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## Examining the Impact of Mental Health Education on Bias and Stigma in CIT Trained Officers

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# Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Jennifer Loretta Krause

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Walden University  
2021

Abstract

Examining the Impact of Mental Health Education on Bias and Stigma in CIT Trained

Officers

by

Jennifer Loretta Krause

MS, Walden University, 2013

BA, Benedictine University, 2011

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counseling Psychology

Walden University

May 2022

## Abstract

The purpose of this quantitative, correlational nonexperimental research was to examine the relationship between the mental health education received through Crisis Intervention Team (CIT) training and the perceptions of public mental health stigma, self-stigma, and attitudes toward seeking mental health services among law enforcement officers. The study's theoretical framework integrated gender-role conflict theory and Goffman's stigma theory in explaining the influence of the police culture on officers' adoption of more traditional masculine roles. This research used three instruments: the Attitudes to Mental Illness questionnaire to measure perceptions of public stigma, the Self-Stigma of Seeking Help Scale to measure self-stigma, and the Inventory of Attitudes Toward Seeking Mental Health Services to measure attitudes toward seeking mental health services. The sample consisted of 48 law enforcement officers from across the United States who completed an online 60-question survey. A multivariate analysis of variance revealed no mean differences in perceptions of public stigma, self-stigma, and attitudes toward seeking mental health between CIT-trained and non-CIT-trained officers. This finding indicated that mental health education received through CIT training did not predict perceptions of stigma or attitudes toward seeking mental health services. Future research could compare law enforcement departments and employ longitudinal designs. Research findings have the potential to effect positive social change by bringing awareness of the need for improving mental health training for law enforcement. Such efforts are likely to enrich the mental health quality of officers and the communities they serve.

Crisis Intervention Team Program as a Predictor of  
Mental Health Seeking Attitudes and Stigma Among Law Enforcement Officers

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## Dedication

I would like to dedicate this dissertation to my parents, Tom and Dolores Krause. They taught me the most important goal in life is to, no matter what hand you are dealt, always try to make this world a little better. They also taught me the value of education. However, their biggest influence might be showing me what it looks like to never give up. I love you and miss you every day.

I would also like to dedicate this dissertation to the men and women of law enforcement, especially my uncle Harry and my cousin Amy, who have served their cities with grace, integrity, and dignity. These men and women sacrifice so much of their lives and themselves to try to keep the rest of us safe. They deserve better than what we, as a society, give them. I will be forever grateful.

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## Chapter 1: Introduction to the Study

### **Overview of the Problem**

The job of the law enforcement officer has long been known to be stressful. The experience of unfavorable judicial decisions; time away from family; an everchanging, nonroutine work environment; and the risk of death and danger can lead to cumulative stress responses (Clark-Miller & Brady, 2013; Fleischman et al., 2018). Many officers have experienced critical trauma or know another officer who has. Changes in the societal climate have gone further to increase stress for law enforcement (Thorton & Herndon, 2015). Law enforcement does not have the same positive image that it had in the past. The failures of some officers and departments have caused many groups, such as Black Lives Matter and informal neighborhood groups, to openly question law enforcement (Wade, 2017). Officers are ambushed in their squad cars, attacked in restaurants, and crucified by the media for doing their jobs as they were trained (FBI.gov, 2017; Tully & Smith, 2015). Encounters with persons with mental illness resulting in negative and fatal outcomes have elicited media scrutiny, statements that the police should have done a better job, and criticisms of their actions (Tully & Smith, 2015). Cumulative stress from daily duties and organized hatred as well as critical incidents can lead to mental health and emotional distress (Levenson, 2007).

Mental health issues and emotional distress are met with stigma in law enforcement (Britt et al., 2007). Law enforcement officers fear being viewed as troubled, ineffective, untrustworthy to carry a firearm, or weak, as it could result in them being denied promotions or special team assignments (Clark-Miller & Brady, 2013). Some

officers believe that mental health issues can be experienced by other people but not themselves (Manzella & Papazoglou, 2014). Many officers also fear that mental health professionals may not keep their problems confidential. They are concerned about their emotional problems being shared with superiors. The strong adherence to the police culture and the belief that officers must maintain a certain image that is characterized by strength, fearlessness, and perceived invincibility are factors that deter them from seeking help (Levenson, 2007; Woody, 2005).

Due to the stigma attached to mental health issues and emotional distress, many officers choose to suffer in silence (Manzella & Papazoglou, 2014). In fact, the stigma attached to mental illness is found to be one of the major reasons why individuals do not seek treatment (Wahl et al., 2011). Thorton and Herndon (2015) stated that 1 in 7 officers live with undiagnosed posttraumatic stress disorder (PTSD). Instead of seeking services, officers internalize feelings, turn to alcohol, increase cigarette smoking, and distance themselves from friends and family. Negative coping strategies lead to depression, somatic problems, memory impairment, sleep disturbances, increased startle response, and suicidal ideation (Manzella & Papazoglou, 2014).

Those in law enforcement have acted as the gatekeepers to the mental health system since deinstitutionalization. However, they had not been trained to effectively manage or identify encounters with persons with mental illness (Franz & Borum, 2011). Law enforcement and communities have been looking for a better way to deal with this type of interaction and produce more favorable outcomes. Crisis Intervention Teams (CIT) were developed in 1988 in response to an incident involving law enforcement and a

mentally ill person. The encounter resulted in the death of Joseph Robinson, the person with mental illness (Compton et al., 2008). The CIT was developed as a collaborative method involving mental health professionals, law enforcement agencies, and the community. The training for law enforcement as part of CIT includes mental health education (such as education on identifying disorders), lessons from people who live with mental illness and their family members, de-escalation techniques, and services that provide alternatives to arrest (Compton et al., 2008; Tully & Smith, 2015).

The mental health education received through CIT training has been shown to decrease the stigma associated with mental illness as well as decrease social distance (Bohora et al., 2008). Officers report feeling more comfortable, empathetic, and effective. Mental health education has also provided officers with a better understanding of behavior and the challenges of mental illness (Bonfine et al., 2014; Tully & Smith, 2015). Officers report being able to talk about mental health issues with others and where and how to receive treatment (Fleischman et al., 2018; Tully & Smith, 2015). Fleischman et al. (2018) stated that CIT trained officers feel comfortable talking to others and referring them for services. However, it is not known whether there is a significant difference between CIT-trained and non-CIT-trained officers in the decrease of mental health stigma, public and private, or their attitudes toward seeking treatment if the change identified in previous research is found across law enforcement. Addressing this distinction could be valuable for future research and may have implications for how officers are trained.

## **Problem Statement**

Police officers are placed in high-stress situations daily. The life and safety of officers are threatened regularly; from horrific crime scenes, to standoffs, to the never-routine traffic stop, officers are tasked with facing the worst that society has to offer (Fleischman et al., 2018). Many officers have known others who have been injured or killed in the line of duty. Trauma from these incidents can affect the way that an officer works and lives (Manzella & Papazoglou, 2014).

The stigma of mental illness has long been present in society (Wahl et al., 2011). In jobs such as the military or law enforcement, mental illness has been viewed as a weakness leading to seclusion and denial of promotions or the ability to join special teams (Britt et al., 2007; Fleischman et al., 2018). As a result, many avoid admitting to mental health issues or getting mental health services. Fleischman et al. (2018) wrote that officers self-medicate for depression with drugs and alcohol. Suicide is the leading cause of death for law enforcement officers. Suicide rates among law enforcement officers have reached 12 per 100,000, compared to 13 per 100,000 in the civilian population (Kulbarsh, 2017). Research has examined the ability of mental health education to reduce police officers' social distance and bias against others with mental illness. However, existing research has not examined whether the reduction of public and private mental health stigma translates into a more positive attitude toward the personal need for mental health services. This study was aimed at understanding whether there are differences between CIT-trained and non-CIT-trained officers in public stigma, private stigma, and attitudes toward seeking mental health treatment.

### **Nature of the Study**

This quantitative study used a correlational nonexperimental research design. The research involved a between-group comparison analyzing the differences in public and private mental health stigma and attitudes toward seeking mental health services between CIT-trained and non-CIT-trained officers. The correlational design does not take into account or attempt to control for outside factors (Price et al., 2015). While some believe that correlational research should primarily be used if the researcher does not believe that a correlation exists, the design is beneficial when the researcher cannot manipulate the independent variable(s). For this study, it would have been impossible and impractical to manipulate the mental health education received through CIT training and an individual's level of public and private mental health stigma (Price et al., 2015). The lack of manipulation of variables by the researcher made the correlational research design a reasonable choice, as it was in line with the purpose of this quantitative study, in which I sought to examine the relationship between CIT trainings' effect on public and self-stigma and attitudes toward seeking mental health services.

### **Purpose of the Study**

The purpose of the study was to understand the differences between CIT-trained officers and non-CIT-trained officers on their perceptions of mental health stigma and their attitudes toward seeking mental health treatment. It was hypothesized that there would be a decrease in public and self-stigma among CIT-trained officers versus non-CIT-trained officers. It was further hypothesized that those with less mental health



stigma, public and private, as a result of CIT training, would have more positive attitudes toward seeking mental health treatment when needed.

**Research Questions and Hypotheses**

RQ 1. Is there a difference in self-reported attitudes of law enforcement officers toward seeking mental health services, as measured by the Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS), between those who have completed CIT training and those who have not completed CIT training?

H<sub>01</sub>. There is no significant difference in self-reported attitudes of law enforcement officers toward seeking mental health services, as measured by the IASMHS, between those who have completed CIT training and those who have not completed CIT training.

H<sub>a1</sub>. There is a significant difference in self-reported attitudes of law enforcement officers toward seeking mental health services, as measured by the IASMHS, between those who have completed CIT training and those who have not completed CIT training.

RQ 2. Is there a difference in the perceptions of public mental health stigma, as measured by the Attitudes to Mental Illness Questionnaire (AMI), between CIT-trained officers and non-CIT-trained officers?

H<sub>02</sub>. There is no difference in the perceptions of public mental health stigma, as measured by the AMI, between CIT-trained officers and non-CIT-trained officers.

H<sub>a1</sub>. There is a difference in the perceptions of public mental health stigma, as measured by the AMI, between CIT-trained officers and non-CIT-trained officers.

