Merrimack College
Merrimack ScholarWorks

Criminology Student Work | Criminology

Spring 2021

Carrying Trauma from Birth to Work: Adverse Childhood Experiences in Law Enforcement Officers and their Implications

Stephen Levesque

Follow this and additional works at: https://scholarworks.merrimack.edu/crm_studentpub

 Part of the Law Enforcement and Corrections Commons, and the Mental and Social Health Commons

Carrying Trauma from Birth to Work:
Adverse Childhood Experiences in Law Enforcement Officers and their Implications

Stephen Levesque
Master of Science in Criminology & Criminal Justice
Merrimack College
May 2021

Abstract

Previous research has drawn attention to the discrepancies of mental health between civilians and sworn law enforcement officers. The extant literature shows that law enforcement officers suffer from mental health disorders at far greater rates than the general public (Henderson et al., 2015). Most of the literature focuses on the progression of an officer's law enforcement career. Little is discussed about prior traumatic experiences in the lives of police officers, especially those experiences which leave lasting scars on officers who go on to possibly relive their own trauma through their work. The current research was intended to fill that void. By looking at prior history of trauma in police officers, the research was to examine adverse childhood experiences in those officers to attempt to help explain the mental health crisis in American police officers. In using the generally accepted Adverse Childhood Experience questionnaire, the research was intended to quantify the mental health issues that officers enter into the profession with, and possibly explain the egregious levels of officer suicide, as well as other negative outcomes. Although the research was unable to be completed as designed, implications are discussed, as well as reasons why the research could not be conducted. From this, discussions regarding preventative treatment occur, including the revamping of mental health screenings of incoming cadets. Strain theory's importation model is applied to police officer's experiences. Additional policy implications and directions for future research are discussed.

Carrying Trauma from Birth to Work: Adverse Childhood Experiences in Law Enforcement Officers and their Implications

Policing in the United States is a hot-button topic in these current times, with constant media reports of excessive use of force and officer suicides. It is evident that an in-depth analysis into policing is needed to try and curb these negative outcomes that seem to be so pervasive in policing. One topic of merit focuses on police officers' mental health, given the grueling and traumatic nature of the job. Police officers are generally the first, first-responders on the scene of any incident, and are forced to see things and work around things that most people never see.

Although the compounding effects of this trauma may contribute to the epidemic of police officer suicides and mental health problems, there are other contributing factors which may have a correlation with these issues. Adverse Childhood Experiences, a globally recognized contributor to mental health problems in adults and children, could also be present in these officers who exhibit such mental health problems that may lead them to suicide, excessive use force, and other negative outcomes. Much research has been done correlating Adverse Childhood Experiences to negative mental health outcomes in individuals over their life course, and, additionally, much research has been done into which factors contribute to higher rates of mental health issues in police officers compared to the general public. However, no research has examined both of these issues seeking a connection between the two. No research has ever looked into what officers *enter into the job with*... until now.

In the following pages, a detailed review of literature highlights what previous research has shown as the implications of Adverse Childhood Experiences in individuals throughout their lives. Additionally, numerous studies are reviewed which discuss the epidemic of mental health problems in law enforcement officers and their effects on the officers as well as those they serve.

The original purpose of this work was to conduct a quantitative study on Adverse Childhood Experiences in law enforcement officers, and to see whether or not officers with higher Adverse Childhood Experience scores are less likely to achieve rank and have higher Adverse Childhood Experience scores than the general population. Although this study could not be completed, below is an in-depth discussion on the proposed study as well as its implications. The application of importation vs. deprivation theories are explored at length, as well as practical implications of the hypothesized results as it relates to police hiring, retention, use of force, and other police performance outcomes.

Although the study was not completed, the implications of the prospective data cannot be overstated. The purpose of this paper is to detail the prospective study and hopefully leave a roadmap for future research into this extremely important topic. I hope that the following discussion and literature review will not only show just how important the implications are for both the officers and the community, but also pave the way for future research into this new perspective of police officer mental health.

Literature Review

Mental Health in Police Officers

Previous literature has done much to explore the severe and marked differences in mental health deficiencies in police officers (Henderson et al., 2015; Martin & Martin 2017). Much discussion has taken place of the implications of these mental health deficiencies in officers. These issues can have negative effects on not only the personal life of the individual officers, but also on the officer's work performance. Shift work, the high degree of danger, and multiple other factors contribute to the toll the job takes on all officers.

Taking a quantitative approach to police officer's mental health is extremely difficult, however, and the vast rates of under-reporting of different mental illnesses can be assumed to be great. This has been a lightly discussed topic in research, as it directly affects the possibility of valid data. A general veil of silence around mental health is exacerbated by the macho-persona of American law enforcement creating a code of silence that is not easily broken.

However, as Martin and Martin (2017) point out, mental health issues should be lower in law enforcement officers than the average population, given the extensive mental health screening they must pass in order to enter the profession. Therefore, the commonly accepted notion that mental health issues within law enforcement come from (and only come from) the experiences these officers encounter on the job. However, the hypotheses as laid out above may provide a contrary explanation.

The hard facts of law enforcement mental health are clear and marked. In a presentation at the Anxiety and Depression Conference in Miami, Florida in 2015, Henderson et al. (2015) presented a complete and stunning summation of the crisis law enforcement officers face with their own mental health. Henderson and colleagues (2015) report the following:

- 75% divorce rate compared to 50% rate among average citizens.
- 25% alcohol dependence rate.
- 2-4 times more likely to commit domestic violence.
- 2 times the rate of depression.
- Suicide rates of 16.4-18.1 per 100,000 officers.
- 8-11 year shorter life expectancy.
- 80% of officers considered overweight.
- 25 times more likely to die of heart disease.

These statistics not only show severe and dangerous mental health deficiencies but also physical health maladies as well. Therefore, there is not only an epidemic of poor mental health in law

enforcement officers as shown by research, but consistent combinations of both mental *and* physical health concerns.

