

The 'cost' of caring in policing: From burnout to PTSD in police officers in England and Wales

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Abstract

This article looks at secondary trauma of police officers caused by working with traumatised victims, examining what is the true 'cost of caring' for police officers in England and Wales. It will discuss common work-related 'stressors' in policing and review the concepts commonly associated with secondary trauma such as 'burnout', 'vicarious trauma', 'compassion fatigue', 'secondary traumatic stress' and their impact. It will conclude with some recommendations and highlight the serious lack of literature on this topic, making secondary trauma and post-traumatic stress disorder in policing an under researched area, particularly in relation to the effects of cumulative trauma in policing.

Keywords Policing, trauma, PTSD, burnout

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Introduction

Charles Figley famously referred to the trauma experienced by some therapists when working with traumatised victims as the 'cost of caring' (Figley, 1995). This article will focus on secondary trauma caused by working with traumatised victims and examine what is the true 'cost of caring' for police officers in England and Wales which is an under researched and unexplored area of study. Having explored the literature, this article will conclude with some recommendations of how better to support our officers and highlight the serious lack of literature on this topic, making secondary trauma and post-traumatic stress disorder (PTSD) in policing an under researched area, particularly in relation to the effects of cumulative trauma in policing within England and Wales. This article is believed to be the first to evaluate the available research on the development of secondary trauma and 'cumulative' PTSD on police officers in England and Wales which this is an area with very little existing literature or attention. Policing as a profession has been widely recognised as being inherently stressful (Anshel, 2000; Collins and Gibbs, 2003; Gershon et al., 2009; Skogstad et al., 2013; Tuckey, 2007), with it being generally accepted by most police officers that exposure to trauma is an occupational hazard and that there is little that can be done to prevent exposure to traumatic events (Birch et al., 2017; Gershon et al., 2009; Hartley et al., 2013; Tuckey and Scott, 2013). Over the last few years, there has been an increased focus in understanding the impact of mental health in policing, particularly in the light of cuts to policing and increasing demand within the role. However, in England and Wales, there continues to be little empirical interest in this area, leaving this important, life changing and potentially life ending topic largely uninvestigated. Systematic records are not kept on vicarious trauma in police officers, and police officer suicides are

not recorded in the way that would make them possible to study as a consequence of vicarious trauma. Unlike some other areas of work such as psychotherapy and social work, there is little study of the effect of the work police officers do, on their mental health. It could be argued that the work of any police officer is as stressful and distressing as that of a social worker yet it receives far less study from the academic world, especially in England and Wales. Some countries such as Canada have a more formalised approach to PTSD in police officers (Centre for Addiction and Mental Health Canada, 2018). This article will attempt to pull together the few existing articles from England and Wales as well as drawing on international articles to attempt to provide a picture of how the work the police do can negatively impact their mental health. One significant piece of literature from England was carried out by the mental health charity MIND who conducted research into 'blue light services' in England, looking at the mental health and well-being in police officers, fire brigade, ambulance and search and rescue personnel (MIND, 2015). They launched a survey across all four services, and there were 3,627 responses (1.5% response rate). There were 1,194 responses from police officers, and the research showed that 91% of police personnel experienced stress, low mood or poor mental health, with policing having the highest levels of officers having personal experience of mental health problems among all services. MIND highlighted that the key stressors were not dealing with traumatic incidents (33%) but were organisational change (57%), excessive workloads (55%) and 'pressure' from management (47%). The findings relating to the impact of stress in policing were replicated by a survey conducted by the Police Federation of England and Wales (Elliott-Davies and Houdmont, 2016). A survey was sent to all officers within the 43 police forces within England and Wales and 16,841 responses were received (14% response rate). In relation to the question relating to experiencing stress, low mood, anxiety or other difficulties regarding their health and well-being, 80% responded positively, with 92% of respondents stating these feelings were caused or made worse by their work. This survey was replicated in 2018 with over 18,000 officers taking part (15%). Of those that took part, 79.3% reported having experienced feelings of stress, low mood, anxiety or other difficulties with their mental health and well-being within the previous 12 months, with 94.2% indicating that these difficulties had been caused or made worse by work, such as high workloads and a poor work/life balance (Elliott-Davies, 2018). More recently, initial findings from Police: The Job & The Life survey (Police Care UK, 2019) highlighted that from a survey of 16,857 responses from police officers and staff that 90% of police workers who responded had been exposed to trauma, and almost one in five had symptoms consistent with either PTSD or complex PTSD. There are obvious limitations with these surveys as they are just a 'snap shot' in time, the response rates only reflect small numbers of officers who took part (so the responses may not truly reflect the feelings of policing as a whole) and they may not have actually reached those officers who were off sick suffering from stress and mental health problems, but they do potentially provide interesting insights into the impact of the pressures on policing at this time. While all policing roles are clearly demanding, it has been recognised that some are more stressful than others such as those involving violence (including domestic abuse), child abuse and serious sexual abuse and child homicide investigations which have been found to have a profound effect on the officers that investigate them (Astin, 1997; Brown et al., 1999; Gray and Rydon-Grange, 2019; Roach et al., 2017, 2018; Skogstad et al., 2013). Additionally, cases involving children have been shown to impact officers more deeply than cases involving adults (Roach et al., 2017, 2018). There is some, limited evidence to suggest that working as a fire arms officer (where decisions made as part of a working day can mean life or death) is strongly linked to PTSD (Barr et al., 2004; Carlier et al., 1997). However, there is a paucity of research in this area making strong assertions difficult to draw. There is some contradictory evidence that suggests that the initial psychological screening of fire arms officers and ongoing support results in them reporting lower levels of stress than other officers (Sheard et al., 2019). An additional possible explanation for investigative roles (especially those of

