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Motivational Interviewing: Improving the Delivery of Psychological Services to Law Enforcement

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Law enforcement officers are a high-risk population for the development of several debilitating mental and physical health problems, increasing the need for effective psychological interventions. This article reviews: (a) mental health problems that police officers are at risk of developing, (b) factors in the law enforcement profession that increase the need for mental health services for officers, (c) the current state of psychological interventions with law enforcement personnel, and (d) how the empirically supported technique of motivational interviewing (MI) may improve the overall success of the psychological treatments most widely used with this population. MI is an interview delivery style that has been shown to be highly successful with treatment-resistant populations. We propose that the incorporation of MI into current mental health services for law enforcement officers may help to reduce their resistance to change, particularly in those mandated for treatment, thus increasing the benefits of the intervention. We also suggest that future research examining the value of MI specifically for law enforcement professionals is warranted.

Keywords: police, law enforcement, motivational interviewing, psychotherapy

Over the last 30 years, law enforcement personnel have received considerable attention regarding the impact of their occupation on their mental and physical health. Overall, law enforcement has been found to be a very resilient group with generally low rates of mental disorders. However, there is evidence that police officers have both a significantly lower life expectancy than the general

population by a mean difference of 21 years (Violanti, Fekedulegn, et al., 2013) and high levels of psychological distress (Pasillas, Follette, & Perumean-Chaney, 2006). A burgeoning body of research has identified the most common causes for these problems: occupational stress (Gershon, Barocas, Canton, Li, & Vlahov, 2009; Violanti, Fekedulegn, et al., 2013) and police culture (Loyens, 2009; Terrill, Paoline, & Manning, 2003).

Although many psychological interventions have been implemented to improve the overall functioning of police officers, their impact has been inconclusive. Central to the frustration of many of these efforts is resistance to the delivery of the interventions stemming from the interaction of police culture and the stigma of mental health problems. The primary goal of psychological services for police officers is to restore them to an adequate level of functioning so that they can continue to perform their duties safely and effectively (L. Miller, 2004). We propose that one strategy for overcoming the challenges encountered by mental health service providers is motivational interviewing (MI; W. R. Miller & Rollnick, 1991). MI is a therapeutic delivery style that has proved effective in decreasing resistance to treatment and in improving clinicians' ability to establish positive therapeutic alliances in a variety of settings (W. R. Miller & Rollnick, 2002). In the following sections, we: (a) review the mental health problems that police officers are at risk of developing, (b) examine the factors that place them at risk, (c) describe the current state of psychological interventions with law enforcement personnel, highlighting the challenges in the delivery of those services, and (d) propose MI as a valuable tool for those providing mental health services to law enforcement officers.

Mental Health Problems Experienced by Law Enforcement

Due to the stress of their occupation and certain maladaptive coping strategies supported by police culture, police officers have

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been shown to be at risk of developing a number of mental and physical health problems. Considerable research has been conducted to establish which problems are occurring in police officers at higher rates than the general population, and which are at a level of increased risk for police. Those problems that have been documented as being more prevalent in police than the general population include: alcohol abuse (Ballenger et al., 2011; Davey, Obst, & Sheehan, 2001; Lindsay, 2008; Ménard & Arter, 2013), depression (Hartley, Burchfiel, Fekedulegn, Andrew, & Violanti, 2011; Violanti, 2010), cardiovascular disease (Hartley et al., 2011), cancer (Gu, Charles, Burchfiel, Andrew, & Violanti, 2011), posttraumatic stress disorder (Ménard & Arter, 2013), relationship problems, such as marital discord and domestic violence (Kirschman, Kamena, & Fay, 2014; McCoy & Aamodt, 2010; Neidig, Russell, & Seng, 1992; Zavala, 2013), and suicide (Aamodt & Stalnaker, 2001; Chae & Boyle, 2013; Milner, Spittal, Pirkis, & LaMontagne, 2013; Violanti, Robinson, & Shen, 2013).

Risk Factors

Compared with other groups, law enforcement officers are at higher risk for developing emotional and/or interpersonal difficulties due to a variety of factors specific to their work, most notably occupational stress and police culture.