These results are also similar to those found by Martin and Martin (2017) who studied police suicide exclusively. Again, pointing to the assumption that law enforcement officers should be more mentally healthy due to screening, the suicide rate for law enforcement officers is between 14-17 per 100,000 officers compared to the national average of 13 per 100,000 population. Broken down, this leads to between approximately 125-150 officer suicides per year, or over 10 per month. Although this number seems relatively small, the rates are still highly elevated from the national average, especially in a workforce defined by mental toughness. Martin and Martin (2017) further go on to report that retired law enforcement officers are over 10 times as likely to commit suicide after retirement than the average citizen, and that law enforcement suicides are committed 91% of the time by firearm. Although this may open up the discussion of access to firearms leading to a higher suicide rate overall, these numbers cannot just be used to discuss means versus motives.

There is much in the way of disagreement among academics, scholars, and public health officials when discussing rates of suicide among both law enforcement officers and the general population. Perin (2007) reports that 2004 data from the National P.O.L.I.C.E. Suicide Foundation shows approximately 447 law enforcement officers committed suicide that year, or roughly one officer committing suicide every 17 hours. Seeing the great variation between the numbers reported by Martin and Martin (2017) and Perin (2007), a discussion should be had regarding the accuracy of these numbers. Certain investigative methods by police departments in investigating potential officer suicides might differ from those done on the general population,

notes Perin (2007). Therefore, a fully accurate number is hard to quantify, but many will agree that even a single suicide is too many, and preventative policies should be implemented.

Further, officers have long been known to suffer from post-traumatic stress disorder (PTSD) and post-traumatic stress symptoms at higher rates than the average population. Foley and Massey (2019, p. 24) note that "the issue of PTSD is particularly pertinent to policing as the role of a police officer differs from most other occupations, as the nature of their work means that they are likely to be exposed to multiple sudden and unexpected potentially traumatic events (PTEs) within their career." These PTEs, they go on to say, result in a 15% rate of PTSD in American police officers, compared to the general population's rate of 7.8%; nearly half.

These stressors do not just come from PTEs however, as researchers Gershon, Barocas, Canton, Li, and Vlahov (2009) studied 1072 metropolitan police officers to determine what were the greatest stressors: institutional, personal, or work-experienced. Of the officers surveyed, each was asked about police stressors (traumatic experiences on the job), work stressors (how they felt while at work), and adverse outcomes (coping mechanisms for stress). Contrary to notions put forward like those by Foley and Massey (2019) indicating critical stress incidents lead to the stressors, Gershon et al. (2009) found that the highest levels of stress came from reported levels of depression and work stress. Of the respondents in their study, 84% reported being tired at work, 70% irritable at work, and 54% reported being depressed at work. Of those who reported they were constantly and highly stressed at work, 70.6% reported depression, 60.4% reported alcoholism, and 69.2% reported high levels of aggression. Therefore, Gershon and colleagues (2009) posit that critical stress incidents merely compound organizational and work stressors, which make up the bulk of the stressor's officers face. Given that these are stressors which can

be aggravated by, or are indicative of, mental health disorders, the notion that outside forces and events explain an officer's mental health issues come into question.

Sleep patterns in police officers was the focus of the 2011 study by Rajerantnam et al. (2011), where the researchers studied the varying level of sleep disorders found in 4,957 law enforcement officers. Although possible reasons for sleep disorders have been discussed above, including shift work and overtime, the results from the study show sleep disorders at almost endemic levels. Rajerantnam et al. (2011) found that of all officers surveyed, 40.4% screened positive for some type of sleep disorder. Even more frightening, Rajerantnam and colleagues (2011) found that 26.1% of officers surveyed stated they had fallen asleep behind the wheel at least one time in the last month. The implications of this are serious, as officers spend a majority of their day in a vehicle and are often driving at greater speeds and performing maneuvers that an average citizen, fully rested, do not perform. In addition, recent years have shown an uptick in police officer ambushes, and those officers who succumb to extreme weariness and fall asleep in their cars are easy prey for such actions.

It is clear from past research that police officers clearly exhibit marked differences in rates of mental and physical health than the average citizens. Officers are more likely to commit suicide and exhibit rates of depression, cardiac issues, and sleep disorders (Martin and Martin 2017; Perin 2007; Henderson et al. 2015; Rajerantnam et al. 2001). But many researchers disagree as to what causes this extreme increase. Whether these rates are increased due to cumulative critical incidents (Foley & Massey, 2019) or stressors both on the job and off (Gershon et al., 2009), there is little agreement in academia on the true cause of this. However, almost all research has almost exclusively focused on issues which come about *from* the job, and not those which officers *come into* the job with. Prior trauma before entering into the police force

may account for more than work stressors or critical incidents, however, this has not been studied. Therefore, a comprehensive look into Adverse Childhood Experiences is necessary for the understanding of this research, and the possible links to police officer mental health issues.

Adverse Childhood Experiences and Their Effects

Adverse Childhood Experiences, also known as ACEs, are described by the Centers for Disease Control (2019) as,

> "potentially traumatic events that occur in childhood (0-17 years) such as experiencing violence, abuse, or neglect; witnessing violence in the home; and having a family member attempt or die by suicide. Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding such as growing up in a household with substance misuse, mental health problems, or instability due to parental separation or incarceration of a parent, sibling, or other member of the household."

These experiences, per the CDC (2019) have numerous negative mental and physical health effects on individuals, which can leave the individual predisposed to a number of mental and physical health issues described above. The general format of reporting ACEs is a questionnaire in which the respondent answers (in its most basic form) yes or no to items identified in the above quotation, with each yes being one reported ACE.

The first research ever completed looking at ACEs and their effects on individuals, and arguably the most complete, was performed by Felitti et al. (1998). Researchers mailed an ACE questionnaire to 9,508 adults who had just completed a physical examination with their primary care physician. Of these respondents, 52.1% reported at least one ACE, with household substance abuse (25.6%) and sexual abuse (22%) as the highest reported ACEs. Felitti et al. (1998) also reported that individuals with 4 or more reported ACEs, as compared to those with no reported ACEs, were:

- 12.2 times more likely to have attempted suicide.
- 4.6 times more likely to suffer from depression for two or more weeks during the past year.
- 7.4 times more likely to be an alcoholic.
- 4.7 times more likely to abuse drugs (and 10.3 times more likely to inject drugs).
- 2.2 times more likely to smoke tobacco.
- 2.2 times more likely to develop heart disease.

These findings by Felitti and colleagues (1998) were the first to correlate higher levels of ACEs with both physical as well as psychological maladies. The researchers also found that reported levels of illnesses were graduated; the higher the number of ACEs reported, the higher the likelihood of developing mental and physical illnesses.