child homicide, sexual violence and child abuse) being especially distressing comes from emerging evidence demonstrates that working with live victims and viewing their distress has more of an emotional impact than working with dead victims (Horvath and Massey, 2018). Speaking to the parents of a dead child, presents its own unique distress. The impact of dealing with these investigations cannot be understated as both Violanti (1996) and Ahern et al. (2017) argue that not only do the negative effects of dealing with traumatised victims lead to some officers experiencing psychological distress and fatigue, these negative consequences of 'caring' may not even end when officers change roles or eventually retires from policing.

The 'cost of caring'

Secondary trauma occurs when there is an emotional connection to a traumatised individual, and the primary trauma sufferer passes their symptoms onto another (the carer) (Figley, 1995). The impact of secondary trauma caused by repeated exposure to traumatised victims has been widely studied within a number of 'caring' professions such as therapists (Sodeke-Gregson et al., 2013), emergency nurses (Duffy et al., 2015) and paramedics and firefighters (Regehr et al., 2002). This is why in policing and other professions the effects of hearing the traumatic events retold by victims can, in certain circumstances, have negative emotional effects, not only on the officers but also on their colleagues, their families and the communities they serve (Gershon et al., 2009; Schnurr et al., 2016; Violanti, 2010). The four most commonly recognised conditions associated with working with traumatised victims are burnout, vicarious trauma, compassion fatigue and secondary traumatic stress. These terms have to some degree become interchangeable (Nimmo and Huggard, 2013; Perez et al., 2010; Shoji et al., 2015) and relate to what Figley (1995) described as the 'cost of caring', which he depicted as how an individual may absorb the emotional distress of the primary trauma survivor, and experience symptoms of a similar nature as a result of caring.

