. I hope through doing that and over time that it will catch on faster, and then when they become the new culture of change, that it will be a better environment to them, right? But for the senior people, I think that it's easier for us to tell the young ones hey, it's okay, go talk to people. But we're not ready, and a lot of us are not ready to accept that as an actual avenue, right? We're not… we're not actually doing what we tell them to do... we are hearing of some younger kids that are reaching out sooner, which is a good thing.

Participant 7 reflected a similar sentiment:

> I would say probably the biggest change…is that we've been able to integrate [the clinician program] in from day one. So, the way my mental health stuff went when I onboarded in 2016, was basically "oh hey, we have a peer support program, here's the people. If you need to go talk to someone, go talk to them." And that was it.

With new generations of officers entering the field with a more accepting attitude toward mental health help and a wider range of mental health resources being accessed and encouraged, officers may stay in the field for longer and be healthier through the duration of their career. Participant 4 reflected that if an embedded clinician could be introduced at the academy training level, perhaps the cultural shift around mental health stigma would accelerate as recruits return to their home agencies with a more positive outlook on help seeking. Participant 4 went on to say that new recruits coming into law enforcement

> …have much better coping mechanisms and skills. But then all I hear from people outside is well, we're not hiring the same caliber. I beg to differ. In fact, I feel like we're hiring a higher caliber...they're so much more mindful. And they're coming out of the Academy with better habits than I sure as shit ever did. At least they have the conversation, and most of them are starting to have that conversation about making sure they have good checkpoints.

A few of the senior officers interviewed in this study have spent time teaching at their regional police academies, and reflected a sense of hope that officers entering the field now will have less stigma than they themselves experienced. The other officers who participated in the study also reflected a shift in culture around mental health, especially in the last few years. While there is still a long way to go in the mission to reduce mental health stigma for officers, the study participants reflected a sense of hope that the shifts they've experienced in the last few years will

continue, and that the embedded clinician program is a strong pathway towards future generations of officers experiencing less mental health stigma.

Research Question 2

How did the embedded clinician program in the participants' departments contribute to the perception of mental health stigma among officers?

The purpose of research question 2 was to elicit insights into how an embedded clinical program might contribute - either positively or negatively - to the experiences with mental health stigma for officers. Two themes emerged: first, that the cultural competency of the clinician is significant to being able to impact mental health stigma, and second, that the self-stigma level may be where an embedded clinician program can make the most difference related to mental health stigma for officers.

Theme 3: Cultural competency of the clinician is key to reducing stigma.

Cultural competency, as it pertains to this study, means that the clinician is familiar with law enforcement culture and norms. This played a significant role for every participant, as the strong consensus was that for the program to be effective, the fit of the clinician was the most important factor. Police officers make quick judgments of people, appreciate candor and authenticity, and are hesitant to open up to anyone in general, but especially mental health professionals, as Participant 7 described:

> particularly in law enforcement, we deal with people who are lying and are false all the time, and everyone comes to work and puts on the cop face, and then we go out and we manipulate people while they're trying to manipulate us, and back and forth, and so it's very easy for people… for cops in particular, [to] sniff out someone who's not genuine.

> And then we're also simultaneously, instantly judgy. So it's like, oh…It took me 2 seconds of talking to you, and I hate you…there is no fixing that.

Participant 6 expressed that they recently had a state mandated mental health training where the clinician leading it came out with

> … "you guys are broken. All you guys are broken, and you guys need [therapy], because you're all busted up, you know?" Broken toys or whatever...I think if somebody comes in and says that, immediately everyone's gonna be like, I'm not talking to you.

It is important that the embedded clinician be able to meet officers on their terms, perhaps outside of an office with a couch, sound machine, and soft light; rather, meeting with them on a ride-along, in the police cars, where officers are comfortable. Participant 3 brought up an example from the Lethal Weapon movie franchise where the police psychologist has to clinically evaluate Detective Riggs, and it's in her office with a couch, it feels very stiff and formal. While that is the stereotype that officers have in mind when they think of what it means to meet with a "shrink," it is not an environment that builds the trust and rapport needed for officers to feel safe. Participant 3 highlighted that the clinician in their department has integrated in and is accepted because "[the clinician] isn't coming out there in a white coat and spectacles, and [being like] it's your 2100 meeting time….just [the clinician] being there and having availability…just being [themselves]" is what has allowed their clinician to integrate into the department. This suggests that a clinician who is comfortable working in settings outside of an office, being willing to be authentic and genuine, understanding the culture of law enforcement, can successfully embed in a department. As Participant 3 describes, the clinician being integrated into the department allows a certain acceptance of mental health support, and "it clears that veil, opens up that

curtain, shines a light on it" to give permission for officers to acknowledge mental health challenges and access support with reduced fear of stigma.