Similar to the findings of Felitti et al. (1998), modern research has shown strong correlation of ACEs to mental and physical illnesses. In a study of Iowans by Downey et al. (2017), researchers focused on health risks as they correlate to ACEs. Of all respondents, 58% reported at least one ACE, with emotional abuse topping the chart at 35%. Downey et al. (2017) also reported that if an individual reported the ACE physical abuse, 68% also reported another ACE. Much like Felitti et al. (1998), Downey, Godmunson, Pang and Lee (2017) used the '4 or more' ACE bar as their highest echelon of abuse, and reported that those falling into this category:

- 3.5 times more likely to smoke tobacco than someone reporting no ACEs.
- 3.2 times more likely to be clinically depressed than someone reporting no ACEs.
- 2.8 times more likely to experience heart disease or have a stroke than someone reporting no ACEs.
- 3.8 times more likely to develop some type of respiratory ailment like COPD and chronic bronchitis than someone with no ACEs.
- 2.1 times more likely to develop diabetes than someone reporting no ACEs.

However, Downey and colleagues (2017) reported that respondents reported ACEs and health risks resulted in a bell-curve. This showed that those who reported 2-3 ACEs most consistently showed 2-3 health risks. This could be due to the fact that a lower number of individuals reported 4 or more ACEs, however it also did show that the group which reported the lowest number of health risks were those who experienced no ACEs.

Anda et al (2004) studied the correlation between ACEs and performance at work. Of 9,633 employed adults surveyed for ACEs, respondents were also asked to report job problems, financial problems, absenteeism, and health and wellbeing. Of those who reported the emotional abuse ACE, those individuals were 2.1 times more likely to have job problems, 1.8 times more likely to have financial problems, and 1.9 times more likely to show levels of absenteeism than those reporting no ACEs. Although these numbers may be alarming, Anda et al (2004) reported that for those individuals that reported more than 4 ACEs, they were 3.22 times more likely to report poor health and wellbeing than those who did not report any ACEs. Anda and colleagues (2004) discussed the implications of job problems and absenteeism as they apply to that individuals' job prospects, as well as its costs to the company that individual works for. Companies will lose productivity and will also lose money, as they have to pay for someone to fill that individuals' slot when they are absent. If the company does not pay for time off, that may contribute to an individual's reporting of financial problems.

In an attempt to aggregate ACE scores among US children, and stratify them by demographics, Crouch, Probst, Radcliff, Bennet and McKinney (2019) conducted surveys of 46,635 households in order to define trends in special populations most likely to report ACEs. Four ACEs in particular were focused on: parental divorce, economic hardship, exposure to violence, and living in a disruptive household. Researchers also asked for demographic

information, including poverty, age, race, parental living arrangements, health care needs, parental education, and primary language spoken. Crouch et al. (2019) found that the highest reported ACEs were economic hardship (22.5%) and parental divorce (21.9%). The researchers further found several demographic predictors for ACEs: age 13-17, special healthcare needed, family structure (whether two parents divorced, single parent, or living with someone other than parent), and living below the federal poverty line, all had high statistical significance when it came to almost all ACEs measured. However, having a special medical condition, poverty, and living arrangements were most predictive of all four ACEs measured. This creates an archetype of an individual most likely to experience high levels of ACEs: those individuals who grew up in a poor, single parent or no parent household who also suffers from a medical condition.

Critiques of ACE studies have also been discussed, mainly critiquing the notion that individuals who have mental health issues are more likely to report or even remember ACEs from their past. This was the main hypothesis of a study by Frampton et al. (2018), who believed that individuals suffering from depression are more likely to focus on, and therefore remember and report, ACEs from their childhood. They further argued that because 20% of American's suffer from clinical depression, those individuals are more likely to report a new ACE once they develop depression and therefore skew data.

However, from their sample of 284 Canadian adults, Frampton, Poolea, Dobsona and Puschb (2018) reported no net change in those individuals who develop depression and then report ACEs. Therefore, their hypothesis that depression begets more ACEs simply because the individual focuses on their ACEs more was disproven. Frampton et al. (2018) further reported that those who reported depression *consistently* reported higher ACE scores than their mentally healthy counterparts.

Dube (2018) also discussed critiques on ACEs and their applications, mainly those having to do with public perception of their validity to correlate upbringing and mental health. Citing much of the above research, Dube (2018) posits that validity has been established, and rather the pushback to the utilization of ACE studies has been public perception. He discusses the US Army's near adoption of utilizing ACE questionnaires during the recruitment process. In 2005, the US Army investigated the possibility of using ACE questionnaires in order to flesh out those not mentally suited for the Army. Although the validity of these questionnaires was agreed upon, the idea received significant pushback by officials. Because officials believed the questions to be extremely private, they believed recruits would not be comfortable answering the questions and would be deterred from service.

Due to the resounding similarities between the military and American law enforcement (para-military design, rank structure, use of violence, etc.), it can be argued that the reasons Dube (2018) reported the US Army did not wish to use ACE questionnaires in recruitment could be similar to the reasons why this researcher's hypothesis has never been tested. Given that ACEs are a clear barometer for mental and physical health in adults, it should be used as a gauge as to whether a police officer's mental health issues can be explained by past trauma. However, only one piece of research has ever broached the subject.

Psychophysiological Impacts of Childhood Trauma in Police Cadets

In the only ever attempt at measuring prior trauma in police officers, Pole et al. (2007) sought to determine the effects of childhood trauma on officers' psychophysiological responses to being startled. Researchers hooked 90 police cadets with no reported mental illnesses to a machine which would measure their psychophysiological responses to being startled. Of those 90 cadets, they were separated into two groups: one which reported one or more incidents of

childhood trauma (not utilizing the ACE questionnaire), and one which reported no childhood trauma. Once attached to the measurement device, these cadets were then subjected to a test where they were exposed to three different levels of threat. First, the low threat test, where the cadet was exposed to a noise which would startle them. Second, the cadet would be hooked up to a machine that would shock them but told they would not be shocked, and then were exposed to the same noise. Last, the high threat exposure where they would be exposed to both a noise and shock.