Burnout

Burnout was a term first used by Freudenberger (1974) to describe 'staff burnout' in himself and co-workers in medical 'free' clinics in New York, working with individuals who were considered as being 'emotionally demanding' including addicts. The concept of burnout was then further advanced by Maslach (1976, 1982) to explain a form of 'interpersonal stress' or psychological strain which could significantly impact on an individual's motivation and dedication to their career and were frequently found in those caring professions who are engaged with emotionally demanding roles (Maslach et al., 2001). Emotional exhaustion is the core symptom of burnout (Maslach and Jackson, 1981), but those suffering can also experience physical symptoms such as fatigue and exhaustion; emotional symptoms such as irritability, low morale, reduced self-esteem; attitudinal symptoms such as pessimism and cynicism; and behavioural symptoms such as poor work performance and withdrawal, as well as a loss of personal accomplishment and difficulty in coping (Bakker and Heuven, 2006; Kahill, 1988; Maslach, 1982, 1987; Maslach and Jackson, 1981; Maslach et al., 2001; Pines and Aronson, 1988). The causes of burnout are still not fully understood, and there are conflicting ideas about its causation (Heinemann and Heinemann, 2017), but it is believed to be characterised by a slow onset and continued deterioration if left untreated (Klaric' et al., 2013). Perez et al. (2010) studied 28 child pornography investigators and found that 54% of them were suffering from high levels of emotional exhaustion and cynicism, although this study is very small, it gives insight into the difficulties these specialist workers experience. Further support for the impact of child protection work on officers comes from studies such as Anderson (2000), who in a study of 151 child protection workers with more than 2 years' experience, she found emotional exhaustion and burnout to be commonplace with a burnout rate of 62%. Kohan and Mazmanian (2003) claim

that the cumulative effects of dealing with the negative experiences and traumatic events throughout an officers' career may increase the risk of burnout. This is supported by Jupp and Shaul (1991) and Pines and Maslach (1978) who also argue that the more experience you have (and therefore the more traumatic events you have been involved with) the greater the risk of experiencing burnout. Lim et al. (2010), however, gave a conflicting view and established from their meta-analysis of mental health professionals that one of the most critical factors for predicting burnout was age, as younger mental health professionals were seen to be more vulnerable to burnout, and therefore it was not related to cumulative exposure. They described how this may be due to a lack of experience or training, although even this was not fully established as those with greater professional qualifications also suffered from burnout. Horvath and Massey (2018) also found no relationship between years worked as a forensic physician and symptoms of burnout when studying the Faculty of Forensic and Legal Medicine.

Compassion fatigue

The term compassion fatigue was coined by Joinson (1992) who noted emotional changes experienced by nurses when spending time with traumatised victims, which she considered as a specialised form of burnout experienced by those that 'care'. This was supported by Figley (2002b) who explained that by the very act of caring for a traumatised individual there is usually a 'cost' to the caregiver. Compassion fatigue is different to burnout as it is believed to be caused by demonstrating empathy towards the suffering of others which leads to physical, mental and emotional exhaustion as well as feelings of hopelessness and dissociation (Klaric' et al., 2013; Radey and Figley, 2007). This was found by Tehrani (2010) and Conrad and Kellar-Guenther (2006) who in their respective studies of family liaison officers and child protection workers found that not only were up to 50% experiencing 'high' or 'very high' levels of compassion fatigue, but additionally they were more likely to feel that there was no justice in the world compared to the other groups studied. The importance of having belief in a just world was found to be a protective factor against development of psychological symptoms in staff at the Faculty of Forensic and Legal Medicine (Horvath and Massey, 2018). There is also some evidence that the development of compassion fatigue may be further complicated by a lack of organisational support within the workplace (Massey et al., 2019; Schauben and Frazier, 1995; Turgoose et al., 2017). The four significant factors which seem to increase the likelihood of developing compassion fatigue are poor self-care, previous trauma, lack of satisfaction within the workplace and lack of control in the workplace (Radey and Figley, 2007). It may be possible to prevent compassion fatigue by changing roles, reinforcing a positive attitude at work, increasing personal resilience, managing workloads, taking appropriate time off, having a positive work environment, increasing and maintaining professional competence and boundaries with traumatised victims as well as having the confidence to ask for help when needed (Figley, 2002a; Radey and Figley, 2007; Salston and Figley, 2003). A recent study also found that personality differences and self-care are key to protecting against the negative psychological outcomes of the stress of policing (Burnett et al., 2019). However, this list of potential protective factors seems unlikely to be attainable at this time due to the decreasing numbers of police officers and the increasing demands placed upon them, including increased workloads and non-policing-related calls (such as attendance to someone in a mental health crisis) which have to be attended.