RQ3. Is there a difference in perceptions of self-stigma, as measured by the Self-Stigma of Seeking Help Scale (SSOSH), between CIT-trained officers and non-CIT-trained officers?

H<sub>o3</sub>. There is no difference in the perceptions of self-stigma, as measured by the SSOSH, between CIT-trained officers and non-CIT-trained officers.

H<sub>a3</sub>. There is a difference in the perceptions of self-stigma, as measured by the SSOSH, between CIT-trained officers and non-CIT-trained officers.

### **Theoretical Framework**

This quantitative study was based on a combination of gender-role conflict (GRC) theory and Goffman's stigma theory. Wester et al., (2010) wrote, "GRC theory stresses the importance of understanding how behaviors associated with a traditionally socialized male gender role interfere with positive outcomes in situations that require more traditional actions" (p. 287). The male gender role involves being strong, independent, protective, and able to handle any situation. Conflict arises when distress occurs. Males may feel as though not being able to handle distress makes them weak or a failure (Wester et al., 2010). GRC theory, as discussed by Mansfield et al., (2003), indicates that

higher levels of gender-role conflict are associated with negative attitudes toward help-seeking behaviors.

Goffman's stigma theory addresses how individuals protect their personal identity and manage impressions of themselves when they possess a quality that is different from the approved standard of conduct, behavior, or appearance within a society (Cranevale, 2007). Goffman used the term *discredited* for people who possess a quality that is different than the norm. Under Goffman's theory, a discredited person is a stigmatized person (Cranevale, 2007). A stigmatized person will choose whether they want to share their discrediting quality with others based on how comfortable they feel in the situation. If they are with other discredited people, they may show their stigmatizing quality. However, when they are around normal people, they may choose to hide the quality (Cranevale, 2007). Controlling the visibility of the quality controls the perceptions of others and makes the individual feel as though they are perceived as normal (Cranevale, 2007).

The police culture is similar to the male gender role in the perceived expectation that the officer must be strong, independent, and capable of handling problems on their own, in addition to possessing the ability to take care of others (Wester et al., 2010). Wester et al. (2010) discussed the conflict that officers feel when job-related pressures, trauma, or stresses are felt in stating that the admittance of need for assistance or the recognition of an emotional problem is contrary to the characteristics of the police culture. Goffman's stigma theory would indicate that because the norm for the police culture is not congruent with mental or emotional distress or help-seeking behaviors,

officers will hide the distress they feel as well as use other coping mechanisms that are part of the norm, such as alcohol use or aggressive behaviors (Cranevale, 2007).

Individual officers may believe that they are the only ones who are experiencing distress or trauma (Karaffa & Koch, 2013). There is a fear that if the officer chooses to stray from the norm, they will be met with stigma, will receive punishment, will be ostracized, and will be viewed as weak and unable to handle their jobs (Karaffa & Koch, 2013; Wester et al., 2010). There is stigma attached to not only experiencing emotional distress, but also seeking mental health services (Wester et al., 2010). It is proposed that the mental health education provided through CIT training is sufficient to cause a change in public and self-stigma. It is also proposed that the decrease in public and self-stigma will be demonstrated by CIT-trained officers' attitudes toward seeking mental health services when in need.

### **Definition of Terms**

*Mental health stigma:* Negative views, opinions, or stereotypes due to the characteristics or behaviors associated with mental illness (Vogel et al., 2006).

*Public stigma:* The felt experienced reaction of others to behaviors, physical appearances, or diagnoses that differ from the norm (Vogel et al., 2007).

*Self-stigma:* Internal concerns and beliefs related to feelings of shame, guilt, inadequacy, and inferiority due to mental health issues (Vogel et al., 2007).

*Avoidance factors:* Factors that influence the decision to seek mental health services (Vogel et al., 2007).

*Crisis Intervention Teams (CIT):* Officers within a law enforcement agency who are specially trained in mental health education, de-escalation and calming techniques, restraint tactics, disorder identification, and centers or facilities to take persons with mental illness. The team may also include mental health professionals and community outreach coordinators, though these professionals were not part of this current study (Compton et al., 2008).

*Police culture:* Shared beliefs and norms that build a coercive force among law enforcement. The police culture is relied on for safety and support for fellow officers (Woody, 2005).

*Social distance:* The distance between societal groups based on the level of intimacy tolerated (Ritter et al., 2010).

*Self-medicate:* The use of nonprescribed drugs or alcohol to treat or escape from stress, life disruptions, or mental health issues (Chopko, et la., 2013).

*Attitudes to Mental Illness Questionnaire (AMI):* A 20-item questionnaire used to assess a person's beliefs associated with mental health stigma (Singh et al, 1998).

*Self-Stigma of Seeking Help Scale (SSOSH):* A 10-item scale used to assess feelings related to self-stigma (Vogel et al., 2006).

*Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS):* A 24-item scale based on three subscales used to assess a person's willingness to seek mental health services and beliefs about mental illness (Mackenzie et al., 2004).

## **Assumptions, Limitations, And Scope and Delimitations**

### **Assumptions**

The assumptions made for this study included but were not limited to the assumptions that all participants would respond truthfully and to the best of their knowledge and that participants would be able to respond to the survey in a safe, comfortable, and confidential environment.

### **Limitations**

The limitations of this study could have related to the participant sample. It was possible that the sample would only be derived from one area of the country or from one type of department (rural, small city, or large city). Another limitation may have been that those who volunteer for CIT training may already have a positive disposition toward people with mental illness and views of mental illness; therefore, the CIT training may not have been the cause of any change, if found.

### **Scope and Delimitations**

The goal of this study was to examine whether the mental health education received in CIT training has any effect on mental health stigma, public and self, and a person's attitudes toward seeking mental health services. The scope of this study was limited to law enforcement officers. However, it was delimited, as any law enforcement officers reached in the United States, both CIT trained and non-CIT trained, would be invited to participate in the study. I assumed, however, that the majority of participants would be from law enforcement agencies in a medium-sized city in central Illinois. It

would depend on the versatility of the sample population to determine the generalizability of the results for law enforcement in the United States.

### **Significance of the Study**

The stigma and potential consequences of admitting to needing mental health services have led to many law enforcement officers self-medicating with alcohol and, experiencing disruptions in their work and family lives, in addition to contributing to high suicide rates (Manzella & Papazoglou, 2014). Previous research has addressed the attitudinal change toward mental illness following CIT training. A decrease in social distance and an increase in understanding and empathy have been documented as a part of the positive attitudinal change (Ritter et al., 2010; Tully & Smith, 2015). However, as discussed by Compton et al. (2008), attitudinal change means very little if not reflected in behavioral change. Through this research, I sought to identify whether the mental health education gained in CIT training influences whether officers have a more positive attitude toward seeking mental health services themselves. The findings could be valuable in understanding how to break through the stigma and encourage officers to reach out for help.

### **Implications for Social Change**

As a society, people call upon law enforcement officers to not only protect them, but also come to action after a crime has occurred. Law enforcement officers are placed in dangerous situations and view some of the most horrific scenes that the human race has to offer, while being expected to not let these events affect them emotionally or mentally. In this research, I aimed to examine the effects of mental health education on

stigma, both public and self-stigma, and attitudes toward seeking mental health treatment. A decrease in public and self-stigma is thought to encourage or increase the willingness of officers to seek mental health services. Officers can learn that it is acceptable for them to say, “I am not okay” or “I need help.” If this hypothesis is correct, the findings of this research may lead to future research and, potentially, the inclusion of mental health education as a standard part of law enforcement training.

### **Transition Statement**

The preceding chapter created an outline of the research. Provided was an overview of the research problem, the nature of the study, the research questions, the benefits of the research, and the framework and design to be used in conducting the study. Also discussed were the assumptions and limitations, as well as definitions of specific important terms. The areas discussed will be expanded upon in the following chapters.



## Chapter 2: Literature Review

### **Introduction**

This section outlines the literature that is discussed in this chapter. The research is organized by topic area, leading to a conclusion of current research and identification of a gap that allowed for this research. The articles presented were gathered through the Walden University library using EBSCO host search, PsycInfo database, and “snowball” references. The search terms used were the following: *law enforcement, mental health stigma, Crisis Intervention Teams (CIT), CIT, crisis intervention, mental health treatment, suicide, alcoholism, domestic violence, and peer support programs*. A compilation of scholarly journal articles, thesis, and organizational information is the result of the searches.

### **Mental Health Problems in Law Enforcement: Job Stress and Effects on Home Life**

The job of law enforcement has long been known to be stressful (Fleischman et al., 2018). Those in law enforcement are faced with not only one of the most dangerous jobs in the world, but also a job whose nature can take a toll on the entire mind, body, and spirit. Police officers are faced with situations that can lead to a cumulative stress response (Clark-Miller & Brady, 2013; Fleischman et al., 2018). For example, the experience of unfavorable judicial decisions, time away from family, an everchanging, nonroutine work environment, and the risk of death can all elicit a stress response. Wester et al., (2010) wrote, “variables such as long, irregular hours, rotating shifts, public scrutiny, and constant possibility of job-related injuries take a significant toll on officers, wearing down what might have been adaptive coping strategies” (p. 286).

Changes in societal climate have gone further to increase stress for law enforcement (Thornton & Herndon, 2015). Law enforcement does not have the same positive image that it had in the past. The failures of some officers and departments have caused many groups, such as Black Lives Matter and unofficial groups from communities where critical incidents have occurred, to declare war on law enforcement (Wade, 2017). Officers are ambushed in their squad cars, attacked in restaurants, and crucified in the media for doing the jobs that they were trained to do (Tully & Smith, 2015). Steinkopf et al., (2015) stated that occupational stress from community attitudes and civilian complaints had a greater impact on officers' stress response than general police duties. Second to occupational stress, witnessing or experiencing a traumatic event such as harm to self or other or death is a major cause of distress (Chopko et al., 2013). Many officers have known others who have been injured or killed in the line of duty. Trauma from these incidents can affect the way in which an officer works or lives (Manzella & Papazoglou, 2014). The term "survival" in police culture involves more than just making it through a shift or even to retirement alive; it also includes avoiding injury or public criticism (Woody, 2005).