Pole et al. (2007) found that those cadets who had reported childhood trauma had exhibited higher psychophysiological indicators of stress through each of the threat stages than the group which did not report childhood trauma. This supports the idea that individuals who have a history of childhood trauma will react more negatively to negative (i.e. threatening) stimuli than individuals who did not. However, this study does not attempt to discuss any mental health issues between the two groups, given that the researchers controlled for previous mental illness by screening out individuals who tested positive for it.

This is the only study which attempted to discuss childhood trauma in officers. However, Pole et al.'s (2007) aim was to discuss psychophysiological responses to negative stimuli in police cadets with a history of childhood trauma. The research excluded any indication of mental health issues in order to stratify the two groups by past childhood trauma and control for all else. The study also used police cadets rather than police officers, also mitigating line of duty critical incidents, given that the cadets have yet to experience the job. Pole and colleagues' (2007) research has implications regarding work performance, and those individuals with childhood trauma may go on to develop mental health issues through the course of their work, however as this was not the purpose of the research, it was not discussed.

Need for The Proposed Research

That is why the proposed research is necessary. No one has ever researched the correlation between ACEs and police officer's mental health. As has clearly been established by the literature reviewed above, police officers have higher rates of multiple mental and physical health issues compared to the general population. And as seen in previous research, most of the mental and physical health issues that are observed in police officers are the same as those found in individuals who report higher levels of ACEs than the general population.

Whether individuals who enter into law enforcement develop these mental and physical health issues over time, or whether they come into the profession with ACE levels higher than the general population, is something which has never been studied. Thus, the current research would have attempted to bridge the divide between two major issues: the mental health epidemic in law enforcement and a possible contributing factor, Adverse Childhood Experiences.

The Study

The purpose of the study was to determine whether police officers have elevated levels of Adverse Childhood Experiences and if those ACE levels contribute to decreased likelihood of seeking and attaining rank. As the literature detailed above suggests, many of the mental and physical health issues police officers exhibit can be correlated with ACEs. Given that this has never been studied before, this research attempted to come at the issues of police officer mental health from a different angle. Through an-in depth quantitative survey utilizing ACE and demographic questions, the research attempted to answer the question as to whether officers have higher ACE scores than the general public and to glean whether specific age groups or ranks exhibit higher ACE scores than others. Finally, the research also attempted to show whether

higher ACE scores preclude officers from reaching higher ranks, as will be shown through average ACE scores for each rank. Therefore, it is hypothesized that police officers have higher ACE scores, and this can be a facet in the mental health deficiencies in police officers and that police officers who have higher ACE scores are less likely to achieve rank above that of patrolman.

Methodology

Through an anonymous online survey including the ACE test, as well as other demographic information including gender, age, years of service, and rank, the proposed research measures the ACE scores for officers and stratifies their scores into clusters using their demographic information. This survey was to be administered as an online survey, leading to greater anonymity and thus increasing the likelihood of honest and valid answers to these highly sensitive questions.

A simple random sample of municipal police departments in Essex County, MA was used to select the participating municipalities. Of 34 incorporated municipalities in Essex County, 10 municipalities were chosen by simple random sample. Once those ten municipalities were chosen, a request for participation was sent to the Chief of each police department. This request was accompanied by a copy of the survey and an informed consent form, in order for the Chief of Police to make a decision regarding participation. Once those Chiefs of the selected police departments agree to participate in the online survey, each sworn officer in the police department was to be asked to participate via an email link. However, participation was to be fully voluntary and thus response rates may likely vary. Criteria for inclusion included that the respondent must be a sworn law enforcement officer working for the department selected by the simple random sample, whereas law enforcement officers who do not work all year (i.e. Special Police Officers

who only have police powers for part of the year) would not be selected nor allowed to participate.

Comparison data for general ACE scores was to be taken from the Behavioral Risk Factor Surveillance System ACE Dataset, which is a yearly state-based telephone ACE report which to this day has had over 200,000 respondents. The BRFSS Data is representative of 23 states. Although law enforcement officers could be included within this comparison data, given the large number of respondents and the low probability of law enforcement officers making up a significant proportion of these respondents, this dataset would suffice as an adequate comparison.

The primary variables of interest are the ACE score of each respondent, given that the respondent is a police officer, and a multitude of control variables. The ACE score of the respondent (ranked from 0 reported ACEs to the maximum amount of 13) is the independent variable, which may show correlation to lower attained rank (the dependent variable). The rank variable will be measured as such: 1 = Reserve Patrolman, 2 = Patrolman, 3 = Corporal, 4 = Sergeant, 5 = Detective, 6 = Lieutenant, 7 = Captain, 8 = Deputy Chief, 9 = Chief. In the case of two ranks being purported in the last covariate (Det. Sgt.), the higher of the two ranks was to be chosen for coding purposes. The control variables include the respondents age (in years), their gender (1 = male or 2 = female), their race (1 = white, 2 = black, 3 = Hispanic, 4 = Asian or Pacific Islander), their years of service (number of years the respondent has been on the job). As was stated above, BRFSS ACE scores and percentages would be utilized for comparison group data.

The ACE scores as given by respondents were to be calculated using the binary (0 = no and 1= yes) ACE-IQ Test from the World Health Organization. This allows for a general

calculation of ACE scores utilizing a commonly accepted ACE test created by a multinational organization with a history of measuring mental and physical health issues. The ACE portion of the survey was to be taken completely from this WHO ACE-IQ test in order to decrease the possibility of respondent confusion.

The Study Process

As was described briefly earlier, the study failed to be completed during its beginning stages. Originally, only 5 departments were chosen by simple random sampling, and the Chiefs of those departments were sent an email containing a request for participation, the informed consent form, a rough draft of the survey, and an authorization letter required by Merrimack College's Institutional Review Board in order to begin collecting data. Although repeated emails were sent out two more times during a two-week period, no responses were received. Therefore, an additional 5 departments were chosen via simple random sampling. Again, over the span of two weeks three emails were sent to each department's Chief. I received one formal denial, yet the other four failed to respond to my request.

As a last resort, I contacted three departments of which I had a personal relationship with in order to conduct a convenience sample. Although such a convenience sample would lack representativeness and generalizability, this was the only option available at the time. However, I was only able to procure one agency's acceptance to participate in this research. The Chief of this department was extremely willing to participate, and mentioned that he believed the research was of quality and beneficial to the profession as a whole.