Two subthemes emerged that relate to cultural competence: trust (rapport and confidentiality), and the role of accessibility. When it comes to trust, rapport and confidentiality are vital components for officers. Traditionally, police culture is highly skeptical of mental health providers (Drew & Martin, 2021), so having a clinician in the department can easily generate fear or paranoia, particularly if the department has higher levels of structural stigma. If officers are afraid that their conversations with the clinician won't be confidential, or that the clinician will try to take their badge and gun if they disclose any mental health concerns, not only does the stigma remain intact, but it can create other barriers to care. Participant 2 stated that "if there's any idea or thinking that…it might hurt their career in the future" it would stop officers, himself included from accessing the services. However, if officers know they can trust the confidentiality of the clinician, stigma and fear decrease. Multiple participants reported that they weren't sure how many officers used the clinician's services, but they felt that any level of use was a positive sign of trust and confidentiality with the clinician. Participant 5 described confidentiality this way: "a lot of the conversations happened offline…and as long as they can be secretive to a point…then that will allow success. It's the secret handshakes that lead to maybe a phone number, or a contact." Even in departments with supportive administration, assurance of confidentiality is the key to the success of the embedded clinician program and the reduction of mental health stigma for officers.

Rapport between clinician and officers is a vital part of trust. Participants expressed that officers want to know that the clinician can meet them where they are at, be able to engage in

banter, and be able to handle the gritty reality of what officers experience. Participant 5 explained the necessity of rapport with the clinician:

> For my department, I think because we know [the clinician], it's us talking about [the clinician], not talking about the program. We talk about a person, not a position...it wasn't really having the clinician, it was having the relationship with [the clinician]...I think if you had brought a James Smith, and he had been the mental health guy, and none of us had ever met him before, I'll be honest, I'd never have talked to him.

Participant 8 framed it similarly, but highlighted that knowing the embedded clinician is not going to be afraid of what the officers need to discuss:

> I think [having the clinician in the department] helped build that trust. That was part of what I think some of the barriers were, just like having that clinician who's a known entity instead of a stranger that you go to…and you're like, I've never met this person before, I don't know what their experience is with this, even though they're a licensed clinician. They could be a child therapist, and here I am talking about murder or something. I think that certainly helped erode that barrier. I think that having that gone helps things along.

When officers get to know the clinician and develop the rapport needed, it opens the door to seek care with less stigma. Rapport and confidentiality go hand-in-hand with building the trust needed for officers to know they can safely access the embedded clinician support without fear of stigma.

Accessibility was an important part of the clinician's cultural competency for the participants. Due to the stresses of shift work and staffing issues that generate significant overtime demands on officers, finding time to seek out a therapist that can work with the

scheduling needs of officers can be difficult. Participant 3 described scheduling as a main challenge for officers: “time and scheduling, specifically for night crews. But I know that [the clinician] is there on Wednesdays for between day shift and night shift…if somebody outside was looking for counseling, it would specifically have to be on a day off.” Having the embedded clinician consistently available reduces this common barrier to care for officers. Participants expressed that having the embedded clinician consistently offer in-department hours also contributes to building the trust needed for officers to be comfortable with clinical resources. For participants, regular department hours also means that the clinician is around frequently enough to know what’s going on with calls and stressors for the officers, so they can easily follow up when a critical incident occurs. Participant 7 described how the embedded clinician availability helps reduce stigma:

> The ability and availability of people to talk to a mental health care provider at work is great. Having her available is nice because she is disconnected [from department drama and dynamics], but still culturally competent…[officers] are like “yeah, it’s nice being able to talk to her because I know it’s not gonna get back to anyone.” You know, it’s not gonna join into the scuttlebutt… I just picked up the phone and was like, hey, “When's your next opening?”...and being able to have that availability there is super helpful, because we already know what that resource is. … [otherwise] life happens, it falls through the cracks. You know, a couple days go by, or you have a negative impact because you can’t get anything. Instead, it’s [dial tone sound] you know, or you text, “hey call me ASAP.”

With the presence of rapport and confidentiality, paired with accessibility, the embedded clinician program lowers the barriers to care - including reducing the stigma associated with help

seeking for many officers. It becomes acceptable to acknowledge that they know the clinician, and possibly more acceptable to even acknowledge that they have confided in the clinician.

Theme 4: Self-stigma seems to be the most impacted by the embedded clinician.

Of the levels of stigma officers experience, the internalized self-stigma seems to be one of the most significant barriers for officers. Even before an individual enters law enforcement, they have pre-existing notions about mental health and help-seeking. For example, from media in popular culture like Participant 3's example of the encounters with the psychologist in the Lethal Weapon movies, or from previous experiences with mental health clinicians, these ideas can set up officers to be pre-disposed to self-stigma around mental health. Then, upon entering the occupation of law enforcement, this self-stigma can become more deeply entrenched by the structural stigma dynamics of a department, or through cultural norms like the "old school mentality" often referenced by study participants. Encountering mental health calls in the field with individuals who are presenting with extreme, acute mental health symptoms such as psychosis, can also contribute to reinforcing the self-stigma officers carry. Participant 7 explained that for their embedded clinician program, shifting stigma ran into this challenge:

> A lot of it is dealing with preconceived notions about what mental health is, which are usually based on people's experience from before they come into law enforcement. So sometimes you have to help them overcome that … and then also the other thing is helping people understand, especially younger officers, like the mental health services that are provided to the people we come in contact in our profession are not the same as what you're getting.