Job-related stress in law enforcement can often manifest in negative ways. Law enforcement officers have high rates of family disruption such as marital conflicts or divorce, alcohol and substance abuse, domestic violence, physical and psychological problems, and suicide (Clark-Miller & Brady, 2013; Woody, 2005). Thornton and Herndon (2015) suggested that 1 in 7 law enforcement officers are living with undiagnosed PTSD. Further, negative coping strategies lead to depression, somatic

problems, memory impairment, sleep disturbances, increased startle response, and suicidal ideation (Manzella & Papazoglou, 2014). Among those in law enforcement, a common fear is that an individual is the only one experiencing unfavorable internal reactions (Karaffa & Koch, 2016).

Alcohol and substance abuse prevalence rates are greater among those in law enforcement than in the general population (Steinkopf et al., 2015). Chopko et al., (2013) discussed binge drinking, specifically, as having a greater rate in law enforcement when compared to the general public. Officers experiencing a stress response often choose to suffer alone, which leads to increased rates of self-medication (Fleischman, 2018; Wester et al., 2010). While discussing problems with others may be perceived as weakness in the police culture, alcohol use as a means of coping is thought to be condoned. Some officers use alcohol as an attempt to suppress feelings or symptoms of distress (Chopko et al., 2013). Chopko et al., (2013) found that 22.5% of law enforcement officers met the standard for moderate to high risk of alcohol abuse, with more than half of those meeting the standard for binge drinking (five or more alcoholic beverages in 1 day).

For those in law enforcement, the distress experienced, and the effects of alcohol use often overflow into personal relationships. Some officers experiencing distress isolate themselves. Family members may then feel alienated, which greatly increases relationship stress (Chopko et al., 2013). Clark-Miller and Brady (2013) discussed domestic violence as one of the consequences of the high stress seen in police officers. Oehme et al. (2011) wrote that 60,000-180,000 families are involved in a domestic violence incident every year. It has been suggested that 20%-40% of law enforcement

officers perpetrate domestic violence, while others have stated that domestic violence is not more common in law enforcement than in the general population. However, the research in this area is minimal (Oehme et al., 2011). It is proposed that aspects of the job such as the use of weapons, exercise of authority, and imposition of control spill over into home life as much as other aspects of police culture, especially when there is the occurrence of emotional distress (Clark-Miller & Brady, 2013; Oehme et al., 2011). Reported incidents of domestic violence have included choking, hitting, beating, pushing down stairs, shooting, using stun guns, committing rape, threatening to kill, as well as killing partners and their family members. The “blue wall” or “code of silence” is a part of the police culture that keeps actions, behaviors, and secrets from being shared with others as a means of protection. The culture of the “blue wall” or “code of silence” has perpetuated these occurrences and discouraged others from reporting or discussing help-seeking behaviors (Oehme et al., 2011).

Suicide rates among those in law enforcement are slightly lower than those in the general population, with suicide being the leading cause of death among members of law enforcement. Suicide rates among law enforcement officers have reached 12 per 100,000, compared to 13 per 100,000 in the civilian population (Kulbarsh, 2017). Officers who suffer from PTSD (diagnosed or undiagnosed) as a result of job-related stress also have increased rates of suicidal ideation (Mishara & Martin, 2012). However, suicide ideation is more likely to be associated with family disruption. Mishara and Martin (2012) discussed that even with suicidal ideation, police rarely sought professional mental health treatment. Suicide completions most often occurred with ill health, alcohol abuse, or

domestic problems, or after a disciplinary event. The suicide of a fellow officer is considered one of the top eight critical incidents that officers experience, and it can take months or even years for officers to recover (Mishara & Martin, 2012).

The police culture is another factor that can have a negative impact on how officers respond to stress and emotional distress. The police culture begins during training, when the goal is to break down the individual and rebuild them in the image desired (Wester et al., 2010). The police culture is a tight group that relies on a coercive nature for safety and support. Conflicts of beliefs within the police culture can lead to high levels of stress and dysfunction (Woody, 2005). Those who do not fit into the police culture are punished or ostracized. They are met with negative performance reviews, poor classroom grades, and less lucrative assignments (Wester et al., 2010). Those who do not initially share the groupthink attitude may feel inferior or change their beliefs to be in line with the norms of the group (Karaffa & Koch, 2016). The police culture continues to be supported because being presented with danger, having to act in authority, and having the mandate to use coercive force are tasks that are so few (Woody, 2005).

The bond that is required in law enforcement for “survival” is the same bond that separates and alienates individuals from their families and social relationships, and that dissuades them from seeking mental health treatment (Woody, 2005). The police culture pushes toward isolation, leading to mental, physical, and behavioral problems. Police culture supports the illusion that officers are unable to have healthy relationships, emotional disturbances, and somatic disorders (Woody, 2005). Law enforcement officers do not want to be thought of as unable to handle their jobs or as unreliable. Loss of

control of emotions can lead to poor decision making when part of their jobs is to make split-second decisions during ambiguous situations (Karaffa & Koch, 2016).

Males in law enforcement often have the machismo attitude, which is reinforced through the police culture (Wester et al., 2010). The male gender role involves being strong, protective, and capable of handling all situations. When distress occurs from job-related pressures, inner conflict may also occur. Males who experience this conflict between being the capable man and experiencing distress are far more likely to feel stigmatized for seeking counseling services (Vogel & Wade, 2009; Wester et al., 2010). There is fear that seeking mental health services suggests weakness and failure (Wester et al., 2010). Wester et al. (2010) wrote, “relying on others, admitting a need for assistance, or recognizing and labeling an emotional problem, run contrary to those characteristics which make a successful police officer” (p. 288).

### **Mental Health Stigma**

Mental health issues and emotional distress are met with stigma in law enforcement (Britt et al., 2007). The police culture fosters attitudes and beliefs suggesting that emotional or mental distress means that a person should not be trusted and is unable to carry a firearm. It also promotes the attitude that emotional and mental distress mean that a person is weak and should be denied promotions or special team applications (Clark-Miller & Brady, 2013; Levenson, 2007; Woody, 2005). There is the desire or misconception among officers that mental health issues occur in other people and not in themselves (Manzella & Papazoglou, 2014). Another misconception is the fear that what is shared with a mental health professional will be shared with superior officers and that

confidentiality does not apply. It is the police culture that continues to foster the belief that officers must maintain a certain image, which is suggested to further complicate stressors and their desire to seek help (Levenson, 2007).

The stigma attached to mental health and emotional distress has caused many officers to suffer in silence (Manzella & Papazoglou, 2014). The stigma attached to emotional and mental distress and illness is presented as a leading factor in avoidance of seeking mental health services as well as a leading factor impeding on recovery (Vogel et al., 2006; Wahl et al., 2011). Thorton and Herndon (2015) stated that 1 in 7 officers live with undiagnosed PTSD. However, other emotional or mental distress among officers is thought to occur at a much higher rate (Steinkopf et al., 2015). Instead of seeking services, officers internalize feelings, turn to alcohol, increase cigarette smoking, and distance themselves from friends and family (Manzella & Papazoglou, 2014).

Vogel et al. (2007) discussed five major avoidance factors for seeking mental health treatment: social stigma, treatment fears, fear of emotion, anticipated utility and risks, and self-disclosure. Avoidance factors have a greater influence on the decision to seek counseling than approach factors. The influence of the avoidance factors is thought to increase the closer a person gets to seeking help (Vogel et al., 2007). Stigma is the most significant barrier to seeking mental health treatment (Vogel et al., 2007). Less than 40% of people with mental health issues seek any type of professional help. Less than 11% seek help from a mental health professional, and that number decreases to less than 2% when the statistic focuses on nondiagnosable concerns (Vogel et al., 2006). Many view counseling as a last resort (Vogel et al., 2007).

Vogel et al. (2006) discussed stigma as having two forms: public stigma and private or self-stigma. Public stigma comes from society and the felt experienced reaction to behaviors, physical appearances, or diagnoses that differ from the norm. Public stigma associated with seeking services may be separate from public stigma regarding mental illness. Research suggests that the mere act of seeking treatment will provoke others to view a person as less emotionally stable, dependable, or interesting, no matter what the diagnosis (Vogel & Wade, 2009). Public stigma regarding seeking services comes from the fear that others will view an individual as less emotionally stable and dependable, whereas public stigma regarding mental illness involves having negative opinions and beliefs about others with mental illness (Vogel & Wade, 2009).

Self-stigma deals with internal concerns and beliefs regarding mental health (Vogel & Wade, 2009). Self-stigma refers to the internalized feelings of shame, guilt, inadequacy, and inferiority that result from public stigma (Vogel et al., 2007). Self-stigma also deals with self-esteem, self-worth, confidence, self-regard, and self-efficacy. Self-stigma plays the greatest role when symptoms are pronounced but not severe enough to warrant mandatory treatment. Self-stigma affects the decision regarding whether or not to seek treatment. Thoughts of “am I a failure?” or “am I weak?” often plague a person’s mind (Vogel & Wade, 2009).

While there is some debate among researchers, Vogel and Wade (2009) wrote that self-stigma is a greater avoidance factor for mental health services than public stigma. However, this is due to the belief that self-stigma is an internalized reflection of public stigma and is the individual’s perceptions thereof (Vogel et al., 2006). Vogel and Wade



(2009) posited that “self-stigma is particularly important in the help-seeking process” (p. 21). Vogel and Wade further noted, “Perceptions of public stigma initially contributed to the experience of self-stigma, but then self-stigma and not public stigma influenced help-seeking attitudes and eventually help seeking willingness” (p. 21).

In discussing how mental illness and people with mental illness are viewed by society, Wahl et al., (2011) wrote that researchers had formulated a list of public views and inaccurate negative beliefs, including dangerousness, unpredictability, unattractiveness, unworthiness, and being unlikely to be productive members of society (p. 47). The public and media create and reinforce stigma by providing negative descriptions of individuals with mental illness (Vogel et al., 2007). The stigma of mental illness is shown to be pervasive in society, despite dissemination of general mental health knowledge. Stigma has been found to be one major reason that a person with mental health issues may not seek treatment (Wahl et al., 2011). Stigma has a negative effect on more than just the decision to seek treatment; it also plays a role in recovery, treatment adherence, discrimination, discouragement, isolation, and damage to self-esteem (Levenson, 2007; Lyons et al., 2009; Vogel & Wade, 2009; Vogel et al., 2007; Wahl et al., 2011).