Therefore, due to the fact that only one department of roughly 20 members had accepted to participate, the research was put on hold. Given the sensitive nature of the survey, it was expected that only a small percentage of eligible officers would agree to participate, given that

participation on an individual level was fully voluntary and received no compensation for participation. Given that even with 100% participation from this department (which would be extremely unlikely) only 20 participants would not provide enough viable data to demonstrate any correlation of statistical significance.

Why the Study Failed

Although only one Chief shared their reasoning behind their denying participation in the study, common trends in police culture were clearly present and contributed to the lack of participation in the survey. As is common knowledge, the stigma associated with mental health problems precludes many from talking about them; especially when that stigma goes almost completely against the essence of a profession. As noted above, police officers tend to appear emotionally closed off, oftentimes as a coping mechanism for the stressors of the job. To admit to mental health problems or trauma could possibly make them lesser in the eyes of their fellow officers and supervisors. Additionally, admitting childhood trauma is, in general, difficult to discuss and would lead many department Chief's weary that few-to-none of their officers would participate in a survey about childhood trauma.

Another concern which came to light was that individual departments do not want to be implicated with research into mental health. Although it was discussed in detail that all information would be collected anonymously, it was told to me by one Chief that they were extremely hesitant to connect this research with their organization. Clearly, the stigma again came into play. With such a low number of possible agencies participating (at the time of this conversation, there was a possibility of having three agencies participate), this particular Chief believed that due to the low number of participating agencies it would be possible to connect the data back to their department. Although I repeatedly attempted to assuage their concerns, I was

advised that a broader anonymous survey may be a better way to obtain willing participants with greater trust that the information would be collected anonymously with a lesser likelihood that data could be attributed to any one department. I believe that this could be a better way to collect more data that is generalizable to the whole population of police officers, rather than data collected which would be from a smaller geographical area. Additionally, the comparison data which was to be used in the study is from a national source; therefore, a national survey would be more appropriate than one confined to a smaller geographic area with less demographic diversity.

Even though anonymity was a top priority, there is a minimal risk that a participating agency's responses be used against them when the data is published and linked to them. For example, could public perception change towards a certain department by the citizens they serve if it comes to light that officers have experienced childhood trauma? Although it would be wholly unethical to find out without the consent of the participants, stigma against individuals with mental health disorders or traumatic pasts may place departments in a negative light if it is reported that at least some the officers have childhood trauma in their past. Conversely, it may humanize these departments and the officers that work there. It could possibly bridge the divide between victims and officers, knowing that the officer that person is speaking with has also experienced trauma in their lives and have been able to become a productive member of society. If police officers are seen by some as respected in the community, the possibility of humanizing them by showing that they have overcome traumatic pasts may have a positive impact on public perception of the police.

A final consideration as to why the Chiefs of the selected agencies declined to participate in the survey: Do they fear negative perceptions of themselves by their subordinates? If the Chief

of a municipal police department sent out an email requesting officers to participate in a survey on their mental health, there is always the possibility that the officers will feel as if they are being targeted by their commanding officer. And the Chief's willingness to participate may make officers who do not wish to discuss such things feel as though they are being forced into speaking about their childhood trauma. This could cause a drop in morale or a loss of faith in the Chief of Police, which many Chiefs are extremely keen not to lose. So, many Chiefs would not allow 'outsiders' into their department to conduct research, which has been a consistent theme in much criminal justice research. Therefore, it is not unreasonable that the Chiefs did not agree to participate in the study for those reasons.

Implications of Prospective Data

Although the proposed study failed to be completed, the need for the research remains urgent and necessary. As outlined above, the study could shine a light on the numerous mental health issues police officers face in this country. Additionally, what could've come to light through the data could have long lasting implications on hiring practices, treatment, and policing as a whole. As was discussed in the previous sections of this article, the proposed research hypothesized that police officers have higher ACE scores than the general population and that police officers who have higher ACE scores are less likely to achieve rank higher than patrolman. If these hypotheses were to be supported by a correlation from the study's data, the implications could be massive.

First, a correlation between a higher rate of a globally recognized contributor to negative mental health and psychophysical outcomes (ACE's) in law enforcement officers versus the general public would give way to a completely different discussion on police officer's mental health and career longevity. As was previously outlined in the literature review section, this

correlation has never been studied nor even proposed until this current study. Most discussions on officer mental health revolve almost exclusively around on-the-job activities and traumas. Although there are very few who argue that these traumatic instances *do not* influence negative mental health outcomes in officers, the implications of the proposed study could fill a glaring hole in the extant literature. Rather than looking at things that occur *on the job*, the implications of looking at what occurs in an officer's life *before the job* could arguably be equally, if not more, important.

Importation vs. Deprivation: A Correctional Theory Applied to Law Enforcement Officers

Importation and deprivation are two criminological theories generally applied to the correctional system. These two different theories have been seen as either opposing or mutually-contributing factors which are correlated with not only recidivism but also prisoner behavior while incarcerated. Sykes (1958) discussed the deprivation model, wherein he argued that social isolation, frequent contact with violence while in prison, and numerous other pro-criminal factors that exist as a result of *being placed* in a prison are likely to promote recidivism and misconduct in prisons.

On the other hand, importation theory, as it has been applied to prisons (and almost exclusively prisons), argues that recidivism and behavioral issues within/after prison are based on the individual characteristics of those incarcerated which they *bring with them* into prison (Dhami, Ayton, & Loewenstien, 2007). These researchers found that negative, antisocial behaviors pre-incarceration (i.e. unemployment, excessive substance use/abuse, etc.) all had negative correlations with behavior within prison and recidivism. Therefore, it could be argued that those prisoners *brought with them* negative behaviors which amplified the negative effects of incarceration on them. These two theories have yet to be applied to law enforcement officers,

and that seems to be a disservice to the occupation and those who choose to enter into it. Deprivation model applies to the effects of the environment *during*, and importation applies to the *before*. Sound familiar?