When structural stigma, particularly fear of repercussions against their job, impacts officers, it often heightens self-stigma to the point that officers will hold back from seeking help

until they are experiencing some sort of potential breaking point. Participants labeled this as fear, pride, or just the “good old boys’ mentality.” Participants also reflected that having an embedded clinician program can provide some nexus points for when that breaking point comes for people in their departments. Ease of access to a culturally competent clinician, even if just for referrals to outside services, grants permission for officers to seek help with less shame. Participants 1 and 6, in discussing the benefit of having a culturally competent resource available in the wake of critical incident exposure, pointed to the normalization that the clinician can offer when an officer’s initial reaction to a situation can make them feel disoriented or crazy. A trusted clinician can also support the transition for an officer at a point of crisis to trusted sources of care, such as referrals to culturally competent inpatient care, and it feels less threatening because the clinician has built the trust and rapport with the members of the department. Having a culturally competent embedded clinician can impact officers’ self-stigma by demonstrating understanding, trust, and shining a light on the importance of good mental health for officers. As demonstrated in theme 1, structural stigma might not be easily shifted by the embedded clinician’s presence, but self-stigma can be shifted for individual officers who are exposed to a culturally competent embedded clinician.

Comparison of Results to the Literature Review

After analyzing the data and themes, the findings were consistent with existing research. Reflected extensively in every interview was the pervasiveness of mental health stigma for officers at the structural, peer, self, and public levels (Gyamfi, 2024; Richards et al., 2021; Soomro & Yanos, 2019). Furthermore, the interviews reflected that stigma is, in fact, transmitted from generation to generation of officers, much like how patterns are transmitted in family systems (Bowen, 1985; Kerr & Bowen, 1988). Also clearly present in the interviews were the

impacts of subsystems on how mental health stigma presents in departments, which is consistent with Minuchin's view of family systems being made up of varying levels of subsystems (Minuchin, 2012). This served as confirmation that the blending of stigma theory with family systems principles is an effective framework for examining this topic of how an embedded clinician may impact mental health stigma in police departments.

Research Question 1: What are the perceptions and lived experiences of police officers working in departments with embedded clinicians related to reducing or eliminating the stigma of mental health care?

Theme 1: Structural stigma- policy and administration's attitude- can impede or support the clinician's impacts.

Consistent with the literature examining mental health stigma in police officers, structural stigma emerged as a significant factor in the interviews (Bikos, 2020; Hofer & Savell, 2021; Ricciardelli et al., 2020). Policies and administration attitudes about mental health concerns, especially policies that are punitive of officers who seek mental health care, directly influence the impact that the embedded clinician program can have. Negative attitudes about care seeking, attempted weaponization of officers utilizing the in-house clinician resource, or policies that seek to break down confidentiality, can all pose significant barriers to the embedded clinician being able to impact stigma (Bikos, 2020; Whittington & Basham, 2024). In contrast to the existing literature on negative structural stigma, the participants also brought the perspective that if they have supportive administration, whose attitudes and policies are pro-officer wellness and support the confidentiality and role of the embedded clinician, the officers in those departments face lower structural stigma that allows the embedded clinician to have a net positive impact on mental health stigma (Bonner & Crowe, 2022).

Theme 2: Generational shifts in stigma are gradual but noticeable.

Consistent with Bowen's ideas of multigenerational emotional process being passed from generation to generation, with gradual shifts between each generation (Kerr & Bowen, 1988), changes in mental health stigma in the participants' departments were observed. Peer stigma (Jaafar et al., 2024; Ricciardelli et al., 2020) seems to be shifting as older generations of officers change their perspectives on mental health care. This is translating to how they train the new generation of officers coming into the field, with older officers encouraging younger officers to access mental health support earlier in the career (Bonner & Crowe, 2022). As talking to an embedded clinician or accessing other mental health resources becomes more normalized, the generational shifts will continue towards a reduction of stigma not just on the peer level, but also on the individual self-stigma level, which is also consistent with research suggesting that exposure to mental health resources does decrease stigma for officers (Whittington & Basham, 2024).

Research Question 2: How did the embedded clinician program in the participants' departments contribute to the perception of mental health stigma among officers?

Theme 3: Cultural competency of the clinician is key to reducing stigma.

Consistent with existing research, it is important to officers that any clinician they work with be culturally competent (Arjmand et al., 2024a; Arjmand et al., 2024b).Cultural competence is comprised of more than just familiarity with law enforcement culture; it includes the key value of trust (rapport plus confidentiality) and accessibly. A culturally competent clinician (Arjmand et al., 2024b) who protects confidentiality (Whittington & Basham, 2024) and can build trust with the officers to be accessible for mental health support (Padilla, 2023) makes a good fit for an embedded clinician program and, per participants' experiences and perceptions, reduces

mental health stigma for officers. Consistent with studies about the impacts of embedded clinicians in military units, embedded clinicians who are culturally competent seem to reduce mental health stigma by being present, trustworthy, building rapport, and being accessible to the individuals being supported (Martinez et al., 2023).

Theme 4: Self-stigma seems to be the be most impacted by the embedded clinician program.

Consistent with the literature, self-stigma was found to be a significant barrier for officers, but also one that may be most impacted by exposure to an embedded clinician. Self-stigma significantly prevents officers from seeking care (Grupe, 2023) and may be reinforced by police culture itself (Soomro & Yanos, 2019) as it values self-reliance, being “tough,” and encourages distrust of outsiders. Additional enforcement of self-stigma is found in exposure to mental health calls on the job, prompting officers to internalize fear of being seen as “crazy” by coworkers if they are honest about a mental health struggle (Newell et al., 2022). However, participants identified the embedded clinician as a resource that can help address these contributing factors related to stigma for officers. Participants repeatedly stated that the familiarity and relationship with the embedded clinician make seeking care less of a barrier. This is consistent with research findings that officers familiar with wellness resources or previous experience seeking care (Whittington & Basham, 2024) experience less stigma around help seeking. This suggests that the embedded clinician program may reduce self-stigma through familiarity with officers, normalization of reactions to calls, and through accessibility in the department system; all consistent with existing literature on this topic.