People with mental illness experience shame, ostracism, and marginalization. Many describe the stigma as worse than the condition (*The Lancet*, 2016). Having a hospital stay or mental health diagnosis is often met with social rejection (Vogel et al., 2007). Everyday social encounters are changed, which can effect self-esteem by making the person feel like an outsider or inferior (Lyons et al., 2009). Stigma is often displayed

in the community through avoidance and name calling. Others may assume that a person cannot get better and that their mental health issues will always be a concern no matter what the reason for seeking treatment (Lyons et al., 2009).

Some disorders elicit greater stigma because they are perceived as being disgraceful or shameful. Cryer et al., (2018) discussed that the perceived controllability of a disorder had an influence on the level of stigma associated with it. If the disorder or symptoms were perceived to be controllable, then greater stigma was attached and vice versa for disorders that were not perceived to be controllable (Cryer et al., 2018). This was found to be consistent with all mental health issues except suicide and suicidal thoughts. Suicide and suicidal thoughts are not perceived as controllable, but the level of stigma attached is increased. It is thought that societal and cultural norms of being shameful and taboo come into play (Cryer et al., 2018).

Stigma and discrimination have a huge impact on a person's life (Lyons et al., 2009). Once a diagnosis is in place, the individual has received a new stigmatized social identity. Stigma can be found in obtaining employment, attitudes of colleagues and supervisors, as well as when returning from work following receiving services. Employers may view the individual as unreliable or incapable of handling the job (Lyons et al., 2009). Stigma may even be felt from family members. The stigma experienced from family members or friends can have a greater negative impact on the individual than stigma received from the general public (Chopko et al., 2013; Lyons et al., 2009). This influence can further disrupt an already-disrupted family (Chopko et al., 2013).

Efforts to change public stigma and understanding have found small to insignificant results (Lyons et al., 2009). Lyons et al. (2009) measured qualitative change in stigma for the period between 1997 and 2007/2008. The greatest positive change was found among the professional setting, where those with mental health issues in 1997 were met with cruelty and ridicule. Those with mental health issues in 2007/2008 still faced negative attitudes but it was more dismissive and passive aggressive. However, people still experienced taunting, ridicule, demotion, and termination following returning to work from sick leave involving mental health care (Lyons et al., 2009). The last 30 years of research has continued to identify the stigma and expectancy of avoidance or denial of emotional trauma as a theme even with vast improvements in preparing officers for trauma (Thorton & Herndon, 2015).

### **Crisis Intervention Teams, Mental Health Education, and Stigma Reduction**

CIT were developed in 1988 in response to an incident involving law enforcement and Joseph Robinson, a mentally ill person that resulted in the death of the person with mental illness (Compton et al., 2008; Fisher & Grudinkas, 2010). Law enforcement and the community were looking for a better way to deal with this type of interaction and produce more favorable outcomes. The CIT was developed as a collaborative method between mental health professional and agencies, the community, and law enforcement. The training for law enforcement as part of CIT includes mental health education, such as identifying disorders, lessons from people who live with mental illness, and family members of people with mental illness, de-escalation techniques, and what services are available as an alternative to arrest (Compton et al., 2008; Tully & Smith, 2015).

The CIT is implemented in some form in almost every police agency across the United States (Fisher & Grudzinskas, 2010; Franz & Borum, 2011; Laing et al., 2009). The Memphis CIT training model requires a minimum 40 hours of training. Officers can be chosen for CIT training by superiors or officers can volunteer for selection. Selected officers are trained in disorder identification, given knowledge of the development and the actions of an individual with the most common disorders, taught calming techniques, restraint techniques, and knowledge of where to take a person experiencing a mental crisis in order to receive care (Fisher & Grudzinskas, 2010; Franz & Borum, 2011). The education comes in the form of classroom training, lecture, and experiential learning exercises (Cuddeback et al., 2016). There is a collaboration among law enforcement, psychologists, social workers, and local mental health centers/facilities. The partnership with the mental health facilities guarantees emergency care for each individual brought to the facility (Fisher & Grudzinskas, 2010; Franz & Borum, 2011).

The goal of the CIT trained officers is to help de-escalate situations that could potentially be dangerous when interacting with person with mental illness (Bohora et al., 2008). Canada et al., (2012) stated that the problem police officers faced was that persons with mental illness do not respond well to traditional police tactics causing situations to escalate resulting in injury to the subject of the officer. Prior to training, many officers were fearful entering situations involving mental illness due to the unpredictability of behavior. Bonfine et al., (2014), cited in Clayfield et al., (2011) and Psarra et al., (2008) in stating while perception regarding mental illness may be negative, many officers have an interest in gaining a better understanding and learning methods to work with people

with mental illness. After receiving training, they felt more prepared and understood that the mental illness and the behaviors related to such were not the fault of the individual (Hanafi et al., 2008). Many of the officers who went through training now understood that those with mental illness could be helped and approached with empathy (Hanafi et al., 2008).

Tully and Smith (2015) discussed that officers without CIT training are more likely to view those with mental illness as a burden on society or dangerous to the community. Ritter et al., (2010) stated that one of the roles of the CIT is to decrease the stereotypical beliefs most commonly associated with mental illness through the provision of in-depth knowledge. CITs' address fears and concerns associated with mental illness as well as the potential for violent behavior (Ritter et al., 2010). Demir et al., (2009) discussed that the belief of causation has a major impact on helping behaviors and stigmatizing views. CIT training is shown to increase knowledge of causation thereby increasing positive attitudes and beliefs (Demir et al., 2009).

Corrigan et al., (2012) wrote that there are three types of stigma reduction mental health education programs: classroom education/lecture, interpersonal contact, and advocacy. Advocacy was found to be the least effective way to change stigma. Corrigan et al., (2012) and Chen et al., (2016) both discussed contact-based education as having the greatest effect on stigma reduction. However, research varies whether the classroom component or direct contact had the greatest influence on post-educational change (Wong et al., 2019). CIT training utilizes both classroom education and interpersonal contact/contact-based education in providing mental health education (Compton et al.,

2008). Chen et al. (2016), citing Corrigan and Penn (1999), in saying, “Through education and contact, strategies like the provision of personal experience with mental illness, the correction of myths, and the in-depth discussion on the topic could effectively change public stigma toward people with mental illness” (p.282).

Contact based education uses direct contact, video contact, as well as workshops with people who have lived experiences (Chen et al., 2016). The discussion of recovery stories and normalization through identification of similar interests challenges the stereotypical beliefs which contribute to mental health stigma (Chen et al., 2016; Corrigan et al., 2012). Wong et al., (2019) discussed that contact-based education may contribute to longer periods of stigma reduction following mental health education albeit longitudinal research in this area is scarce suggesting that overall stigma reduction is short-term.

Many CIT trained officers come out of training with more compassion and patience for persons with mental illness (Tully & Smith, 2015). It was further discussed that there is a decreased social distance (Cuddeback et al., 2016), a decrease in perceived dangerousness, and overall attitudes towards persons with mental illness improved (Bohora et al., 2008; Canada et al., 2012). Cryer et al., (2018) discussed that there is a direct relationship between perceived controllability of a disorder/symptoms of a disorder and the stigma attached. The more something is perceived to be controllable, the greater the stigma attached (Cryer et al., 2018). The benefit of CIT training is that officers learn the facts regarding mental health disorders. Canada et al. (2012) discussed that preliminary evidence for the reduction of stigma and improvement of negative beliefs

have been found amongst CIT research. This is evidenced by the reaction of participants in Tully and Smiths' (2015) research regarding the effectiveness of CIT training. The participants expressed that, "CIT has helped us understand what the mentally ill are going through" and, "CIT has opened my eyes about mental illness and has even made me more patient with my own son who has ADHD" (p.61).

### **Help-Seeking Behavior in Law Enforcement**

Help-seeking behavior can be influenced by a number of factors. Societal, cultural, and internal concerns blend together to make pressures for or against help-seeking. Mansfield et al., (2003) discussed help-seeking behaviors to be more positive when it was perceived as normal. Gulliver et al., (2010) stated that negative attitudes toward help seeking often came from stigma (fear of others finding out, belief that they should be able to handle one's own problems) and the belief that treatment will not help. People will utilize friends and family as helpers before seeking professional help (Gulliver et al., 2010). However, when the norm for the societal or cultural group is the expectancy to not have the need and be looked down upon or be ostracized if one does, a person will attempt to conform to the norm and avoid seeking help (Mansfield et al., 2003).

"According to Goffman, society categorizes people on the basis of normative expectations – dividing the 'normals' from the 'deviants'" (Cranvele, 2007. p.10). Goffman's stigma theory states that an individual will attempt to control the stigma felt by hiding qualities that differ from the group norm. It is posited that controlling the visibility of things such as emotional or mental distress will control perceptions of others

of oneself (Cranvele, 2007). The police culture is an environment that is based on strength, mentally, emotionally, and physically (Woody, 2005). The norms of the police culture would create an environment in which a person, under Goffman's stigma theory, would choose to hide their discrediting qualities. However, under Goffman's stigma theory, if it became normal or acceptable in police culture to talk about distresses or seek mental health services then officers would stop hiding these qualities and their attitudes towards seeking mental health treatment could change (Cranvele, 2007; Woody, 2005).

Research regarding help seeking behaviors following CIT training is limited (Fleischman et al., 2018; Karaffa & Tochkov, 2013). Fleischman et al., (2018) discussed as a secondary finding that CIT trained officers said they would be willing to seek outside treatment help if in need. Karaffa and Tochkov (2013) discussed help seeking behaviors of law enforcement officers in general in finding that the police culture and stigma act as barriers to help seeking attitudes. Age and gender also act as variables for help seeking behavior with females and older men having a more positive attitude (Karaffa & Tochkov, 2013). However, the avoidance factors remain the same. "Officers are warned throughout their career that losing control of their emotion, or the situation, could lead to negative evaluations by superiors, limit their career mobility (Kirschman, 2007; Shearer, 1993), or result in reassignments (Delung, 1990)" (Karaffa & Tochkov, 2013. p.79). To increase mental health service utilization among law enforcement officers, stigma and occupational concerns must be addressed (Fleischman et al., 2018; Karaffa & Tochkov, 2013).