Although it is clear that deprivation in prisons can clearly instigate negative outcomes for those incarcerated (much like consistent emotional trauma on law enforcement officers), the importation model has been studied at great length, and important correlations have been established. Numerous studies have been conducted to see whether deprivation or importation models act independently of one another, however this has been found to not be the truth. Both Thomas (1977) and Armour (2012) noted that the individuals suffering from the worst outcomes in prisons are those who not only face the general deprivation effects of incarceration (made worse by enhanced security prisons like SuperMax prisons) but *also* import anti-social and negative psychosocial characteristics. This is further supported by Huey's (2008) research on prison suicide, which showed that prisoners who both imported negative characteristics and suffered the pains of deprivation were more likely to commit suicide in prison than those who came to prison well-adjusted with positive pre-prison attributes.

It could also be argued that deprivation occurs in policing. Shift work, rotating schedules, and a number of other factors have an anti-social effect on police officers, and many will argue that these have pushed them away from friends and family. Police officers often work on the exact opposite schedule as the general public, and yet when they are off duty they are expected to assimilate right back into society as if their world does not run perpendicular to most other people. Many officers can go a month without a weekend day off (without mandatory or voluntary overtime), making it difficult to socialize with others outside policing. This can create an isolating effect on officers, slowly loosening friendships and other relationships the longer the

officer stays in the field. Combining that physical isolation with the unfortunate mental isolation of working an extremely dangerous job which breeds hypervigilance, lack of trust, and a social isolation can make officers *not want to* seek the company of others. This can easily be argued to fulfil all characteristics of deprivation.

Therefore, if the proposed study's hypothesis is shown to be true, then officers additionally import higher ACE scores (and the subsequent negative mental health issues pursuant to them) into their social ecosystem within the police department and within their own lives. If officers bring with them (import) childhood trauma that is globally recognized to be statistically correlated with negative mental health outcomes, then can the importation and deprivation models both be used *concurrently*? Would it not stand to reason that those officers with the highest ACE scores imported, suffering from the deprivation of policing, be at higher risk of suicide than those who are not? Could this help explain the monumentous disparity between the suicide rates of the general population and that of law enforcement officers? This is an additional avenue which could be pursued with the data collected from the current study.

Lastly, it is also interesting when discussing the same theories, deprivation and importation, as they apply to two seemingly opposite groups of people. Police officers and prisoners seem to be antonyms in almost every sense, so it seems interesting that both deprivation and importation affect them both in ways which are arguably similar (data from this research could be used to argue this). Although the dissimilarities between the two groups are marked, prisoners have also served their sentences in 'boot camp'-like correctional institutions which share eerie similarities to police training academies. These types of correctional programs focus on breaking the offender of previous antisocial behaviors through rigid, militaristic type instruction and then reforming them into productive members of society. Through drill and

ceremony, physical training, and rigid instruction, it was believed that these offenders could be reformed and be able to rejoin society with a skillset they would not be able to have gotten in their previous lives.

This is almost exactly what the modern-day police academy is designed to do. Young men and women are brought in from all walks of life and stripped of their identity, trained aggressively, and forced to work as a team for the common good. Through rigorous physical, mental, and academic training, young officers are put through 6 month-plus police academies in order to turn them into the best officers they can be. When viewed side by side with some correctional boot camps, the training regimens are nearly identical. This apparent dichotomy between police and prisoners should not be used to gloss over the fact that there are similarities between the two groups, much like the presence of both importation and deprivation in their lives.

Discussion

The implications of higher ACE scores in police officers have been discussed in detail in the previous section. But what about the proposed study's second hypothesis that higher ACE scores in officers will lead to a lower rank attainment? Although the research would be required to purport any type of positive or negative correlation, it has been noted in research on ACE's that individuals with higher ACE scores have lower educational attainment. Therefore, an inference can be logically drawn that officers that have higher ACE scores *also* may have lower educational attainment.

Although not always often the case, rank increases with education. Years ago, any type of further education past high school was seen by police as overkill, whereas currently there is a cultural shift in law enforcement to push individuals who want to become police officers towards

higher education. Currently, “about one third (30.2 percent) of police officers in the United States have a four-year college degree. A little more than half (51.8 percent) have a two-year degree, while 5.4 percent have a graduate degree” (Gardiner, 2017). Additionally, Gardiner (2017) also detailed in her national report that 32.1% of police chief’s (or organization CEO’s) have graduate degrees, which would account for much of the nation’s total of master’s level officers. Although the data from this study may help to determine whether a correlation exists between ACE’s and rank attainment, it is clear from the above data that a correlation exists between education and rank, thus opening the hypothesis up for further testing and discussion.

Moreover, could requiring educational standards during the hiring process possibly prevent those who have not attained higher education (and therefore are more likely to have higher ACE scores) from entering into the profession? Although many argue that educational standards are racially discriminatory due to the racial disparity in higher education attainment, there has long been a push to get officers degrees past high school. As Gardiner (2017) also points out, police departments which have higher-educated Chiefs are more likely to both require education past high school or an Associate’s degree, as well as employ more educated officers than the national standard. This could be used as a way to recruit more highly educated officers who may have lower ACE’s and a less likelihood of importing negative mental health issues into their professional lives.

On the opposite end of the spectrum, much previous research into juvenile delinquency has shown that delinquency and juvenile aggression is highly correlated with childhood trauma (Kang & Burton, 2013). Therefore, it could be argued that childhood trauma and Adverse Childhood Experiences in officers can contribute to aggression later on in those officers’ careers. This is another avenue of further study, wherein there may be a correlation between officers with

higher ACE scores and those who have higher use of force complaints. In this current climate of the public perception of policing tending towards the negative, where images of police brutality are flashed on television screens daily, this could be a worthwhile investigation into the inner workings of officers and their proclivity towards excessive force. If individuals can be pre-screened for ACE's and a correlation is present, then those individuals could be specifically targeted for intervention before use of force complaints enter their personnel file.

An additional course for further study is to research whether there are ACE's that are more likely to occur *within the household of a law enforcement officer*? As was discussed in the literature review, law enforcement officers have higher rates of mental health issues, suicide, substance abuse, and, in some cases, domestic abuse. Whether these are imported or through trauma on the job, this could create a cycle of ACE's in law enforcement officer households. If a police officer leans on alcohol to cope with the stressors of the job, and drinks so heavily they become abusive to their spouse or children, that then transfers ACE's to *their own children*. Additionally, law enforcement is a family affair; families who live within the 'blue' family are often surrounded by other officers from other families through acquaintances and work friends of the law enforcement officer in their household. And given that law enforcement is often a career path followed by subsequent generations, these cyclical ACE's, passed on by one officer with mental health issues to their children and so on, can become a slippery slope for generations of officers and potential officers.