Occupational Stress

Over the last several decades, most research on the mental health of police officers has focused on the sources of occupational stress, which include: (a) the community (e.g., civilian complaints, unfavorable community attitudes; Adams & Buck, 2010), (b) the department (e.g., administration, peers, nepotism; Shane, 2010), and (c) the nature of the work itself (e.g., shift work, traffic stops, domestic violence calls; Gibson, Swatt, & Jolicoeur, 2001; Vila, 2000). Research has consistently indicated that officer perceive internal and community stressors as significantly more stressful than their police duties (Adams & Buck, 2010; Carlan & Nored, 2008). Further, there is evidence that, although exposure to traumatic critical incidents (e.g., suicides) increases the risk of suicidal ideation (Crosby & Sacks, 2002), moderating variables (e.g., coping strategies, social support) are major factors in the emergence or deterrence of psychological and physical problems experienced by officers (Gershon et al., 2009; Ménard & Arter, 2013).

Another occupational risk factor for police is sleep deprivation related to shift work and long hours. In fact, 33% of police officers report sleeping less than 6 hr in a 24-hr period (Hartley et al., 2011). Insufficient sleep and inadequate coping resources compound the severity of negative reactions to police stress (Vila, 2006), resulting in increased risk of death due to cardiovascular disease (Violanti, Fekedulegn, et al., 2013), cancer (Gu et al., 2011), and suicide (Bernert, Kim, Iwata, & Perlis, 2015).

Police Culture

Police culture, founded on the loyalty and adhesion created among officers by shared experiences, hazards of the job, and the authority to use force (Lott, 1995), has been the subject of much discussion (Westley, 1970). Although it is unclear whether there are several subcultures or one “monolithic” police culture (Paoline,

2004), there is consensus on specific themes across most officers, often labeled “traditional police culture.”

Although adopting police culture is viewed as critical to a long and successful career, and can be beneficial in many ways (Woody, 2005), it can also place an officer at risk by permeating his or her life so fully that it becomes the officer’s primary sense of identity, thereby creating an “us versus them” mentality. When combined with a strong sense of loyalty and secrecy, the risk for undesirable outcomes is heightened (Loyens, 2009). Traditional law enforcement culture also values machismo, action-oriented behavior, and authoritarianism (Gerber & Ward, 2011; Ryan, Bartels, & Kreiner, 2008), which can be very effective on the job, but has the potential to be intimidating and problematic within personal relationships (Anderson & Lo, 2011). When it becomes difficult for police officers to switch from their work role and persona to that of parent and/or spouse, a minor disagreement with a family member could be misinterpreted as a challenge to the officer’s authority and viewed as an indication of disrespect, increasing the risk for relationship problems and domestic violence (Blumenstein, Fridell, & Jones, 2012; Tyler, 2000). Decreasing relationship dysfunction in officers is particularly important in light of research that has identified a healthy marriage as a strong protective factor against suicide (Violanti et al., 2009).

Additionally, officers who strongly adhere to police culture and embrace an “us versus them” mentality isolate themselves from activities and relationships that are not law enforcement–related, but may be beneficial to them (Blau, 1994). Those on the outside who desire to help (e.g., mental health professionals, researchers, family) can find it difficult to infiltrate the law enforcement culture due to officers’ strong sense of loyalty to one another and reluctance to “break the code” of silence that pervades the profession. Mental health professionals are perceived as outsiders; therefore, establishing rapport with officer clients can be difficult and slow to develop, if it develops at all (Silva, 1991).

Psychological Services and Law Enforcement

Despite the clear need for accessible and effective psychological interventions for law enforcement personnel, research on the most effective treatments has been inconsistent. Although a variety of treatment approaches have been used, indications are that many have not had a positive impact (Patterson, Chung, & Swan, 2014). This is largely due to: (a) the nature of the strategies used in the treatment of police officers and (b) officers’ negative perceptions of mental health professionals, stemming from their traditional view of them as an adversary rather than an ally, largely instigated by the influence of police culture (Depue, 1979).

Interventions With Law Enforcement

Due to the focus on police stress over the past 30 years, significant steps have been taken to intervene and maintain the level of functioning of police officers. These intervention efforts fall under the rubric of direct and indirect interventions (Gupton et al., 2011).