### **Gap in Research**

The mental health education received through CIT training has been shown to decrease the stigma against mental illness as well as decrease social distance (Bohora et al., 2008). Officers report feeling more comfortable, empathetic, and effective in their interactions with persons with mental illness. The mental health education has also provided officers with a better understanding of behavior and the challenges of mental illness (Bonfine et al., 2014; Tully & Smith, 2015). Officers report benefiting from the stories of people with lived experiences and having a much better understanding of the etiology of disorders (Tully & Smith, 2015). Officers reported being able to talk about mental health issues with other and where and how to receive treatment (Fleischman et al., 2018; Tully & Smith, 2015). Fleischman et al. (2018) discussed that CIT trained officers feel comfortable talking to other officers and referring them for services. While not the primary focus of the study, Fleischman et al. (2018) also asked if CIT officers would be willing to seek mental health services if they were in crisis. Slightly more than half of the officers who participated said they would be willing to seek outside help if they were in crisis. However, we do not know if that is a significant change from non-CIT trained officers. Research has shown that public and self-stigma is prevalent among law enforcement not only because of general public inaccurate beliefs but also due to the culture among law enforcement (Fleischman et al., 2018; Karaffa & Koch, 2016; Woody, 2005). This gives us reason to think that Fleischman et al. (2018) findings would not be standard across law enforcement. Addressing this distinction could be valuable for future research and may possibly have implications for how officers are trained.

## Chapter 3: Research Method

### **Introduction**

The purpose of this study was to examine the relationship between mental health education received through CIT training, public and self-stigma for seeking mental health services, and attitudes toward seeking mental health services. The study compared the scores of CIT-trained officers and non-CIT-trained officers on the AMI, SSOSH, and IASMHS. The scores were analyzed using one-way multivariate analysis of variance (MANOVA) to determine if a difference occurred between the two groups. In Chapter 3, I also explain the research design, research questions, hypotheses, instrumentation and data, and data collection process. Additionally, the participant selection process, research setting, participants' rights, and my role as the researcher are addressed.

### **Research Design**

This quantitative study used a nonexperimental research design. The research was a between-group comparison analyzing the differences in public and private mental health stigma and attitudes toward seeking mental health services between CIT-trained and non-CIT-trained officers. The correlational design does not consider or attempt to control for outside factors (Price et al., 2015). While some believe that correlational research should primarily be used if the researcher does not believe that a correlation exists, the design is beneficial when the researcher cannot manipulate the independent variable(s). For this study, it would have been nearly impossible and impractical to manipulate the mental health education received through CIT training and an individual's level of public and private mental health stigma (Price et al., 2015). The lack of

manipulation of variables by the researcher made the correlational research design a reasonable choice, as it was in line with the purpose of this quantitative study, in which I sought to examine the relationship between CIT trainings' effect on public and self-stigma and the attitudes toward seeking mental health services.

Other design methods were considered for this research but dismissed for a variety of reasons. For example, a qualitative design was considered but dismissed because it would have allowed for too many response outcomes, possibly outside the realm of the avoidance factors. The qualitative design would not have allowed the research to focus on specific factors and outcomes.

Other quantitative research designs were considered as well. A true experimental design, as defined by Creswell (2009), would have required the ability of the researcher to randomly assign participants into groups that either received CIT training or did not, which was beyond the scope of my ability. A pre-posttest design was also considered. Under the pre-posttest design, I could have measured the change in stigma and the willingness of officers to seek treatment prior to and following training (Creswell, 2009). While this could have produced a better picture of the change, this was also excluded for logistical issues. The quasi-experimental design fits best when examining an already-existing population group and focusing on specific variables.

### **Research Questions and Hypotheses**

RQ 1. Is there a difference in self-reported attitudes of law enforcement officers toward seeking mental health services, as measured by the Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS), between

those who have completed CIT training and those who have not completed CIT training?

H<sub>01</sub>. There is no significant difference in self-reported attitudes of law enforcement officers toward seeking mental health services, as measured by the IASMHS, between those who have completed CIT training and those who have not completed CIT training.

H<sub>a1</sub>. There is a significant difference in self-reported attitudes of law enforcement officers toward seeking mental health services, as measured by the IASMHS, between those who have completed CIT training and those who have not completed CIT training.

RQ 2. Is there a difference in the perceptions of public mental health stigma, as measured by the Attitudes to Mental Illness Questionnaire (AMI), between CIT-trained officers and non-CIT-trained officers?

H<sub>02</sub>. There is no difference in the perceptions of public mental health stigma, as measured by the AMI, between CIT-trained officers and non-CIT-trained officers.

H<sub>a1</sub>. There is a difference in the perceptions of public mental health stigma, as measured by the AMI, between CIT-trained officers and non-CIT-trained officers.

RQ3. Is there a difference in perceptions of self-stigma, as measured by the Self-Stigma of Seeking Help Scale (SSOSH), between CIT-trained officers and non-CIT-trained officers?

H<sub>03</sub>. There is no difference in the perceptions of self-stigma, as measured by the SSOSH, between CIT-trained officers and non-CIT-trained officers.

H<sub>a3</sub>. There is a difference in the perceptions of self-stigma, as measured by the SSOSH, between CIT-trained officers and non-CIT-trained officers.

### **Setting and Sample**

The research survey was available to participants online through SurveyMonkey.com. The sample consisted of law enforcement officers, both CIT trained and non-CIT trained. Participants were reached through law-enforcement-focused websites, Facebook pages, and the law enforcement agencies in which they were employed. Multiple law enforcement agencies were contacted for permission to hang flyers asking for participation. While the sample was one of convenience, I used multiple outlets to help in reaching a population large enough to achieve power as well as one that represented multiple agencies and agency types.

### **Instrumentation**

The survey began with general demographic questions gathering information regarding age, gender, race, years in law enforcement, and whether participants were CIT trained as well as the number of years since CIT training occurred. There were also three self-report measures for measuring law enforcement officers' perceptions of mental illness (public stigma) as well as self-stigma and attitudes toward seeking mental health services. The IASMHS (Mackenzie et al., 2004) was used to evaluate Research Question

1. The AMI (Singh et al., 1998) was used to evaluate Research Question 2. The SSOSH (Vogel et al., 2006) was used to evaluate Research Question 3.

### **Crisis Intervention Team Training**

While not an instrument implemented by the researcher, CIT training was an important variable and intervention in this research. The Memphis model of CIT training entails a minimum of 40 hours of mental health education. Officers are trained in disorder identification, given knowledge of the development and actions of individuals with the most common disorders, taught calming techniques, and provided with knowledge of where to take a person who is experiencing a mental crisis to receive care (Fisher & Grudzinskas, 2010; Franz & Borum, 2011). The education comes in the form of classroom training, lecture, and experiential learning exercises (Cuddeback et al., 2016). There is collaboration among law enforcement, psychologists, social workers, and local mental health centers/facilities. The partnership with mental health facilities guarantee emergency care for each individual who is brought to the facility (Fisher & Grudzinskas, 2010; Franz & Borum, 2011).

### **Self-Stigma of Seeking Help**

The SSOSH (Vogel et al., 2006) is a 10-item measure of self-stigma for seeking mental health services responded to using 5-point Likert type response options ranging from *strongly disagree* to *strongly agree*. The scale was designed to measure mental health self-stigma, which is a leading reason why people do not engage in therapy (Vogel et al., 2006). The scale was designed by drawing on Corrigan's (2004) discussion of self-stigma and was originally constructed with 28 items. The number of items was reduced

following input by other psychology professionals and testing on the validity and item-total correlation of the individual items. Psychology professionals were given the opportunity to review the items and state whether they thought the items were relevant. It was determined that five items could be dismissed before testing for validation. The remaining items were tested for item validity and scale validity. Any item producing a factor load less than .50 was rejected. Based on this criterion, 13 more items were dismissed. The final 10-item scale has five reversed items (Vogel et al., 2006). For example, “I would feel inadequate if I went to a therapist for help” pairs with the reverse item “my self-confidence would not be threatened if I sought professional help.”

As predicted by the developers, the SSOSH is negatively associated with anticipated benefits and positively associated with anticipated risks of seeking mental health services (Vogel et al., 2006). This is in line with the idea that those who perceive a greater self-stigma will also have less positive views toward seeking professional mental health services. According to Vogel et al. (2006), the 10-item SSOSH has an internal consistency of .91. Through three studies, the SSOSH (Vogel et al., 2006) has been cross validated for reliability, producing coefficients of .86 to .90 with test-retests producing coefficients of .72. A confirmatory factor analysis showed that all items loaded at  $< .50$ , confirming the unidimensional factor structure. Vogel et al. (2006) discussed that the SSOSH showed evidence of validity (construct, criterion, and predictive) to state that the scale measures the single construct that it was intended to measure. The correlation between scales on Studies 2 and 4 produced scores of .48 and .46, providing construct and criterion validity. Construct validity was measured through correlation with the

Disclosure Expectations Scale and the Social Stigma for Seeking Psychological Help Scale. Criterion validity was measured through correlation with Intentions to Seek Counseling Inventory and the Attitudes Toward Seeking Professional Psychological Help Scale (Vogel et al., 2006).

### **Inventory of Attitudes Toward Seeking Mental Health Services**

The second measure examining the attitudes of participants toward seeking professional mental health services was the IASMHS (Mackenzie et al., 2004). The IASMHS is a 24-item questionnaire consisting of three subscales: psychological openness, help-seeking propensity, and indifference to stigma (Mackenzie et al., 2004). The psychological openness subscale assesses the participant's openness to admitting that there is a problem, as well as their openness to the idea of seeking treatment. The help-seeking propensity subscale measures how willing a person is to seek out professional mental health services. The indifference to stigma subscale measures how the individual perceives others as viewing them for seeking professional mental health services (Mackenzie et al., 2004). The subscales play an important role in understanding how stigma affects willingness to seek treatment. The IASMHS (Mackenzie et al., 2004) has shown full scale Cronbach's alpha values at .87. Test-retest reliability coefficients were .85. The individual scale values were broken down to psychological openness showing a Cronbach's alpha of = .82, and a retest reliability coefficient of  $r = .86$ . The help-seeking propensity scale showed a Cronbach's alpha of = .76, and a retest reliability coefficient of  $r = .64$ . The indifference to stigma scale showed a Cronbach's alpha of = .79, and a retest reliability coefficient of  $r = .91$  (Mackenzie et al., 2004).