Summary

Analysis of the eight participant interviews provided extensive insight into how an embedded clinician program in a police department may impact mental health stigma for officers. In response to research question 1, analysis indicates that structural stigma in a department can either support or impede the impacts of the embedded clinician program. Structural stigma is a known and significant barrier for officers to seeking care, and it may be a determining factor in how the embedded clinician can impact stigma. Additionally, interviews revealed that a generational shift is occurring in the departments represented in the interviews, and the embedded clinician plays a key role in that culture shift around mental health stigma between generations. In response to research question 2, the cultural competence of the clinician is a significant factor in impacting mental health stigma. Beyond just understanding law enforcement officers and culture, the embedded clinician needs to build trust through rapport and confidentiality, as well as accessibility, to effectively impact mental health stigma for officers in a positive way. Finally, self-stigma is the level of stigma that might be most impacted by the embedded clinician program as officers overcome internalized feelings of shame, pride, or weakness and access the resources of the embedded clinician program. These findings are consistent with existing literature on the topic of mental health stigma in police officers and the barrier to care seeking it creates. In the next chapter, implications of these findings and recommendations for practice, policies and future research based on participants' insights will be outlined.

Chapter 5: Discussion, Recommendations, and Study Summary

The problem addressed in this study was the mental health stigma experienced by U.S. police officers that often prevents them from accessing mental health care, resulting in high rates of PTSD and suicide (Drew & Martin, 2021; Soomro & Yanos, 2019). The purpose of this qualitative phenomenological study was to explore the perceptions and lived experiences of police officers working in departments with an embedded clinician program with a focus on the reduction or elimination of the stigma to receive mental health care and influence help seeking among officers who need support. This study consisted of the completion of eight interviews with rank-and-file officers to explore their perceptions of mental health stigma in their departments, and how having access to an embedded clinician might impact that stigma for officers. The interviews were analyzed for themes related to two research questions centered on this type of program.

Themes emerged that indicate that an embedded clinician program can positively influence mental health stigma for officers, but that structural stigma can get in the way of a program's effectiveness. Generational shifts around stigma are naturally occurring, and the presence of an embedded clinician provides an avenue to normalize mental health support early in officers' careers. For an embedded clinician to effectively impact mental health stigma in a department, they must be culturally competent. This means not only that the clinician understands law enforcement culture, but they are able to establish trust with officers through rapport, confidentiality, and accessibility. Finally, of all the stigma levels experienced by officers (structural, peer, public, and self-stigma), self-stigma seems to be the stigma most directly impacted by the embedded clinician.

Limitations to this study include the fact that it is possible that participants likely volunteered because they have a positive view of the program. While an overall rich narrative was provided by participants about the impacts of an embedded clinician program, there is a perspective from officers who do not have a positive view of mental health or embedded clinicians that would be beneficial to explore. An additional limitation lies in the lack of diversity among the clients in regard to ethnicity and gender.

This chapter will explore the implications of the study findings for clinicians interested in working with police departments, as well as implications for public safety administrators to consider as they address wellness needs within their departments. Recommendations for future practice and future research will also be discussed.

Implications

Theme 1: Structural stigma resulting from policies and administration's attitude can impede or support the impact of the embedded clinician.

It is not particularly surprising that the structural stigma experienced by officers would impact the effectiveness of an embedded clinician program. Previous research into law enforcement mental health stigma reflects the impacts of structural stigma in enforcing a culture of silence and "suck it up buttercup" mentality when it comes to mental health struggles (Bikos, 2020; Hofer & Savell, 2021; Ricciardelli et al., 2020). Through the interviews, it became clear that administration, policies, and attitudes from leadership presented one of two forces: either it reinforces the stigma, making it unsafe for officers to pursue mental health support, producing fear of repercussions, or encouraging antagonistic views of mental health concerns, or the structural components around mental health can help support officer mental wellness and help seeking. As Participant 4 stated, in departments where having an embedded clinician is about

optics or is weaponized, this means that help seeking generates an unspoken "scarlet letter," further contributing to stigma rather than reducing it. Of equal note is that while administration's attitude and policies can obstruct the value and impact of the embedded clinician, it can also serve as a significant support in the clinician's impact on mental health stigma. Regardless of the presence of an embedded clinician, the structural influences of administration's attitudes and policies around mental health seem to be the most significant force that influences mental health stigma in police departments.