Indirect interventions. Indirect interventions include training and wellness programs, usually in a classroom setting, emphasizing psychoeducation, awareness of the signs and symptoms of stress-related disorders, and coping skill development. The pur-

pose of these components is to provide a buffer between occupational stress and potential health problems. The length of the interventions varies greatly. Although it is difficult to assess their impact, it appears the effects have been variable. Anshel and Brinthaup (2014) conducted a 2-hr training on coping skills with 11 police officers who reported high levels of job stress, all of whom were from a medium-sized city in the southeastern United States. Based on standardized self-report measures of perceived physical energy levels and coping responses to stress, participating officers reported moderate increases in energy levels, but no significant differences in their use of coping skills in response to highly stressful work-related events. Garner (2008) examined the effects of a 16-hr criticism management/stress inoculation training program (with two, 1-hr boosters) on criticism management for 63 police officers from three agencies in Texas. The training program led to an increase in: (a) perceived efficacy in managing stress and criticism-prone situations, (b) self-reported levels of physical and mental health, and (c) performance evaluations by a supervisor. Oliver and Meier (2009) administered an 8-hr stress management training covering several topics (e.g., definition of stress, signs and symptoms of stress-related disorders, stress reduction techniques, diet, exercise, critical incident stress debriefing) to 132 officers from small-town and rural police departments in West Virginia, which significantly reduced perceived stress, but not anxiety or behavioral symptoms (e.g., number of sick days, citizen complaints). The impact of this program was assessed at 3, 6, and 18 months posttraining. Results revealed that all significant effects had diminished by the 18-month follow-up, reflecting inadequate maintenance of gains.

Direct interventions. Direct interventions include individual counseling, fitness and exercise programs, critical incident stress debriefing, and peer support programs. These interventions are employed when a specific problem, or high risk for the development of a specific problem, has been identified in an officer or group of officers. Tanigoshi, Kontos, and Remley (2008) conducted a clinical trial that randomly assigned 51 police officers from suburban police departments in Louisiana to a wellness training group or a control group providing no training. The wellness training consisted of five sessions over 15 weeks; it incorporated techniques from cognitive therapy, coping skills, relaxation training, lifestyle habits, and stress management. For the officers in the wellness training group, results demonstrated a positive change on a comprehensive measure of total well-being compared with both their pretreatment scores and scores of those in the control group.

In a meta-analysis of interventions to reduce cardiovascular risk in emergency response personnel, those studies that incorporated behavioral counseling, in addition to a fitness and exercise program, were more effective than a risk-factor based assessment, and fitness and exercise program alone (Wolkow, Netto, & Aisbett, 2013). Carlan and Nored (2008) reported that just the presence of a department-sponsored direct intervention can benefit individual officers. They found that of 16 police departments surveyed, officers in departments offering counseling reported reduced overall levels of stress and were more likely to seek counseling if needed.

In a systematic review of 12 studies examining both indirect and direct interventions applied to police samples, Patterson et al. (2014) showed that, overall, the interventions did not result in

statistically or clinically significant change in physiological, psychological, or behavioral outcomes. Suggestions for improvement in treatments based on their findings include a greater focus on cognitive-based and humanistic strategies (Colwell, Lyons, Bruce, Garner, & Miller, 2011), and mandatory counseling to reduce the stigma of psychological services (Carlan & Nored, 2008).

Perception of Mental Health Services

Police officers have historically viewed mental health professionals and interventions negatively, fearing that they will be deemed unfit for duty (L. Miller, 2006; Rudofossi, 1997). A more recent study of the attitudes police have toward mental health professionals has indicated that most have a neutral view, although, as a whole, their attitudes are still more negative than the general population (Karaffa & Tochkov, 2013). Further, the strongest predictor of negative attitudes was ascription to the distrust of outsiders and an "us versus them" mentality. Such negative feelings by police toward the mental health profession discourages seeking treatment services and leads to less than full engagement when they do receive them (Pasciak & Kelley, 2013). To overcome the challenges in developing a satisfactory therapeutic alliance with police officers, and to encourage their active engagement in the process, MI is proposed as a therapeutic delivery style that may have heuristic value with this population.