### **Attitudes Toward Mental Illness Questionnaire**

The third measure examined overall beliefs about mental illness, or public stigma, not just beliefs relating to oneself. This measure was used to evaluate Research Question 3. The AMI (Singh et al., 1998) is a 20-item questionnaire measured on a 5-point Likert scale. Ten reverse items were used to avoid a response bias. A higher score on the AMI reflects less negative feelings toward mental illness or lower levels of public stigma. This scale was developed to measure the attitudes of medical students toward mental health patients, using previous students' feedback. The students were administered the questionnaire before and after their psychiatric rotation to determine whether there was a change in their attitudes, with the hope of improving psychiatric training curriculum (Singh et al., 1998). The items on the AMI focus on the causes of mental illness, treatment, and the consequences and impact of mental illness for the individual and the community in which they live (Singh et al., 1998).

The AMI has only been used by its developers, who have admitted to not formally testing the reliability and validity of the items and the scale. Singh et al. (1998) stated that the AMI shows face validity and "the change in the scores following the attachment also suggest construct validity" (p.119). The AMI was used in conjunction with the Attitudes towards Psychiatry Questionnaire (ATP-30), a well-tested instrument, and produced congruent findings (Singh et al., 1998). Items such as "people with mental illness, generally speaking, are difficult to like," "Violence mostly occurs from mental illness," and "care in the community for the mentally ill puts society at risk" are used to determine a person's general attitude or public stigma toward mental illness.

### **Data Collection**

Data were collected through a self-report survey on Survey Monkey. Website access allows the participant to respond to the survey in a private environment to ensure anonymity. I received approval from Walden University's Institutional Review Board (IRB) (IRB approval number 02-05-20-0345294) to begin data collection on February 5, 2020, and the self-report survey was posted to the survey site. I gained permission from law enforcement agencies to post flyers about participation in the research. I also advertised the research on websites, LinkedIn pages, and Facebook pages that were geared toward law enforcement officers. The data were collected and analyzed for correlation and statistical significance.

### **Data Analysis**

Data analysis occurred through one-way MANOVA. One-way MANOVA is a popular test for social science research and is a multivariate extension of analysis of variance (Green & Salkind, 2014). "MANOVA includes multiple dependent variables rather than a single dependent variable. MANOVA evaluates whether the population means on a set of dependent variables vary across levels of a factor or factors" (Green & Salkind, 2014, p. 200). One-way MANOVA analysis is appropriate for use when evaluating the relationships that group differences in CIT training (i.e., those with training and those without) have on multiple dependent variables (i.e., public stigma, self-stigma, and attitudes toward seeking treatment).

### **Threats to Validity**

Correlational research is open to a couple of types of threats to validity. Internal threats to validity may include the fact that officers may become CIT-trained volunteers because of previous or personal experience with people with mental illness. Due to this research being a between-group comparison and not a pre-posttest, there may be other factors that influence a potential change in stigma and attitudes toward seeking professional mental health services (Campbell & Stanley, 1963). Another potential threat of an external nature could be the sampling procedure. The sample that was used was planned to be a convenience sample. Random selection for groups generally controls for validity threats of this nature (Creswell, 2009). One way to counteract these potential threats to validity is to aim for both sample populations to be as similar in demographics as possible (Campbell & Stanley, 1963). Another way is to discuss the potential limitations of validity during the discussion of findings.

### **Power Analysis**

Similar studies were consulted to determine the effect size obtained. Wester et al. (2010) had a sample size of 178 and obtained an effect size of .15 when measuring gender role conflict and self-stigma. Wester et al. (2010) also achieved an effect size of .18 when measuring gender role conflict and public stigma. Both effect sizes were considered small.

In comparison, Karaffa and Tochkov (2013) used a sample of 158 and were able to obtain an effect size of .37 when measuring attitudes toward seeking mental health services and an increased effect of .55 when measuring willingness to seek treatment;

both variables were correlated with police culture. The slightly larger effect was achieved when using a smaller sample size.

Based on these studies a G\*power analysis was ran to determine a statistically significant sample with a large effect size (.40). A priori analysis was used to determine sample size N with an alpha of .05 and a level of power of .95. The priori analysis is designed to eliminate Type 1 and Type 2 errors and allows for me, as the researcher, to know I am correctly rejecting or not rejecting the null hypothesis (Mayr et al., 2007). A F-test: MANOVA: Global effects power analysis was ran with the stated perimeters yielding a suggested N of 112. Similar to Karaffa and Tochkov (2013), I am able to achieve a larger effect size with a smaller sample size.

### **Protection of Participants' Rights**

There were numerous considerations made in developing this research in an effort to manage ethical concerns and protect the rights of the participants. The survey has avoided asking any questions that might hinder on confidentially sought mental health services as well as diagnosis or treatment. The survey has also avoided gaining information from participants on critical incidents in which they have been involved. This measure was taken to not elicit a trauma response. A consent for participation will be included and must be verified before entering the survey page. The participants will not be asked for a signature but rather to accept the terms. The information gathered such as beliefs about mental illness could have a negative effect on the participants' work if it was to become known. I designed this research so participants can remain completely anonymous and can complete the survey in the privacy of their own home. This measure was taken to

ensure that the individuals' responses and participation cannot be shared with others. Each participants survey will use a numerical identification with no linking information to the participant. Only my dissertation committee and I will have access to the data collected. All research data will be stored in a locked safe for a period of 7 years before being destroyed.

### **Role of the Researcher**

My role as the researcher is to inform on the implications of this research and the future directions of research that the results may make apparent.

My role as the researcher is also to protect the participants from this research causing harm. I must identify ethical concerns and address any issues that do arise. One way of protecting the participants is through insuring informed consent has occurred. Participants will not be allowed access to the survey without giving informed consent. If, in the possibility, a computer glitch has occurred allowing participants to proceed to the research before consenting, the attached survey will not be considered viable.

### **Transition Statement**

Chapter 3 outlined the design of the study, research method and provided a detailed description of the instrumentation, setting and sample, analysis, and data collection. Participants' rights and my role of the researcher was addressed as well. Chapter 3 detailed the instruments to be used to address the research questions as well as which instrument was used for which research question. Sampling power was also discussed and determined to achieve significant power, a sample population would have

to reach 162 participants. It was also discussed how the sample population would be reached.

## Chapter 4: Results

### **Introduction**

This quantitative, survey-based research was designed to examine the relationship between the mental health education received through CIT training and public stigma, self-stigma, and attitudes toward seeking mental health services among law enforcement. This study compared the scores of CIT-trained and non-CIT-trained officers on the AMI, SSOSH, and IASMHS. The scores were analyzed using MANOVA to determine whether a difference occurred. The proposed hypothesis was that the mental health education received through CIT training would result in a decrease in public and self-stigma and a more positive attitude toward seeking mental health services.

### **Data Collection**

This study surveyed law enforcement officers from departments across the United States. Approval for data collection was received from the IRB at Walden University on February 5, 2020 (IRB approval number 02-02-20-0345294). The survey was posted on SurveyMonkey.com on February 12, 2020, and approval to close data collection occurred on October 2, 2020. Participants were invited to participate in this research through an invitation letter, which included a link to the survey on SurveyMonkey.com. Research invitations were distributed electronically through email, messaging apps, posts on law-enforcement-focused Facebook pages, and websites. Research invitations were also distributed physically on printed paper and handed out at various law enforcement agencies after these provided permission for advertising the research. Physical copies were also handed out directly to law enforcement officers through casual meetings.

I experienced many hindrances during data collection. Data collection began on February 12, 2020, at the beginning of the coronavirus pandemic. Prior to states shutting down, 16 responses were received. For the 2 months following, zero responses were received, even though several advertisements and reminders were sent. Reminders to participate and advertisements for the research were done each month during the data collection period. During the months of February and March, 300 paper invitations were distributed. Another 300 were distributed during the months of April and May, along with online advertisements. In the period of June through September, around 600 more invitations were distributed, and multiple attempts were made to gain participants through online advertisements. During this period, only 32 more responses were received, with five of those left blank or only answering a small portion of the survey. In many cities across the United States, there were riots, protests, general upheaval, and social unrest (Mehdizadeh & Kamkark, 2020; Papazoglou, 2020). It is believed that the lack of responses was due to the extended duties of law enforcement officers at this time, such as working overtime during riots and protests and having to enforce COVID-19 mitigations in many communities.

The survey took most participants approximately 10 minutes to complete. It consisted of 60 questions and included demographics, the AMI, the SSOSH, and the IASMHS. Throughout my efforts to garner participants, I only received 48 participant responses. Of the responses, five were incomplete, leaving me with 43 total completed surveys. In consultation with my statistics subject matter expert, it was decided to determine at what rate we would achieve statistically significant findings based on the



data we did have. A preliminary G\*Power analysis using the averages of the scores received so far revealed that the subtle differences could become significant at a sample size of 1,228 participants. Therefore, even achieving the original goal number of participants of 162 would not have changed the findings. Permission to close data collection was granted due to lack of responses.

## **Results of the Data Analysis**

### **Descriptive Statistics**

There were 48 responses to the survey. However, five of those responses were incomplete. Only the 43 completed responses were used for data analysis. The incomplete responses were excluded. The completed 43 responses were made up of 18 females (41.86%) and 25 males (58.14%). The participants ranged in age between 25 and 64 years, with five between 25 and 34 years of age (11.63%), 20 between 35 and 44 years of age (46.51%), 10 between 45 and 54 years of age (23.26%), and eight between 55 and 64 years of age (18.60%). The overwhelming majority of the participants stated that they were White or Caucasian (39, 90.70%). The rest of the sample population reported Black or African American (2, 4.65%), Hispanic or Latino (1, 2.33%), or another race (1, 2.33%).

Responses for number of years in law enforcement were divided among 1-5 years (4, 9.30%), 6-10 years (8, 18.60%), 11-15 years (5, 11.63%), 16-20 years (13, 30.23%), and 21+ years (13, 30.23%). Among the officers in the sample, 26 (60.47%) were CIT trained and 17 (39.53%) were non-CIT trained.

Scores on the AMI, SSOSH, and the IASMHS were used to identify a difference between means of the CIT-trained group and the non-CIT-trained group. The AMI allows for a high score of 100, with a higher score indicating less public stigma. Mean scores for the AMI were 73.08 with CIT training and 72.12 without CIT training. The SSOSH allows for a high score of 50, with a higher score indicating less self-stigma. Mean scores for the SSOSH were 38.5 with CIT training and 38.65 without CIT training. The IASMHS allows for a high score of 120, with a higher score indicating a more positive attitude toward seeking mental health services. Mean scores for the IASMHS were 89.73 with CIT training and 90.29 without CIT training.