Policy Implications

Moving forward with what was just discussed, if the study's hypothesis were to be supported, then what do we do? Clearly, initial screenings during the hiring process can be extremely beneficial to not only the organization but to the individual officers themselves. The

organizations will be able to see those potential officers who are more likely to suffer from mental health issues during their career and also select those officers who may be less prone to violence. That is not to say that potential officers with higher ACE scores *cannot* have fulfilling and positive careers, but those officers may need individualized training and counseling throughout their careers to keep them on a positive path.

But, as was described earlier, the Army's imposition of an ACE test during recruitment was met with fierce opposition, as they believed that it would severely impact recruitment numbers. Although both the military and law enforcement both institute certain mental health tests prior to enrollment, there is much room for improvement. Generally, police mental health screenings involve lengthy, 1,000-plus Likert-type questions, combined with an interview with a psychologist. The intent of this exam is to create a profile of a potential recruit's mental health and to make sure that they are of sound mind to enter into the policing profession.

This type of psychological examination is, in its very nature, an exclusionary examination. Those who do not fall into the psychologically 'preferred' category are excluded from consideration and their hiring process is terminated at that very instance. This puts a great deal of emphasis on the test, as well as a great amount of stress on the candidate whilst taking the test. This stress could, logically, skew the results of the exam (whether the written or oral portion) and paint a different picture of the candidate's mental health than is true.

Implementation of an ACE style psychological examination could turn this stage of the hiring process into an *inclusionary* process where data is collected about the recruit and used to help them. Obviously, there are individuals who will fail any psychological examination regardless of type, but ACE tests could be utilized to target officers who may need special assistance through their careers. There is anecdotal evidence that suggests individuals who come

out of drug-infested environments (which would count as one ACE) have more knowledge about the day-to-day narcotics market than many street cops. Using an ACE exam on that individual, police recruiters and trainers could make sure to support that recruit throughout their career so that those ACE's can be used for the betterment of the officer and their career.

Additionally, traditional mental health exams could be suspended in lieu of expanded or multiple oral boards. Generally, the traditional hiring process of a police officer involves a written general knowledge exam, a physical aptitude test, a psychological exam, a medical exam, an oral board, and then an interview with the Chief of Police. With many sectors trying to innovate hiring practices, it may be worthwhile to change those in policing insofar as the introduction of multiple oral boards with different panels of interviewers. If one panel *included* a psychiatrist who could gauge an applicant's responses to questions and help facilitate conversations and questions which will give the interviewers a better glimpse into that applicant's emotions, this may give those organizations a better understanding of their future officers.

It has also been noted that this current generation of individuals are more comfortable speaking about mental health issues and themselves in general. The older generation, those more stoic and less keen on sharing their experiences and feelings, are now retiring in droves. Instead, this newer generation coming into the workforce, and therefore policing, are more likely to be open with hiring agencies asking them about their past experiences and their influence on decision making and the like. Additionally, some could see this as a way to improve their own mental health self-awareness, whereas taking an ACE exam may make them think of things that they themselves have not recognized or spoken about before. Making officers more aware of themselves, their past, and their motivations may create a more well-rounded officer insofar as

they can see a situation and understand their gut reaction to the stimulus in front of them. Giving officers the tools to make more informed decisions always pays dividends, and these types of hiring programs could assist in that.

As we have discussed at great length, law enforcement officers suffer from a number of mental health issues at a rate which far outpaces the general public. Additionally, Adverse Childhood Experiences are globally recognized to contribute to many of the same mental health disorders that officers exhibit. The research discussed in this paper was designed to explore a possible correlation between law enforcement mental health and Adverse Childhood Experiences. An in-depth methodology was developed, and the research in its earliest stage began. However, due to time constraints and lack of organizational participation, the actual collection of data was unable to be completed.

Although extremely disheartening, the need for this research is still ever present. As we discussed in the preceding pages, there are several important policy implications, not only for the data which was to be collected, but also further studies based off of this research. Given that nothing has been proposed like this, completing the outlined study could have opened the door to a greater discussion on law enforcement mental health in an entirely new light.

Although concrete data and results could not be shared at this time, the discussion in the last few pages is of merit to, not only the profession of policing, but to society as a whole. Policing is an essential part of any safe country, and therefore, making sure officers are mentally prepared and able to carry out their jobs in a professional manner is imperative. Through reasonable and small changes in hiring practices, we may be able to create an even better environment for police and the communities they serve. I would like to invite anyone to pick up where this study failed to take off, and use this proposal as a catalyst for further research into

Adverse Childhood Experiences in law enforcement officers. If there is one lesson to be learned from this, it is that progress may be slow and difficult, but the implications are endless and worth the toil.

References

Anda, R., Fleisher, V., Felitti, V., Edwards, V., Whitfield, C., Dube, S., & Williamson, D. (2004). Childhood abuse, household dysfunction, and indicators of impaired adult worker performance. *The Permanente Journal*, *8*(1), 30-38.

Armour, C. (2012). Mental health in prison: A trauma perspective on importation and deprivation. *International Journal of Criminology and Sociological Theory, 5*(2), 886-894.

Crouch, E., Probst, J., Radcliff, E., Bennet, K., McKinney, S. (2019) Prevalence of adverse childhood experiences (ACEs) among US children. *Child Abuse & Neglect, 92*, 209–218.

Dhami, M. K., Ayton, P., & Loewenstein, G. (2007). Adaptation to imprisonment. *Criminal Justice and Behavior, 34*(8), 1085-1100. doi:10.1177/0093854807302002

Downey, J., Godmunson, C., Pang, Y., Lee, K. (2017). Adverse childhood experiences affect health risk behaviors and chronic health of Iowans. *Journal of Family Violence*, *32*, 557–564.

Dube, S. (2018). Continuing conversations about adverse childhood experiences (ACEs) screening: A public health perspective. *Child Abuse & Neglect*, *85*, 180–184.

Felitti, V., Anda, R., Nordenber, D., Williamson, D., Spitz, A., Edwards, V., Koss, M., Marks, J. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine, 14*(4).