Motivational Interviewing

MI is an empirically supported interviewing strategy and delivery style based on the premise that when an individual is adequately motivated, change is more likely to occur (see W. R. Miller & Rollnick, 1991). MI was originally designed to help maximize motivation and subsequently improve therapeutic effectiveness for substance use populations, but has been adapted to help other challenging populations (Arkowitz & Westra, 2009), including those who may resist treatment and/or are mandated to therapy.

MI emphasizes a collaborative process in which the mental health professional plays the role of guide, focusing on eliciting the motivation for change in an individual by addressing his or her ambivalence. Four principles guide MI: (a) *expressing accurate empathy* in order to create a nonjudgmental atmosphere, referred to as the "spirit of MI" (Mitcheson, Bhavsar, & McCambridge, 2009), which is considered essential to successful treatment (Angus & Kagan, 2009); (b) *developing discrepancy* between the individual's current state and where he or she would like to be in accordance with his or her own goals and values; (c) *rolling with resistance*, where resistance is viewed as an interpersonal phenomenon that is almost essential to progress in treatment; and (d) *supporting self-efficacy*, where both the individual's ability to and responsibility for change are emphasized (W. R. Miller & Rollnick, 2002).

MI as Unique Treatment

MI does not ascribe to a specific theoretical orientation, but it does have many similarities to other treatment modalities. Constantino, DeGeorge, Dadlani, and Overtree (2009) reviewed the convergences between MI and client-centered therapy (CCT; Rogers, 1951), interpersonal therapy (Benjamin, 2003), and the

cognitive-behavioral system of psychotherapy (McCullough, 2000). The strongest links between MI and CCT involved the interaction style between therapist and client (e.g., role of empathy, autonomy support, acceptance, spirit of collaboration) (Csillik, 2013). However, MI does not emphasize Rogers's unconditional positive regard, congruence, or genuineness (Csillik, 2013). Rather, it focuses on adaptive behaviors as the goal of treatment rather than the self-actualization process (Constantino et al., 2009). MI also differentiates itself from other approaches in that it assumes and requires a high level of abstract reasoning that other treatments assume specific clients (e.g., those with severe depression) may not be capable of doing (Constantino et al., 2009; McCullough, 2000).

Empirical Support

MI can be implemented in treatment in one of three ways, each of which is empirically supported: (a) stand-alone treatment, (b) integrated as the delivery style for another treatment, and (c) at the outset of treatment in a pretreatment interview to increase motivation and commitment.

Stand-alone treatment. Although originally designed as stand-alone treatment for alcohol abuse, MI has been successfully adapted into specific treatments for a variety of disorders, including but not limited to, generalized anxiety disorder, depression, lifestyle changes, suicidality, and interpersonal violence (Arkowitz & Westra, 2009; Crane & Eckhardt, 2013). Indeed, a meta-analysis of MI applications for drug and alcohol abuse and unhealthy lifestyles (e.g., diet, exercise) indicated overall moderate effects (Burke, Arkowitz, & Menchola, 2003).

Integrated. Given the convergences between MI and other therapies, MI can easily be integrated into a number of different treatment approaches as an interviewing style (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010). Further, the integration of MI into the therapy process creates a safe and collaborative environment that has been found to increase the overall efficacy of interventions in both individual (Brown & Miller, 1993; Burke, Arkowitz, & Dunn, 2002; Hettema, Steele, & Miller, 2005; W. R. Miller & Baca, 1983; Stapinski et al., 2014) and group settings (Krejci & Neugebauer, 2015; LaChance, Feldstein Ewing, Bryan, & Hutchison, 2009; Velasquez, Stephens, & Ingersoll, 2006; Wagner & Ingersoll, 2013) by increasing motivation to engage more fully in treatment.

Pretreatment. MI has also been used exclusively at the outset of therapy: (a) to increase clients' problem awareness and (b) to focus on change in a manner that complements an existing therapy (Bein, Miller, & Boroughs, 1993; Jensen, Nielson, Romano, Hill, & Turner, 2000).