Vicarious trauma

Vicarious trauma has been described as a normal response to dealing with traumatised victims, of hearing or seeing the effect of trauma repeatedly, even though they have not experienced the event

themselves (McCann and Pearlman, 1990). However, even if considered a normal response to someone else's tragedy, it can be considered as a significant reaction to working with traumatised people, as it describes harmful changes that occur in a person due to the cumulative effect of working with survivors of trauma (Baird and Jenkins, 2003). These changes can lead to feelings of irritability, fear, vulnerability, cynicism and a lack of trust, as well as a distortion of an individual's outlook on the world (Baird and Kracen, 2006; Cantanese, 2010; Hernandez-Wolfe et al., 2015; McCann and Pearlman, 1990). The symptoms of vicarious trauma are not unlike those of PTSD and include experiencing intrusive images through flashbacks, dreams or thoughts, as well as affecting the individual's feelings of control, safety, trust, esteem, and intimacy, regarding both self and others (Cantanese, 2010; McCann and Pearlman, 1990). The effects of vicarious traumatisation are cumulative, building over time and are felt to be permanent (Pearlman and Saakvitne, 1995) eventually leading to a decrease in job performance and empathy (Baird and Kracen, 2006). Prevention and treatment of this condition is difficult, and both Salston and Figley (2003) and Cantanese (2010) highlighted the individual's responsibility to recognise symptoms and take action, which is difficult as this condition develops slowly and the individual may be unaware of what they are experiencing, and there may also be cultural barriers and stigma associated with asking for or receiving help within policing even if the individual realised that they needed help.

Secondary traumatic stress

Secondary traumatic stress was first identified by Figley (1983) when witnessing symptoms in trauma counsellors, which he recognised as being similar to those of the primary trauma sufferer they were treating. He described these symptoms as a 'secondary traumatic stress reaction', which he later went on to describe as 'secondary traumatic stress disorder' (Figley, 1983, 1995); however, this cluster of symptoms is not, as yet, a diagnosable mental health condition. He defined secondary traumatic stress as;

the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person. (Figley, 1995: 7)

The symptoms of secondary traumatic stress can emerge suddenly and without warning (Klaric' et al., 2013) and may be nearly identical to symptoms of PTSD, such as reexperiencing the traumatic event, hypervigilance, avoidance, numbing or persistent arousal (Figley, 1995). Experiencing secondary traumatic stress may, like some of the other conditions described, be a natural consequence of 'caring', as Munroe (1999) suggested that the effects of secondary trauma were an 'occupational hazard' for those working with traumatised victims.

The negative effects of stress and psychological trauma on police officers have been widely studied and include poor performance, sickness, lack of job satisfaction, poor morale and lack of empathy or support for victims (Baird and Jenkins, 2003; Bourke and Craun, 2014; Gershon et al., 2009). Risk factors for the development of burnout, secondary traumatic stress, compassion fatigue and vicarious trauma can include having a personal history of trauma (Bride, 2004; Salston and Figley, 2003; Siebert, 2006), lack of 'self-care' (Ahern et al., 2017), occupational stressors (Maguen et al., 2009) and working with victims of sexual assault (Alexander et al., 1989; Astin, 1997; Farrenkopf, 1992; McCann and Pearlman, 1990; Parkes et al., 2018; Pearlman and Mac Ian, 1995; Remer and Ferguson, 1995; Schauben and Frazier, 1995). While there are clearly a number of negative aspects of working with traumatised victims, not everyone has negative experiences. Hernandez et al. (2007), Engstrom et al. (2008) and Hernandez-Wolfe et al. (2015) all describe the concept of 'vicarious resilience' which explains how those who work with traumatised victims can be positively

influenced and inspired by witnessing the resilience displayed by their clients. Stamm (2002) introduced the term 'compassion satisfaction', which relates to positive feelings when helping someone who is traumatised to start the recovery process and is believed that increasing compassion satisfaction can better equip individuals to deal with workplace trauma and mitigate symptoms of burnout, compassion fatigue and secondary traumatic stress. However, compassion satisfaction may be more common in professions where the worker sees a client over a longer and sustained period of time, as opposed to policing where the officer is not necessarily around to witness the recovery period, as they are more likely to be involved in the initial traumatic response. There is also a difference in role, police work does not require therapeutic intervention, which is more likely to facilitate healing, evoking satisfaction in the professional. Perez et al. (2010) and Conrad and Kellar-Guenther (2006) in their respective studies of child pornography Internet investigators and child protection workers found that although these groups had high levels of burnout and compassion fatigue, they also had high levels of compassion satisfaction from the important work they did – arising from identifying victims, arresting perpetrators and protecting others from the offenders.