**Table 1**

*Descriptive Statistics Between Groups*

	AMI		SSOSH		IASMHS	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
CIT trained	73.08	6.66	38.5	6.24	89.73	12.12
Non-CIT trained	72.12	7.19	38.65	7.27	90.29	15.41

**Tests of Assumptions**

Before evaluating the research questions, the assumptions for a one-way MANOVA were evaluated. The first assumption of the one-way MANOVA was that the sample was independent and random. The survey responses were independent of each other, with no response having a bearing on another or another survey. The participant sample was gained through advertisement and was a product of convenience. The second assumption of the one-way MANOVA was that the population variances and covariances

among the dependent variables were the same across all levels of the factor (Green & Salkind, 2014). Box's test of assumption of equality of covariance matrices was not significant ( $p = .730$ ), meaning that covariance matrices were roughly equal as assumed. Though one should be cautious with the assumption of normality due to the small sample size, there are adequate findings to preliminarily assume normality and move forward with the one-way MANOVA.

The first step in the analysis of research questions was to examine whether there was an overall multivariate effect. Using Wilk's lambda, there was not a significant effect of CIT training on public stigma, self-stigma, or attitudes toward seeking mental health services,  $\lambda = .990$ ,  $F(3, 39) = .133$ ,  $p = .940$ . Due to this finding, no other tests were needed.

### **Research Questions**

Although the overall MANOVA was not significant, the research questions for this study were still evaluated. Each of the research questions is summarized next, along with descriptive statistics for the relevant dependent variables.

#### **Research Question 1 Findings**

Research Question 1 addressed whether there is a difference between those who have completed CIT training and those who have not completed CIT training in terms of self-reported attitudes of law enforcement officers toward seeking mental health services, as measured by the IASMHS. Descriptive statistics for the IASMHS are reported in Table 1. Separate univariate analysis also failed to identify significant effects of CIT training on attitudes toward seeking mental health services among law enforcement  $F(1,41) = .018$ ,  $p$

= .894. These findings indicate that the null hypothesis cannot be rejected, and therefore I conclude that there are no significant differences between self-reported attitudes toward seeking mental health services between CIT- and non-CIT-trained law enforcement officers as measured by the IASMHS.

### **Research Question 2 Findings**

Research Question 2 addressed whether there is a difference in the perceptions of public mental health stigma between CIT-trained officers and non-CIT-trained officers as measured by the AMI. Descriptive statistical analysis revealed mean scores for CIT-trained ( $M = 73.076$ ) and non-CIT-trained ( $M = 72.117$ ) law enforcement officers on the AMI. Separate univariate analysis also failed to identify significant effects of CIT training on public stigma among law enforcement ( $F(1,41) = .200, p = .557$ ). The null hypothesis is accepted, as there were no significant differences between perceptions of public mental health stigma between CIT- and non-CIT-trained law enforcement officers as measured by the AMI.

### **Research Question 3 Findings**

Research Question 3 addressed whether there is a difference in perceptions of self-stigma, as measured by the SSOSH, between CIT-trained officers and non-CIT-trained officers. Descriptive statistical analysis revealed mean scores for CIT-trained and non-CIT-trained law enforcement officers on the SSOSH ( $M = 38.5$   $M = 38.647$ ). Separate univariate analysis also failed to identify significant effects of CIT training on self-stigma among law enforcement officers,  $F(1,41) = .005, p = .944$ . The null hypothesis is accepted, as there were no significant differences in the perceptions of self-

stigma between CIT- and non-CIT-trained law enforcement officers as measured by the SSOSH.

### **Summary**

The aim of this quantitative, nonexperimental research was to examine the relationships between the mental health education received through CIT training and the perceptions of public mental health stigma, self-stigma of mental health, and attitudes toward seeking mental health services. The study compared the scores of CIT-trained officers and non-CIT-trained officers on the AMI, SSOSH, and IASMHS. Statistical analysis determined that public stigma, self-stigma, and attitudes toward seeking mental health services did not differ between CIT-trained and non-CIT-trained officers. In Chapter 5, I will provide a more in-depth discussion of the findings of this research as well as a comparison to other studies. I will also suggest future research directions, discuss the limitations of this study, describe implications for positive social change, and provide a conclusion for this research.

## Chapter 5: Discussion, Conclusions, and Recommendations

### **Introduction**

This research was designed to gain insight into the relationship between the mental health education received through CIT training and public stigma, self-stigma, and attitudes toward seeking mental health services among law enforcement officers. The study took a quantitative nonexperimental correlational approach to assessing group differences between the three criteria variables. Chapter 5 addresses research findings and how these relate to relevant studies from the literature. In addition, the limitations of the findings, a discussion of future directions, implications for social change, and conclusions are presented.

### **Interpretation of the Findings**

This study sought to understand if there were group differences in perceptions of public stigma, self-stigma, and attitudes toward seeking mental health treatment among CIT-trained law enforcement officers versus non-CIT-trained law enforcement officers. Based on previous research findings showing a reduction in public stigma following CIT training, I expected to find a reduction in public stigma and a reduction in self-stigma (Bohora et al., 2008). However, this research was unable to find a statistically significant difference between CIT-trained officers and non-CIT-trained officers on any of the three criterion variables (see Table 1).

Public mental health stigma has been a main topic of research when measuring the efficacy of CIT training, as one of the goals of CIT training is to improve the interactions between those with mental illness and law enforcement officers. Bonfine et

al. (2014) and Tully and Smith (2015) reported following mental health education, law enforcement officers were more comfortable, empathetic, and effective in their interactions with persons with mental illness. Tully and Smith went on to discuss that law enforcement officers reported having a greater understanding of behaviors, challenges of mental illness, and the lived experiences of those with mental health issues. Ritter et al. (2010) discussed that CIT training addressed common stereotypes that are linked to having stigmatizing effects. The knowledge gained through CIT training regarding mental health or illness causation has been found to increase positive attitudes and beliefs (Demir et al., 2009). This research base provided support for the assumption that the present study would yield similar findings on public stigma. It was a surprise that the trend did not lead this way, which may have been due to the limitations, such as low sample size numbers, that this study faced.

During data collection for this research, the United States was in a very unique time. The Covid-19 pandemic had just begun, along with the social unrest stemming from the murder of George Floyd by a police officer (Mehdizadeh & Kamkar, 2020). Police officers were faced with long shifts while dealing with riots and protests. Officers were also asked to take on the role of enforcing COVID-19 mitigations in communities across the United States (Mehdizadeh & Kamkar, 2020). These extended duties placed unusual stress on law enforcement officers. These factors are what likely contributed to the small sample size achieved. Based on a G\*power analysis, I planned to use 162 participants for this research. However, I had a sample size of just 48 with an exclusion of five, leaving

43 viable participants. However, further analysis of the current data trend showed that even with the full sample size, the findings would still have been nonsignificant.

Self-stigma had been less studied in relation to CIT training. Fleischman et al. (2018) stated that officers reported being more comfortable talking to other officers about mental health issues following CIT training. It was also stated that CIT-trained officers were more comfortable referring other law enforcement officers to mental health services. In the discussion of the gap in research, it was stated that it was not known whether this was a significant change from non-CIT-trained officers. However, it was posited that the change would occur as research had shown a change in public stigma and a more comfortable feeling regarding mental illness. It was the assumption that the attributes of the police culture had such an influence that the ability to change self-stigma or the attitude toward seeking mental health services would require more education and exposure than changing public stigma attitudes would.

Police culture is a longstanding culture built on the principle that strength, both mentally and physically, comes first. The police culture is made up of a bond among officers that they use to feel safe and protected by one another (Wester et al., 2010). Mental strength is an important aspect of that bond, as it determines whether another officer can back them up in life-or-death situations. Admitting that one is having a hard time dealing with an incident or is experiencing some form of mental distress is saying that one may be unstable when the time comes to save another officer's life. Goffman's stigma theory indicates that stigma is attached to something that is outside the norm of the group. It is the normal of the police culture to be strong and to pretend that one is



dealing with issues well as to stay within the norms of the group and not face consequences for varying from those norms (Woody, 2005). Therefore, an officer might not admit to having issues with mental distress if they did not want to face the negative consequences that would subsequently come with the admission. According to Goffman's stigma theory, the way to change the stigma attached to a particular belief or thing is to change the groupthink (Cranevale, 2007). It is possible that any change made by CIT training would not be able to last, as officers would adjust to the group norm that places a heavy stigma on mental illness and seeking mental health services.

The finding of no statistically significant change in mental health stigma and attitudes toward seeking services is in line with a qualitative study by Lyons et al. (2009). Lyons et al. (2009) found that efforts to change mental health stigma between 1997 and 2007/2008 produced few results. Cryer et al. (2018) offered the explanation that the amount of stigma attached to mental illness is related to the perceived level of controllability. Mental health issues, such as depression or trauma-related disorders, have a perceived higher level of controllability. For example, there is a common perception that people can just snap out of depression on their own. The perception is that the individual has decided to remain in a depressive state (e.g., sleeping all day, not taking care of oneself, not eating much or overeating, or feeling sad). Conversely, disorders such as schizophrenia are thought to have lower levels of controllability. Symptoms of schizophrenia, such as auditory or visual hallucinations, are not perceived to be controllable by the individual. Therefore, there is less stigma attached to seeking help for this mental illness (Cryer et al., 2018). This may account for the nonsignificant change

that I found among perceptions of public stigma, self-stigma, and attitudes toward seeking mental health services. Police culture embodies the attitude of strength, both physical and mental, as well as the ability to control the situation that one is in. Therefore, mental health issues or distress from work or life events would be perceived as being controllable.

### **Analysis Related to the Theoretical Framework**

This research drew on the theoretical lens of GRC theory and Goffman's stigma theory. It was posited that, in line with Goffman's stigma theory, if aspects of police culture such as the machismo attitude (Wester et al., 2010); expectancy of mental, emotional, and physical strength (Woody, 2005); and inclusive group cohesion (Karaffa & Koch, 2016), could be changed to include normalizing talking about mental health issues or seeking mental health services. Then, the behavior of talking about mental health issues or seeking mental health services would not be deviant and stigma would decrease. While group differences were expected in the level of public and self-stigma, and positive attitudes toward seeking mental health services, the findings of no significance were also in line with the theories posed. This had meaning because Goffman's stigma theory only allows for acceptance or change of thinking by a group on a subject when it becomes the group norm (Cranevale, 2007). If no differences between groups were found, then it would mean that the mental health education received through CIT training was not sufficient to produce a change in the group norm thinking.