Foley, J., Massey, K. (2019) Polic*e* officers and post- traumatic stress disorder: Discussing the deficit in research, identification and prevention in England and Wales. *The Police Journal: Theory, Practice and Principles*, *92*(1), 23–34.

Frampton, N., Poolea, J., Dobsona, K., Puschb, D. (2018). The effects of adult depression on the recollection of adverse T childhood experiences. *Child Abuse & Neglect, 86*, 45–54.

Gardiner, C. (2017, September). Policing around the nation: Education, philosophy, and ... Retrieved April 13, 2021, from https://www.policefoundation.org.

Gershon, R., Barocas, B., Canton, A., Li, X., Vlahov, D. (2009). Mental, physical, and behavioral health outcomes associated with perceived work stress in police officers. *Criminal Justice and Behavior*, *36*(3), 275-289.

Henderson, S., Steinkopf, B., Straud, C., Vincent, N., Crouch, A., Guszowski, K., Van Hasselt, V., Klinoff, V., Hakala, K. (2015). Mental health of law enforcement officers: Current strategies and issues in prevention and intervention. *Anxiety and Depression Conference*.

Huey, M. P. (2008). Deprivation, importation, and prison suicide: The combined effects of institutional conditions and inmate composition (Unpublished doctoral dissertation, 2008). University of Georgia. Doi:2008

Hye-Kyung Kang & David L. Burton (2014) Effects of racial discrimination, childhood trauma, and trauma symptoms on juvenile delinquency in African American incarcerated youth. *Journal of Aggression, Maltreatment & Trauma, 23*(10), 1109-1125. doi: 10.1080/10926771.2014.968272

Martin, T., & Martin, R. (2017). Police suicide and PTSD: Connection, prevention, and trends Law Enforcement Executive Forum, *17*(2).

Perin, M. (2007). Police suicide. *Law Enforcement Technology*.

Pole, N, Neyland, T., Otte, C., Metzler, T., Best, S., Henn-Haase, C., Marmar, C. (2007). Associations between childhood trauma and emotion-modulated psychophysiologica responses to startling sounds: a study of police cadets. *Journal of Abnormal Psychology, 116*(2), 352–361.

Rajaratnam, S., Barger, L., Lockley, S., Shea, S., Wang, W., Landrigan, C., O'Brien, C., Qadri, S., Sullivan, J., Cade, B., Epstein, L., White, D., Czeisler, C. (2011). Sleep disorders, health, and safety in police officers. *Journal of the American Medical Association, 306*(23).

Sykes, G. M. (1971). The society of captives. Princeton, NJ: Princeton University Press.

Thomas, C. W. (1977). Theoretical perspectives on prisonization: A comparison of the importation and deprivation models. *The Journal of Criminal Law and Criminology, 68(*1), 135. doi:10.2307/1142482

Appendix A

ACEs in Law Enforcement Officers Survey:

ACE-IQ 13 Question Binary Test:

1. Physical abuse

Did a parent, guardian or other household member spank, slap, kick, punch or beat you up?
OR
Did a parent, guardian or other household member hit or cut you with an object, such as a stick (or cane), bottle, club, knife, whip etc?
Yes No

2. Emotional abuse

Did a parent, guardian or other household member yell, scream or swear at you, insult or humiliate you?
OR
Did a parent, guardian or other household member threaten to, or actually, abandon you or throw you out of the house?
Yes No

3. Contact sexual abuse

Did someone touch or fondle you in a sexual way when you did not want them to?
OR
Did someone make you touch their body in a sexual way when you did not want them to?
OR
Did someone attempt oral, anal, or vaginal intercourse with you when you did not want them to?
OR
Did someone actually have oral, anal, or vaginal intercourse with you when you did not want them to?
Yes No

4. Alcohol and/or drug abuser in the household

Did you live with a household member who was a problem drinker or alcoholic, or misused street or prescription drugs?
Yes No

5. Incarcerated household member

Did you live with a household member who was ever sent to jail or prison?
Yes No

6. Someone chronically depressed, mentally ill, institutionalized or suicidal

Did you live with a household member who was depressed, mentally ill or suicidal?
Yes No

7. Mother Household member treated violently

Did you see or hear a parent or household member in your home being yelled at, screamed at, sworn at, insulted or humiliated?
OR
Did you see or hear a parent or household member in your home being slapped, kicked, punched or beaten up?
OR
Did you see or hear a parent or household member in your home being hit or cut with an object, such as a stick (or cane), bottle, club, knife, whip etc.?
Yes No

8. One or no parents, parental separation or divorce

Were your parents ever separated or divorced? OR
Did your mother, father or guardian die?
Yes No

9. Emotional neglect

Did your parents/guardians understand your problems and worries? OR
Did your parents/guardians really know what you were doing with your free time when you were not at school or work?
Yes No∗
∗ Note: for this question, it's the "no" answer which scores a "1".

10. Physical neglect

Did your parents/guardians not give you enough food even when they could easily have done so?
OR
Were your parents/guardians too drunk or intoxicated by drugs to take care of you?
OR
Did your parents/guardians not send you to school even when it was available?
Yes No

11. Bullying

Were you bullied? Yes No

12. Community violence

Did you see or hear someone being beaten up in real life?
OR
Did you see or hear someone being stabbed or shot in real life?
OR
Did you see or hear someone being threatened with a knife or gun in real life?
Yes No

13. Collective violence

Were you forced to go and live in another place due to any of these events?
OR
Did you experience the deliberate destruction of your home due to any of these events?
OR
Were you beaten up by soldiers, police, militia, or gangs?
OR
Was a family member or friend killed or beaten up by soldiers, police, militia, or gangs?
Yes No

Demographic and Employment Information:

What is your age (in years)?

What is your gender? Select one. (Male, Female, Prefer Not to Say, Non-Binary)

What is your race? Select one. (white, black, Hispanic, Asian or Pacific Islander)

How many years have you served as a law enforcement officer (in years)?

What is your current rank in your law enforcement agency? Select One. (Reserve Patrolman, Patrolman, Corporal, Sergeant, Detective, Lieutenant, Captain, Deputy Chief, Chief, Prefer Not to Answer)

Are you currently seeking promotion within your agency, or are you likely to seek a promotion? (yes/no)