Acute stress and PTSD

Acute stress can occur when a person is threatened by an extreme or unusual external stimulus (i.e. actual or perceived danger) which can lead to both emotional symptoms such as anger, irritability or anxiety and physical symptoms such as rapid heartbeat, heart palpitations and chest pain. Acute stress can happen to anyone but is usually short lived and manageable, although when it persists those suffering are at risk of serious physical and mental health problems, including PTSD (Anshel, 2000; Litz et al., 2002; NICE, 2005; ICD-10, 2012). While there have been 'mixed' results regarding the potentially linear relationship between acute stress disorder (ASD) and the development of PTSD, recent longitudinal studies have challenged the robustness of the previous research and highlighted that ASD could be a predictor of PTSD after all (Bryant, 2017). There are two diagnostic manuals used by clinicians to diagnose mental health conditions such as ASD and PTSD. These are the 'Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition' (2013), commonly referred to as the DSM-5 and is published by the American Psychiatric Association. The second is the 'International Statistical Classification of Diseases and Related Health Problems', tenth edition (2012) which is commonly referred to as ICD-10. The ICD-10 describes the development of PTSD as a response to a stressful event 'of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone' (ICD10, 2012: 120). The DSM-5 (2013), however, is more descriptive in the nature of the qualifying criteria and states that PTSD has to be caused by exposure to actual or threatened death, serious injury or sexual violence either by direct exposure through witnessing or experiencing the traumatic event or learning that the traumatic event occurred to a close family member or friend. The DSM-5 (2013) is the first psychiatric manual to recognise the cumulative effect of trauma, (criterion, A4) which refers to;

Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g. first responders collecting human remains: police officers repeatedly exposed to details of child abuse)'. (p. 271)

This criterion clearly relates to the cumulative or repeated exposure to traumatised victims and is particularly relevant to police officers (DSM-5, 2013; Friedman and Resick, 2016), particularly those that are required as part of their work to regularly hear the repeated details of rape and child abuse on a daily basis without clinical support or breaks between such incidents. Both the ICD-10 (2012) and the DSM-5 (2013) give the key diagnostic symptoms of PTSD as intrusion (involuntary memories,