Structural stigma usually comes from administration, but it can also come from the guild-level if they aren't supporting progressive programs such as an embedded clinician. Participant 7 highlighted that "I think the administration portion of it…if they're buying into it, then the program is successful. If they are not buying into it, it won't be successful. It only takes one administrative person with a bad attitude to put the kibosh on everything." Participant 5 reflected that

> I know in our state, the unions are a big help in a lot of areas. But they can also hinder some command staff from moving forward in more progressive ideas, if the union itself is scared of those steps, or … they're playing the, well, it could go down a slippery slope. Instead of just giving it a try, right, and trusting the command staff…. we as a group … can't have the loud majority of the union obstructing positive change…

Whether it be from a top-down or a bottom-up source, structural stigma can get in the way of the embedded clinician program's effectiveness. Alternatively, support from both administration and rank-and-file officers can allow for an embedded clinician program to effectively decrease the stigma officers experience around mental health.

Preventing the department administration from weaponizing the clinical program is an additional concern around impacting mental health stigma. If the clinician's services are leveraged in a way that creates even the perception that the clinician is aligned strongly with administration, the rank and file will not benefit from reduced stigma, but it will further entrench the structural stigma for those officers. Protecting the confidentiality and safety of the clinical program from being used against the officers who use the program needs to be a priority. This is an example of where police union support of the program is vital: police unions often carry the power to check abuses of the system by administration, and preventing weaponization of the clinical program is an avenue union leadership can utilize to reduce mental health stigma for officers.

Theme 2: Generational shifts in stigma are gradual but noticeable.

Recurring among the interview responses was the reflection that over the years of the participants' careers, mental health stigma has incrementally shifted towards a less antagonistic view of help seeking. Even for older officers who themselves may not seek support, they often encourage new officers to tend to their mental health and be willing to seek support if needed. This does suggest that the availability of a culturally competent embedded clinician provides a normalization of mental health support not previously experienced by older generations of officers (Bonner & Crowe, 2022; Whittington & Basham, 2024). Like Bowen often discussed related to family systems, patterns are passed down in systems and have to be intentionally shifted by members of the system choosing to do something different (Kerr & Bowen, 1988). If police departments are serious about officer wellness and reducing mental health stigma, intentionally developing an embedded clinician program can be a strong step toward shifting the generational trends in law enforcement in the direction of positive views of mental health and

help-seeking. Between older officers actively encouraging new officers to access mental health resources such as an embedded clinician and the fact that it is being introduced at an earlier point in their careers, it is likely that new generations coming into law enforcement will experience lower levels of mental health stigma than their predecessors.

Theme 3: Cultural competency of the clinician is key to reducing stigma.

In line with existing research, the participants in this study identified certain barriers to care (Hofer & Savell, 2021; Richards et al., 2021; Soomro & Yanos, 2019; Whittington & Basham, 2024). These include lack of ability to find a culturally competent provider, accessibility from a scheduling standpoint, fear of career repercussions, and their own attitudes about mental health care. Also reflected in the interviews was that having access to a culturally competent clinician embedded in their department addressed three of these significant barriers.

If an embedded clinician is going to impact stigma for officers, cultural competency is the most important factor. Most significantly, the clinician's ability to build trust- a combination of rapport and ensuring confidentiality- is likely the main factor in the clinician's control that determines how much impact an embedded clinician can make in a department. This is consistent with the research on embedded clinicians in military units (Lippy et al., 2022; Martinez et al., 2023). Officers don't trust outsiders easily (Richards et al., 2021; Soomro & Yanos, 2019), so the clinician needs to be able to understand law enforcement culture and be willing to put in the time to build rapport with department members. Participant 8 described the value of their department's clinician putting in the time to build rapport and confidentiality:

> Having her available is nice because she is disconnected, but still culturally competent… officers are like "it's nice being able to talk to her because I know it's not gonna get back to anyone." You know, it's not gonna join into the scuttlebutt, you know…And then I

> know on the other side of that, that [the clinician] is really good with talking with people in a … a non-professional setting, so that she's still up to speed on the scuttlebutt. Which, you know, would also be a barrier, because if she… she does a really good job of…Like, we chat, uh, in a non-professional sense, just whenever I see her, just come in, you know, just shoot the breeze and stuff. But then we always… fill her in, "hey, this is… this is what's going on, here's the latest drama," that kind of stuff. And so, her making effort to do that also helps, because then she's filled in and she doesn't have to ask for a bunch of backstory. Because she already knows what's going on while not directly participating in it, which is nice.

In Participant 8's department, the clinician put in the time to get to know people so they are comfortable talking to her and keeping her in the loop when concerns arise with their coworkers. This reflects the level of rapport and confidentiality that cops require to trust the clinician and allow stigma to decrease around talking to a clinician. This example also highlights that cultural competency means being comfortable in a non-traditional setting, whether that be doing ride-alongs, like many participants mentioned, or "shooting the breeze" with officers while they write reports and hang out. A culturally competent embedded clinician who is willing to practice a bit out-of-the-box and build rapport can become integrated into department norms and flow, which seemed to be perceived by the participants as the most significant way the clinician could directly impact stigma.

Theme 4: Self-stigma seems to be the most impacted by the embedded clinician program.