The police culture and the idea of gender roles are very strong and have a long history. The police culture and group cohesiveness are considered a needed bond for

survival (Woody, 2005). GRC theory also addresses the need for the machismo attitude as a protective measure (Wester et al., 2010). Those who are outliers experience negative consequences within the workplace or may be ostracized. The groupthink attitude pressures outliers into conforming and changing their beliefs (Karaffa & Koch, 2016). Police culture would then have to be greatly affected by mental health education as to change the group norm and produce positive change.

Based on my findings, CIT training was not enough to change the attitudes of law enforcement officers toward a more positive view of seeking mental health services. With many departments only training portions of their department, a change in the overall groupthink would be improbable. However, there is the possibility that with complete departments receiving mental health education training such as CIT training, with time, the normalized group position on mental health issues might be able to change based on Goffman's stigma theory (Cranevale, 2007).

### **Limitations of the Study**

It was anticipated that the primary limitation of this study would be obtaining an adequate sample. It is possible that some departments represented in the sample did not have as much interaction with or had a lower volume of mental health crisis calls than a larger, more urban department would. The frequency of mental health calls or interactions with those with mental illness may help to normalize mental illness, whereas lack of contact may keep stigmas in place. Probably the biggest limitation of this study was the small sample size. It was not anticipated that the sample size would be small due to a worldwide pandemic and social unrest in the United States. These types of factors are

extraordinary and nearly impossible to predict. The decision to close data collection after 6 months, having only reached 48 participants—114 participants shy of the anticipated number needed to achieve power as estimated by a G\*power analysis—was made because these two factors were ongoing and further G\*power analysis showed that based on the current sample, 1,268 participants would be needed to find any significant differences between groups. The small sample size was a significant limitation because it reduced the ability to generalize the findings to the research population.

Another limitation of the study was the nature of the study itself. This research was conducted using the self-report survey method. While we encouraged participants to complete this study in a place where they felt comfortable, the responses still relied on a self-report. There may have been concerns of true anonymity, in that participants may have believed that somehow their feelings would be shared with others they might know. Self-report also allows for the limitation of individual subjective interpretation (Frankfort-Nachmais, 2008). The possibility that a participant overinterprets a question's meaning is present with questionnaires such as this. Overinterpretations can lead to a different response than if one took the question at face value.

### **Recommendations for Future Research**

The focus of this research was to understand the relationship between mental health education received through CIT training and public stigma, self-stigma, and attitudes toward seeking mental health services in law enforcement. This study only focused on the mental health education received in CIT training. Future research could measure the effect of different types of mental health education programs and their

impact on public stigma, self-stigma, and attitudes toward seeking mental health services. Future research could also compare mental health education programs to determine if one type of program had a greater effect.

Another approach for future research could take the test–retest route. A researcher could follow a class of officers before CIT training and following CIT training, then again at different points after applying that training in the field. This would provide a baseline of stigma for the officers and be able to measure whether there was an immediate difference and/or if that changed over time. Incorporating the number of mental-health-related calls that an officer receives may be influential in understanding the relationship of stigma and mental health education.

Another approach for future research would be to compare law enforcement agencies that respond to higher number of mental health calls to those with a lesser number of mental-health-related calls. Greater exposure to those with mental illness may increase comfortability, an aspect of stigma, thereby reducing the stigma. CIT training may have more of an effect on stigma when the education and training are followed by exposure.

The approach of future research could also be changed. While this research took a quantitative approach led by the research questions, future research could take a qualitative approach to identify variables that changed officers' perceptions of public stigma and self-stigma and their attitudes toward seeking services. Qualitative research allows for a more open-ended approach to exploring and identifying possible variables.

Another approach for future research could involve a record review of officers who have sought mental health services. The analysis would focus on where they received any type of mental health education, type of mental health education, and their readiness for/acceptance of treatment. This would solely compare those who sought treatment and possibly determine a stand-out factor that led them to that action.

### **Implications for Social Change**

The goal of this research was to better understand the relationship of mental health education received through CIT training and public stigma, self-stigma, and attitudes toward seeking mental health services. Law enforcement officers are tasked with protecting public safety, putting themselves in harm's way, and being exposed to horrific crime scenes or events. As a society and among the police culture, law enforcement officers are expected to be exposed to these events all while remaining mentally and emotionally unharmed. This research was conducted to help identify whether CIT training could lead to a difference in attitudes toward a more positive view of seeking mental health services. This research further opens the opportunity to explore other factors that could influence the training of law enforcement officers and the acceptability of mental health issues.

As has been seen in the United States more overtly over the last few years, the relationships between some communities and police officers are significantly disgruntled. Social unrest has occurred as a result of real and perceived mishandled situations involving members of the community and law enforcement. These types of incidents were the reason for the development of CIT training. The movement of

deinstitutionalization led to the criminalization of and discrimination against those with mental illness (Fakhoury & Priebe, 2007). This research and the future directions could contribute to better relationships between the community and those with mental illness through improving the mental health of law enforcement officers. Law enforcement officers who are experiencing less emotional and mental distress are better able to respond to intense situations, have increased decision-making capability, experience less of the “burnout” feeling, and can engage with the community in a positive manner (Karaffa & Koch, 2016).

### **Conclusion**

In conclusion, this study, which originated from interest in the rising suicide rates among law enforcement officers and what factors prevented them from seeking mental health services, resulted in statistically nonsignificant findings. This finding acknowledges the small sample size as a primary limitation, and analysis recognizes that this research on a much larger scale may produce results more generalizable to the law enforcement population.

While the literature recognizes mental health stigma as one of the five main factors in avoiding mental health services (Vogel et al., 2006), this research found that there are no differences between law enforcement officers receiving CIT training and those not receiving that training in perceptions of public or self-stigma, or attitudes toward seeking mental health services. It is recognized that the ideals of the police culture such as mental, emotional, and physical strength and the supportive bond necessary for survival in the line of duty control the variable of stigma. These ideals produce and

maintain the group norm adequately enough that CIT training is not enough to produce change in stigma or attitudes toward seeking mental health services among law enforcement. It is my hope that this study's findings will guide future researchers in identifying methods of changing perceptions and attitudes among law enforcement toward the acceptability of the use of mental health services.



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## Appendix A: Survey

Background:

1) Gender?

Male                      Female

2) Age?

3) Race?

White/Caucasian                      African-American/Black                      Hispanic  
 Asian                      Native American                      Mixed race                      Other

4) Number of years in law enforcement?

1-5                      6-10                      11-15                      16-20                      21+

5) Have you received Crisis Intervention Team (CIT) training?

Yes                      No

5a) If so, how many years has it been since you received CIT training?

\*Sample scales.

Attitudes to Mental Illness Questionnaire (AMI) (Singh, Baxter, Standen, & Duggan, 1998)

Items are rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree).

1. People with mental illness, generally speaking, are difficult to like
2. The mentally ill should be discouraged from marrying
3. Violence mostly results from mental illness
4. Those with a psychiatric history should never be given a job with responsibility
5. Psychiatric diagnoses stigmatize people and should not be used
6. Mental illnesses are wrongly diagnosed in women and ethnic minorities

7. Those who attempt suicide leaving them with serious liver damage should not be given transplants
8. Psychiatric drugs are mostly used to control disruptive behavior
9. ECT should be banned
10. People who take an overdose are in need of compassionate treatment
11. Psychiatric drugs do more harm than good
12. Depression occurs in people with a weak personality
13. Mental illness is the result of adverse social circumstances
14. Alcohol abusers have no self-control
15. Mental illnesses are genetic in origin
16. People who had good parenting as children rarely suffer from mental illness
17. Care in the community for the mentally ill puts society at risk
18. It is preferable that the mentally ill live independently rather than in hospital
19. Not enough is being done for the care of the mentally ill
20. People with chronic schizophrenia are incapable of looking after themselves

Self-Stigma of Seeking Help Scale (SSOHS) (Vogel, et al, 2006)

Items are rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree)

1. I would feel inadequate if I went to a therapist for psychological help.
2. My self-confidence would NOT be threatened if I sought professional help.
3. Seeking psychological help would make me feel less intelligent.
4. My self-esteem would increase if I talked to a therapist.
5. My view of myself would not change just because I made the choice to see a therapist.
6. It would make me feel inferior to ask a therapist for help.
7. I would feel okay about myself if I made the choice to seek professional help.
8. If I went to a therapist, I would be less satisfied with myself.
9. My self-confidence would remain the same if I sought help for a problem I could not solve.

10. I would feel worse about myself if I could not solve my own problems.

Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS)

(Mackenzie, et al., 2004. As cited by, McClure, 2010)

The term professional refers to individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers, and family physicians). The term psychological problems refers to reasons one might visit a professional. Similar terms include mental health concerns, emotional problems, mental troubles, and personal difficulties.

For each item, indicate whether you disagree (0), somewhat disagree (1), are undecided (2), somewhat agree (3), or agree (4):

Disagree Agree

1. There are certain problems which should not be discussed outside of one's immediate family.
2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.
3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.
4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.
5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional.
6. Having been mentally ill carries with it a burden of shame.
7. It is probably best not to know everything about oneself.
8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.
9. People should work out their own problems; getting professional help should be a last resort.
10. If I were to experience psychological problems, I could get professional help if I wanted to.

11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.
12. Psychological problems, like many things, tend to work out by themselves.
13. It would be relatively easy for me to find the time to see a professional for psychological problems.
14. There are experiences in my life I would not discuss with anyone.
15. I would want to get professional help if I were worried or upset for a long period of time.
16. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it.
17. Having been diagnosed with a mental disorder is a blot on a person's life.
18. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears without resorting to professional help.
19. If I believed I were having a mental breakdown, my first inclination would be to get professional attention.
20. I would feel uneasy going to a professional because of what some people would think.
21. People with strong characters can get over psychological problems by themselves and would have little need for professional help.
22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.
23. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up."
24. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems.

Note. No permission is required to use this inventory.

## Appendix B: Scale Permissions

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