dreams/nightmares or flashbacks); avoidance (avoid distressing memories or external reminders of the trauma such as people, places, conversations, which arouse thoughts, or feelings closely associated with the traumatic event(s)); numbness (detachment, anhedonia, negative thoughts) and moods associated with the traumatic event and hyperarousal (irritability, anger, hyper-vigilance, enhanced startle reaction, insomnia and problems with concentration). For a diagnosis to be made, trauma symptoms need to be evident for more than 1 month and cause significant distress or impairments in the individual's ability to function normally (NHS, 2019). PTSD is not a natural consequence of experiencing a traumatic event, as no two people react the same to trauma (even those people who have experienced the same traumatic event, such as a fatal road accident or sudden death of a child) (Levin et al., 2014; MacEachern et al., 2011; Maguen et al., 2009; Ozer et al., 2003; Vogt et al., 2016). Some people are clearly more vulnerable to the effects of trauma, which has led to extensive research into risk and protective factors for the developments of PTSD. These can be divided into factors either before the trauma occurs (pre-traumatic), factors which are relevant at the time of the incident (peri-traumatic) and those factors relevant after the traumatic event (posttraumatic) (Brewin et al., 2000; DSM-5, 2013; Ozer et al., 2003). Pre-traumatic factors which may make an individual more susceptible to PTSD can include age, experience, gender, personality traits, previous trauma history and isolation due to lack of social support (Bride, 2004; Bryant et al., 2012; DSM-5, 2013; Ellrich and Baier, 2017; Halligan and Yehuda, 2000; ICD-10, 2012; Marchand et al., 2015; Ozer et al., 2003). Previous trauma history may be a risk factor due to an individual's previous experience of a primary trauma resurfacing unexpectedly and without warning when dealing with a traumatised victim or traumatic event, with Maguen et al. (2009) suggesting that 59% of police recruits have been exposed to trauma before joining the police. What is currently unclear is whether the issue regarding having a previous trauma history relates to 'unresolved' trauma or whether they would still be at increased risk if they had sought help and had recovered (Bryant et al., 2012; Cantanese, 2010; Follette et al., 1994; Ozer et al., 2003; Tehrani, 2018). Previous trauma history and other pre-traumatic factors may be identified by initial clinical screening, which would allow protective measures to be put in place through education, training and building a supportive social network to prevent further trauma (Marmar et al., 1996; McFarlane and Bryant, 2007; Skogstad et al., 2013; Tehrani, 2016, 2018). Peri-traumatic factors relate to exposure to the traumatic incident (the 'qualifying stressor') and will include severity, duration and perceived threat to one's life by the traumatic event. This exposure has the greatest impact on the prospect of developing PTSD (Brewin, 2003; Jones et al., 2003; Levin et al., 2014; Marmar et al., 2006). This is particularly relevant to 'single incident trauma' (mass disaster, terrorist incident, sudden death). Carlier et al. (1997) in a study of 262 traumatised police officers found evidence that trauma severity was the only predictor of PTSD symptoms at both 3 months and 12 months post trauma. The understanding of how post-traumatic factors may lead to acute stress and trauma is constantly developing as research investigates this important topic. As previously discussed, it was initially felt that there was a 'linear' relationship between the initial traumatic event and development of subsequent longer term trauma, a more complex relationship is now suspected. It is now proposed that other factors (such as previous trauma history) may explain why some people are more susceptible to trauma than others (Bryant, 2017). This includes how post-traumatic factors are key to reducing the development of PTSD and may include the provision of appropriate support and coping mechanisms after a traumatic event. An important part of this support is through a shared understanding that almost everyone will develop some post-traumatic stress reactions shortly after being exposed to a traumatic event and the creation of a safe environment through the 'normalisation' of symptoms (Dahl, 1989; Marmar et al., 2006). These support and coping mechanisms may be through formal interventions such as critical incident stress debriefing, managerial support, occupational health, ongoing clinical screening, awareness raising through

education and training or informal such as social support (Foley and Massey, 2018). Limiting exposure to or reminders of the traumatic events such as removing police officers from the working environment that caused the trauma in the first place and giving them sufficient time to come to terms with what has occurred can also moderate symptoms (DSM-5, 2013; Greenberg et al., 2015; Marchand et al., 2015). Additionally, a supportive work environment is the most important factor to preventing PTSD which supports the officers from potential psychological consequences and stigma associated with the trauma they may be experiencing (Maguen et al., 2009).

Cumulative exposure to trauma

Trauma experienced as a result of a single traumatic event (which is usually unexpected) has been defined as 'Type I trauma', whereas cumulative exposure to traumatic events, such as that described under criteria A4 from the DSM-5 (2013) can be described as 'Type II trauma' (Sage et al., 2017; Terr, 1991). As already discussed, this type of PTSD is particularly relevant to policing as it relates to the frequent exposure to traumatic material, but so far there is limited research about its impact and the prevalence rates within policing (Brown et al., 1999; Hensel et al., 2015; Levin et al., 2014). Although limited, there is some mixed research regarding the impact of working with sexual assault and child abuse survivors (Parkes et al., 2018). Martin et al. (1986), Follette et al. (1994), Kassam-Adams (1995) and Schauben and Frazier (1995) all argue that working with traumatised victims does increase the likelihood of developing secondary trauma and PTSD. Although these studies looked at a variety of professions, including law enforcement, counselling and psychotherapy, a similar finding was found: the pivotal factor is exposure to traumatised people rather than the profession of the worker that leads to cumulative trauma. Wright et al. (2006) and Powell et al. (2013) in their small studies of police officers working with child abuse victims argue that listening to the accounts of victims of child abuse is not a significant stressor. Updated research within this crucial and growing area of policing is a recommendation for future study as this finding contradicts studies from other fields such as Martin (2005) and Massey et al. (2019). It could be argued that secondary trauma and PTSD are just the price a person pays for choosing to be a police officer; however, statistics collected in other countries show the seriousness of this issue. In addition to suffering long-term and enduring mental health conditions, the effects of secondary trauma can lead to loss of life. This is shown in data from countries that methodically collect police officer suicide statistics, such as that from the police force of Canada which demonstrate that police officers are far more likely to have suicidal ideation than members of the general population (Centre for Addiction and Mental Health Canada, 2018) and that in countries that systematically collect data on police suicides it is shown that more officers die from suicide than in the line of duty (Badge of Life Canada, 2019). This highlights the need, not only for a thorough and detailed approach to this issue but also to a strong and effective response for police officers in England and Wales.