A common thread through most of the interviews was the idea that the relationship with the clinician is what makes a difference, and that relationship can help individuals reduce their own personal self-stigma. Participant 5 described the impact of the program as being about the

relationship with the clinician: "We talk about a person, not a position…for me, it wasn't really having the clinician, it was having the relationship with [our clinician], trusting [them] and [the] program…" Participant 8 described the impact of this relationship with their department's clinician as a shift away from cultural norms of "bottling it up," that now they are "more open to talking about things, if there's something I'm struggling with, or something I can't make a decision on, I phone a friend." This highlights the importance of theme 3, that the right clinician for this type of program has the cultural competency to develop rapport and provide normalization of talking to a clinician. The level of stigma this most directly shifts is self-stigma, which is consistent with the study by Burns & Buchanan (2020) that found that familiarity with a mental health provider reduces this barrier for officers. While structural stigma plays the most direct role in how the stigma in a department impacts officers, the clinician themselves can most directly impact the self-stigma level for officers. This suggests that any clinician doing embedded work in a police department needs to focus on building rapport with each officer to have the strongest possible impact on stigma. Arguably, helping individual officers shift their self-stigma would contribute to a larger cultural shift in a department, making it more acceptable for officers to seek care when needed. This is likely one of the contributing factors to the generational shift in stigma discussed earlier.

Recommendations for Practice

For Clinicians

Participant 7 best summed up what makes an embedded clinician program effective: "culturally competent clinicians are the number one thing. Buy-in from the administration down is probably the second part. And then the third part is availability." This highlights the two

domains of recommendations for practice- those for clinicians, and those for police department administration.

For clinicians who seek to do embedded clinical work in police departments, cultivating cultural competency should be a priority (Arjmand et al., 2024a; Arjmand et al., 2024b). Cultural competency means being familiar with law enforcement culture, building trust (rapport plus confidentiality), and being accessible during in-department hours to all staff members. Study participants repeatedly highlighted the value of the embedded clinician doing ride-alongs, attending shift briefings, and generally integrating into the department culture. This is consistent with research on clinicians embedded in military units, who are integrated into the unit as a member and are thus trusted by the unit members (Martinez et al., 2023). Clinicians who do embedded work need to be comfortable with doing therapy in unorthodox settings. As Participant 4 described:

> It's not necessarily, like, you're in an office, and there's a sound machine, and then I'm on this uncomfortable couch, and… specific questions are asked, or “oh, how do you feel about that today? How did that make you feel? Oh, let's talk about that.” You know, it wasn't so clinical. So, even having…the opportunity to just drive around, and just talking more in a normal setting, to where we as officers feel comfortable, because we don't…I will put it out there: I would say, in general sense, officers don't feel comfortable in an office setting.

Like military embedded clinicians (Barron et al., 2022; Lippy et al., 2022), clinicians in a police department setting need to be willing to navigate ethically gray areas and be willing to put in the time to build the rapport necessary for officers to trust that the clinician will hold confidentiality. Based on the participants’ experiences, building relationships with officers is

what reduces self-stigma, but it also means balancing dual relationships and the challenges that come with working in a small community. At times, this may mean advocating for the needs of rank-and-file with administration, who likely have a very different need or goal than the officer or clinician have. At the same time, the embedded clinician needs to cultivate a good working relationship with administration. This type of program, which can present some unique ethical dilemmas such as multiple dual relationships within the system, may make some ethics professors clutch their pearls and gasp, but culturally competent clinicians in police departments can play an important role in the reduction of mental health stigma for officers and thus need to navigate this gray territory effectively.

For Administrators

This study highlighted some considerations for police administrators as well. Given the clear impacts of structural stigma on officers' mental health and willingness to seek help (Bikos, 2020; Hofer & Savell, 2021; Krick & Felfe, 2020; Ricciardelli et al., 2020), administrations need to prioritize policies that decrease mental health stigma. If a department is building a wellness program that includes an embedded clinician, policies around the program need to support confidentiality for the officers who access that resource (Whittington & Basham, 2024). An example would be a clearly outlined course of action for mandated reporting situations or situations needing an extended higher level of care, such as what the expectations are for when an officer is suicidal or needs to take leave for a stay in inpatient treatment. These policies should include protections to ensure that a minimal number of people will be involved and have an identified point of contact for the clinician to coordinate with in these situations (for example, a trusted peer support supervisor). Additionally, any contract between clinician and department ought to clearly include a clause that any documentation belongs to the clinician and is exempt

from public disclosure rules. It would be expedient if, prior to implementing an embedded clinician program, administration collaborated with the rank-and-file guild leadership to agree upon the parameters of confidentiality, role of the clinician in the department, and ways to protect against the weaponization of the embedded clinician program. For example, if annual mental wellness checks will be part of the embedded clinician program, what is reported to the administration about the checks should be clearly established and agreed upon by the administration, guild, and clinician. The policies around the embedded clinician program, and the protections for confidentiality, ought to be clearly communicated to all department members to encourage rapport and utilization of the embedded clinician.

An additional recommendation for police administrators implementing an embedded clinical program is to ensure that all incoming new officers or lateral hires are introduced to the clinician and are encouraged to utilize the program resource. Participants reflected that they see the new generation of officers coming in are experiencing a normalization of addressing mental health needs sooner, aided by the presence of the embedded clinician. To keep this generational pattern shift going, department leadership needs to support engagement with the embedded clinician.

Some convergence of recommendations for both clinicians and police administration emerged from this study. Both parties are significant stakeholders in any embedded program and need to work together for the program to be effective. This means mutually agreeing upon the boundaries between clinician and administration to support confidentiality. Establishing in-department hours that can accommodate the varying, rotating schedules of officers on shift work, requires administration to agree upon the hours the clinician will be in the department. Offering hours that might overlap day, swing, and night shift would be advisable as a way to reduce this

particular barrier to care. Negotiating what the clinician's availability outside of in-department hours will be, such as in situations of an officer-involved shooting or other critical incidents, or in event of a staff member having a crisis, is an additional conversation around availability.