MI by nonmental health professionals. An advantage of MI techniques is the relative ease with which nonmental health professionals can learn and successfully implement them. For example, MI techniques have been taught to medical professionals to increase the healthy behaviors of their patients (Ambrose, 2008). Further, training in MI techniques has been offered in several formats, from a 3-day classroom trainings to obstetric health professionals (Lindhardt et al., 2014) to interactive computer-based programs (30–45 min in duration) for nursing, dental, and medical students (Carpenter, Watson, Raffety, & Chabal, 2003).

MI and Law Enforcement

MI has been successfully implemented for a wide range of problems, many of which are prevalent among police officers. Some of these include: substance abuse (Burke et al., 2002; Cuciare, Simpson, Hoggatt, Gifford, & Timko, 2013; W. R. Miller, Sovereign, & Krege, 1988), relationship conflict (Musser, Semiatin, Taft, & Murphy, 2008), depression (Flynn, 2011; Riper et al., 2014), and suicide risk (Zerler, 2009).

To our knowledge, only one study has examined the utility of MI with law enforcement professionals. Anshel and Kang (2008) examined the impact of MI in a 10-week behavioral health direct intervention designed to improve fitness and exercise adherence in 67 police officers. Level of physical fitness was based on body composition, blood pressure, cardiovascular fitness, muscle strength, and blood lipid levels. MI was incorporated into a weekly follow-up meeting with a fitness coach. Throughout the 10-week program, the coach and officer discussed short- and long-term professional goals and ways to improve the officer's work and personal life, while drawing on the officer's personal values. Results showed significantly improved physical fitness levels for participating officers in all categories. Specifically, the addition of MI accounted for 73% of the variance in improved blood lipid profiles; exercise adherence averaged 80% for cardiovascular training sessions and 75% for strength training sessions. Overall, the findings indicated that use of MI techniques had a positive effect on the health-related behaviors of the officers.

Conclusion and Future Directions

The combination of occupational stress and police culture has placed police officers at risk of serious psychological and physical problems. Numerous studies have documented difficulties that are common in police officers, such as substance use, depression, domestic violence, posttraumatic stress disorder, and suicide. When police officers do not receive the necessary treatment for their problems and are performing at suboptimal levels, both the community and the officer are at risk. Attempts to provide the necessary mental health services to police officers historically have been unsuccessful. Police culture, the stigma of mental illness and treatment interventions, as well as suboptimal intervention delivery methods have created a barrier between police and the services many of them need.

MI is an intervention delivery style that has proven effective at building a strong therapeutic alliance between mental health providers and various treatment-resistant populations. Further, there is preliminary evidence that MI has potential to enhance the health-related behaviors of police officers (Anshel & Kang, 2008). The current status of the research on MI suggests that the integration of MI into the treatment processes with law enforcement professionals has potential to improve their mental health and performance outcomes. Given the flexibility of using MI in various treatment approaches (e.g., stand alone, integrated, or pretreatment), MI could be incorporated into both direct and indirect interventions that are already employed by most departments. As a stand-alone or integrated treatment, MI could be used for the most common problems among law enforcement professionals for which MI has proven efficient (e.g., substance use, depression, marital discord, health-related behavior). MI has proved to be particularly effective when integrated with cognitive-behavioral therapy (Stapinski et

al., 2014), which is one of the recommended interventions for police (Colwell et al., 2011). MI can also be employed as a pretreatment interview with or before stress management or lifestyle training.

Additionally, MI techniques could be taught to peer support group members to enhance their ability to effectively assist their fellow officers. Such programs have become very popular among law enforcement professionals (Chamberlain, 2000). They are inexpensive (Roland, 2011), easy to implement, and may be more effective because peers are more capable of overcoming the stigma associated with emotional difficulties (Kamena, Gentz, Hays, Bohl-Penrod, & Greene, 2011; Levenson, O'Hara, & Clark, 2010). Such techniques could easily be taught to those leading police peer support groups in addition to the other suggested skills (International Association of Chiefs of Police, 2011).

Current research on MI and interventions directed at enacting positive change in police officers suggest that combining the two may result in greater treatment engagement and efficacy. Research on the effectiveness of MI when integrated with both direct and indirect interventions aimed at improving officer functioning is needed. As action is taken to improve the delivery of well-researched therapeutic approaches, the negative impact of police officers' occupation will be lessened, thus improving their ability to successfully perform their duties and achieve and maintain a high level of physical and psychological well-being.

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