Recommendations – The way forward

Although there is clearly scope for much needed research specifically within policing and trauma, it is also possible to use the knowledge we currently have about trauma and the exacerbating factors to limit the impact of trauma on existing police officers. The Health and Safety Executive (2009) outline that organisations have a legal responsibility to ensure the health and well-being of staff, which means that police forces should attempt to reduce trauma within policing, however it is not possible to do this without measuring, monitoring or studying it. One potential solution to reduce occupational stress is to rotate staff to a less stressful role through tenure. While this may seem an obvious solution, the ability to rotate staff may be difficult in some forces due to a lack of staff wanting to take on more challenging roles such as sexual violence and child protection work, the

expense of training for new staff and the fact that for some officers investigating rape and child abuse is more than just a career, it is why they joined policing, so to move them against their wishes may actually increase their psychological distress (Maguen et al., 2009; Perez et al., 2010; Powell and Tomy, 2011). However, these factors have to be carefully balanced against both the financial and human cost of working with deeply traumatised victims over extended periods of time. As it is not possible to remove trauma from police work as they are intrinsically entwined, focus needs to be placed on supporting officers to do this difficult work. The understanding that the working environment is the most important factor in protecting against trauma (Maguen et al., 2009) suggests that organisational changes that demonstrate compassion and care for staff could help to reduce the impact of the trauma experienced in the line of duty. Evidence from workers at a Sexual Assault Referral Centre shows that opportunities to 'vent' to fellow colleagues, discuss the work and impact of it and time between cases to detoxify from what they have heard, all help to reduce the impact of the trauma (Massey et al., 2019). Psychological approaches have been identified as being beneficial in promoting a resilient police workforce and maintaining operational effectiveness (Gray and Rydon-Grange, 2019). The impact of secondary trauma and cumulative PTSD raises an important question in relation to the primary role of policing: is it still to 'cut crime, no more no less' as described by the then Home Secretary Theresa May (2010), or has it moved from crimefighter to social worker or even emotional supporter (College of Policing, 2018). If the role of the police has changed then what (if any) is the impact on officers of moving from gathering evidence to empathy? Do officers get 'emotionally invested' with the victims (particularly if dealing with young children or people experiencing something they have lived through) and how can they stop themselves? Is this investment 'good or bad' for either the victim or the officer and how does either effect the investigation? If 'caring' is now an officer's primary role, then what are the differences between police officers and other caring professions, and how does the plethora of research conducted within these other caring professions translate into policing, if at all?

Conclusion

This article set out to examine the 'cost of caring' to police officers in England and Wales when dealing with traumatised individuals, but it is felt that this still remains unclear due to the number of significant gaps within the available literature relating to not just PTSD in general but also specifically in relation to the cumulative effects of dealing with traumatised victims. While it is clearly important that this type of trauma has been recognised by mental health professionals through its inclusion in the DSM-5 (2013), it appears that research has not kept pace and explored this potentially critical area of policing. This may be due to some of the historic difficulties in policing supporting academic research or a fear of discovering a concerning trend that would need addressing. More robust research is needed if effective steps are to be made to reverse the current trends of potential emotional damage that individuals experience when working as police officers.

There are a number of limitations within the studies reviewed, yet even with these limitations it is hard to argue that the cumulative effect of dealing with traumatised victims does not cause psychological trauma, particularly when this phenomenon has been well established in other professions. Further research also needs to be conducted regarding the impact of other individual factors, such as having a previous trauma history, age, gender, real or perceived social support to name but a few that may play a significant role in why some police officers are more susceptible to psychological trauma than others. If we don't develop an understanding of this important issue, we will remain unable to effectively support our police forces.

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