Recommendations for Future Research

Future research is necessary to continue to understand how to best reduce mental health stigma for police officers. This study focused on the voices of rank-and-file officers to better understand how an embedded clinician might reduce mental health stigma and offers insights that suggest this type of program can be an effective tool in that mission. However, given the limited sample size of eight interviews, additional studies seeking to understand and evaluate how an embedded clinician impacts mental health stigma would benefit from a quantitative approach, as well as additional qualitative studies to increase the insight into how this type of program can be effective. Future studies would also benefit from including non-commissioned support staff in understanding the impacts of this type of program, as current literature including support staff suggests that non-commissioned staff also suffer from repeated, mostly vicarious, trauma exposure, mental health diagnosis, and organizational stressors at similar rates to commissioned staff (Fix & Powell, 2024; Varker et al., 2023). Additionally, studies that include the perspective of clinicians who are doing embedded clinical work in police departments would be beneficial for a deeper understanding of how to run an effective embedded program.

While this study's participant demographics represent the demographic makeup of policing in general- that is, it is a field primarily comprised of Caucasian males- future studies would benefit from a more diverse sample, including diverse genders, ethnicities, and sexual orientations. It is possible that this study's participants volunteered because they have a positive view of their department's embedded clinician program and of help seeking. While the findings

of this study are consistent with existing literature, a study with participants who do not have a positive view of an embedded clinician program would provide additional insight into this type of program and how it impacts stigma.

Conclusions

The problem addressed in this study is the mental health stigma experienced by U.S. police officers that often prevents them from accessing mental health care, resulting in high rates of PTSD and suicide (Drew & Martin, 2021; Soomro & Yanos, 2019). Police officers have one of the most demanding and dangerous jobs in society, with their duties taking a toll on them physically, mentally, emotionally, and socially (Fuller et al., 2024; Galanis et al., 2021). Police officers are 54% more likely to die by suicide than the general population (Violanti & Steege, 2021). In response to this urgent mental health crisis for police officers, the Task Force on 21st Century Policing released a report outlining key priorities for U.S. law enforcement agencies regarding policy, procedure, and programming. Pillar Six of the report (President's Task Force on 21st Century Policing, 2015) addresses officer wellness and safety, stating that "the wellness and safety of law enforcement officers is critical not only to themselves, their colleagues, and their agencies but also to public safety" (p. 75). The report issued a call for development and support of resources for officers, including the normalization of accessing resources such as mental health clinicians (President's Task Force on 21st Century Policing, 2015). As a result, numerous solutions for officer mental health support have been explored, including embedding mental health clinicians in police departments (Bonner & Crowe, 2022; Crowe et al., 2022). Missing from the research into these solutions is an examination of how this type of program impacts the mental health stigma that is the most significant barrier to care for officers (Drew & Martin, 2021), and the little that has been examined mostly centered around the voices of

administration rather than rank-and-file officers. This study explores how to begin more effectively filling the identified need for understanding how embedded clinicians may impact mental health stigma in a police department.

The purpose of this qualitative phenomenological study is to explore the perceptions and lived experiences of police officers working in departments with an embedded clinician program regarding the reduction or elimination of the stigma to receive mental health care and influence help seeking among officers who need support. Two research questions were established: first, what are the perceptions and lived experiences of police officers working in departments with embedded clinicians related to reducing or eliminating the stigma of mental health care? Second, how did the embedded clinician program in the participants' departments contribute to the perception of mental health stigma among officers?

Eight officers in Washington State that serve at departments with an embedded clinician participated in an interview about their perceptions and experiences around the embedded clinician program and it's impacts on mental health stigma. Analysis of the interviews suggested four important themes in relation to how an embedded clinician impacts mental health stigma. First, structural stigma- policy and administration's attitude- can impede or support the clinician's impacts. Second, generational shifts in stigma are gradual but noticeable. Third, cultural competency of the clinician is key to reducing stigma. Fourth, self-stigma seems to be the most impacted by the embedded clinician program.

The insights shared by the participating officers suggested that an embedded clinician can reduce the stigma that stops officers from seeking mental health support. Having the right clinician in the embedded role makes a significant difference: a culturally competent clinician can become integrated into the department, challenging old norms of "suck it up buttercup" and

creating an accessibility for officers to seek support. Trust- comprised of rapport and confidentiality- built between the clinician and officers opens doors to reducing self-stigma for the officers, contributing to generational shifts as new officers start their careers with mental health care being normalized and accessible. While this type of work poses unique challenges for a clinician, culturally competent embedded clinical programs can play a vital role in reducing mental health stigma for officers, potentially saving lives and shaping the future of officer wellness in positive ways.

Finding viable solutions to support police officer mental health is urgent. With stigma as the identified main barrier to officer mental health care (Soomro & Yanos, 2019), research focused on how to address this barrier is key to addressing this issue. This study is a small step forward in exploring how the specific intervention of an embedded clinician in a police department can impact this barrier for officers. Further research is needed to better understand how these programs can most effectively address officer wellness needs. Research backing the impacts of these types of wellness programs is desperately needed to help inform legislation around officer wellness, inform policies at the federal, state, and local levels, and help administrators make budget decisions for effective spending on wellness resources for officers. A decade after the Task Force on 21st Century Policing's 2015 report, officer wellness remains a significant pillar of modern policing that requires research and policy innovation to save lives.

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Appendix A: Demographic Questions

1. Age
2. Amount of time as a police officer
3. Does your department have an embedded clinician? Yes/No
4. Race: Caucasian/African American/Asian/Pacific Islander/Hispanic/Other
5. Gender: Male/Female/Non-binary
6. Email
7. Phone number
8. Preferred contact method: email/phone

Appendix B: Interview Questions

1. How would you describe the general attitude toward mental health within your department?
2. What do you think are the biggest challenges for officers in your department seeking mental health support?
3. Before the embedded clinician program, how comfortable did you feel discussing mental health concerns with colleagues or supervisors?
4. In what ways, if any, do you think the presence of an embedded clinician has affected stigma around mental health in your department?
5. Do you feel that officers are more or less likely to seek help now compared to before the clinician was embedded? Why or why not?
6. What changes, if any, have you noticed in the way mental health is discussed among officers since the embedded clinician was introduced?
7. How has your personal perspective on mental health or help-seeking changed since the introduction of the embedded clinician?
8. Is there anything else about your experience with the embedded clinician program that you would like to share?

Appendix C: IRB Approval Letter

National University

9388 Lightwave Ave.

San Diego, CA 92123

irb@nu.edu

Notice of Exemption

November 13, 2025

To: Amber Smith

Project Title: An Exploration of the Lived Experiences of Police Officers in Departments with an Embedded Clinician

NU IRB Number: IRB-FY25-26-294

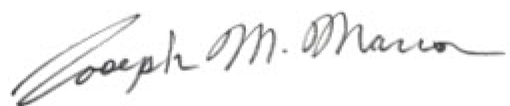
Determination: Exempt from further review 45 CFR 46.101 Category 2.(ii). Research that only include interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met: Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or

Status: Active - Research activities may begin as of November 13, 2025

Dear Amber Smith:

The study referenced above has been reviewed by the National University IRB. The IRB has determined your research is exempt from further review under 45 CFR 46.104, which means you will not need to renew your study and may begin your study effective immediately. However, if you find the need to change your study in any way, you will need to submit a modification to the IRB prior to implementing the changes. This will allow the IRB to determine whether or not the study still meets exemption criteria. Please review your Post Approval Responsibilities here: Approved Documents Guidelines For any questions regarding your protocol, please reach out to the IRB at irb@nu.edu.

Sincerely,



Dr. Joseph Marron, IRB Chair

Dr. Brianne Mongeon, Director, HRPP & IRB

Jenessa Eberhardt, Associate Director, HRPP & IRB

Appendix D: Audit Trail

12/24/25 P1: I realized I need to use an office away from a window facing the street as street noise disrupted the recording a few times. Some potential themes: having a resource like an embedded clinician reduces barriers; admin attitude and policy may influence the stigma around seeing an embedded clinician; personal experience with therapy might influence perception of the program. Does structural stigma more strongly influence the impact the embedded clinician can have? Volunteer referenced newer officers as likely benefitting from it most…perhaps this program reduces stigma from early on in the career such that over time, it will diminish naturally?

12/30/25 P2: sitting near the bookcase worked well to dampen road noise outside building. It was validating to know there are positive impacts from embedded clinician program even if leadership or admin might not totally support help seeking. Participant has experience in the fire and LE world, and that perspective was appreciated. Reflected that even if they opt to seek support external from their department or the embedded clinician, the embedded clinician program is still seen as positive and helpful.

1/8/26 P3: Good insights around self-stigma shifts. Identified that while the program lessens a barrier, may not be the same as shifting stigma. Still reflected that the program is valuable. Theme that the clinician's attitude and activities in the dept matter.

1/13/26 P4:. Gender bias is a significant factor in this officer's experience with mental health stigma at their department, but the impacts of stigma on her don't match the rhetoric heard from their admin. Her interview does solidify the theme that structural stigma- the policy and administrative attitude around mental health stigma- is a strong force that an embedded clinician

can’t necessarily combat alone. Provides a thicker description of impacts of admin and structural stigma factors.

1/15/26- P5: this guy was a straight shooter, very direct. Themes are already evident, including that self-stigma can be shifted by exposure to the clinician, that structural influences impact the success of the program, and that the cultural competency of the clinician matters.

1/16/26-P6: This was an exciting interview as the participant reflected what I’ve suspected about this type of program. Very clear that self and peer stigma play a significant role in how an embedded program impacts a department. Clinician connecting with, and supporting, peer support is important to making sure this program is a beneficial resource and contributes to decreased stigma. Generational shifts has firmly emerged as a theme.

2/4/26-P7- Great interview, client had very clear articulation of the embedded clinician’s impact on stigma in his department. Suggestion for future research: does exposure to co-responder MHPs impact stigma? Participant really reflected on generational shifts.

2/8/26- P8- Last one!! All major themes were definitely repeated. Highlighted importance of the fit of the clinician and relationships with officers as key in competency and impact. Shifts in traditional culture of “suck it up” or “good old boys” reflected.