Post Traumatic Stress Disorder – You CAN recover - By Andy Callaghan

It's no big secret that Police Officers witness trauma often. Everything from domestic and child abuse to shootings and homicides, bad car accidents, cops getting hurt and everyone's worst nightmare – a cop getting killed in the line of duty.

It's also no big secret that we are taught from our very first days in the police academy to be in control of our behaviors and emotions. We also instinctively run toward gun fire, burning buildings and people in trouble. That is what separates us from the civilian population. Cops run toward things that most people run away from. We are taught to act like superheroes. What often ends up happening is cumulative stress starts to build up. Stress in police work is like a bucket that catches rain due to a leaky roof. You either have to empty that bucket out from time to time or it is going to start to ruin things in your home.

What I just described is "cumulative stress." Cumulative stress can lower your resistance and set the stage for PTSD after a significant traumatic event. Other factors that can lower your resistance are; personal traumas, relationship stress, poor health and other non-healthy behaviors. The key point I am trying to make is that a healthy, balanced life will often help your personal responses to trauma.

There are things that you can do to build up your resistance to PTSD. Later in this article, I will talk about "Stress Inoculation." Stress Inoculation and post incident critical incident stress debriefing (talking about the incident) can help you survive in this stressful occupation.

Now that you are aware of factors that may help your reaction to a traumatic event, know that even a healthy balanced officer can suffer from PTSD after a significant event. Sometimes two or more officers witness the same event and have much different reactions.

In order to understand the diagnostic criteria for PTSD, I am going to use the definition straight from the Diagnostic and Statistical Manual (DSM-IV) for the American Psychiatric Association. This is the manual that is used by Mental Health Professionals to diagnose and treat Psychiatric Disorders.

Diagnostic Criteria for Post-traumatic Stress Disorder

A. Exposure to a traumatic event in which both of the following were present:

1. Experienced, witnessed, or was confronted by event(s) involving actual or threatened death or serious injury…of self or others
2. Response involved intense fear, helplessness, or horror

The disorder may be especially severe or longer lasting when the stressor is of human design (e.g. torture, rape).
(DSM-III-R notes that:
some stressors frequently cause the disorder (e.g. torture), and others
produce it only occasionally (e.g. natural disasters or car accidents).

B. Traumatic event is persistently re-experienced in one or more of the following ways:

1. Recurrent, intrusive, distressing recollections of the event . . .
2. Acting or feeling as if the event were recurring, including: "sense of reliving" the experience, illusions, hallucinations and flashbacks – including while awakening or intoxicated
3. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
4. Psychological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma, or numbing of general responsiveness, as indicated by at least 3 of the following:

1. Efforts to avoid thoughts, feelings or conversations associated with the trauma
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma
4. Markedly diminished interest or participation in significant activities
5. Feeling of detachment or estrangement from others
6. Restricted range of affect (e.g. unable to have loving feelings) …

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated from 2 or more of the following:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hyper vigilance
5. Exaggerated startle response

E. Duration of the disturbance (symptoms in B, C, and D) of at least one month
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Acute: if duration of symptoms is less than 3 months;
Chronic: if duration of symptoms 3 months or more;
With Delayed onset: If symptoms were at least 6 months after the trauma).

It should also be noted that PTSD is classified as an "anxiety disorder." The word "anxiety" refers to our body's physical reaction to the traumatic event. The word "disorder" is used because PTSD disrupts the normal function in our lives. In most cases, treatment for PTSD can lead to a FULL recovery. The diagnostic criteria also points out that the possibility of getting PTSD is significantly higher when the stressor is of human design. When death and destruction is witnessed from a tornado, hurricane or earthquake the possibility of getting PTSD is much lower than if you witness shootings, homicides, bombings, etc.

Since President McNesby has asked me to help with peer support for our officers, I have witnessed many officers that are suffering from Acute Stress Disorder (Traumatic Stress) as well as PTSD. Acute Stress Disorder (ASD) can occur immediately after an incident and usually lasts for less than a month. Both ASD and PTSD are normal reactions to abnormal situations. It is important to know that ASD does not necessarily lead to PTSD. There are many things we can do for ourselves and our peers to help diffuse the stress. <u>What is most important to know is that the sooner PTSD and ASD are confronted, the easier they are to overcome.</u>

Earlier I mentioned Stress Inoculation. Stress Inoculation is a method of preparing our minds and bodies for stressful situations. Often in life threatening situations we remain calm, cool and collected because we are trained to react that way. What can be going on inside is an intense feeling of hopelessness, fear or horror. Our heart rate sours, blood pressure goes up and tunnel vision kicks in. Training and taking care of ourselves can dramatically improve our body's reaction to stressful events. Working out, eating right, getting enough sleep and taking care of our spiritual lives will help. You don't have to re-invent yourself either. If you lack in any of these areas start taking "baby steps." Walk instead of drive; eat less junk food, consume less caffeine and alcohol, etc.

One of the most important areas in Stress Inoculation is training. Going to the range and shooting your service weapon will keep you sharp. Shooting is a skill that deteriorates if we don't practice. Remember, we re-act the way we train to act. You can also read some books on street survival. There are also many sources on the internet that can help with this. Please visit our website at www.lepsn.org for more training and PTSD information. Another thing you can do is plan to attend outside training. If the department won't approve it, do it anyway. Attend a Street Survival Seminar; attend a lecture, a combat shooting course, simmunition training, paint balling or anything that might help develop that automatic motor control. Many officers refuse to do this training on their own. I respectfully submit that it is worth the investment in time and money. The life you save may be your own.

Stress Inoculation helps before the traumatic event but what about after? Talking is the key! Talk to a peer that you can trust, someone from our own peer support network (LEPSN), a counselor or a therapist. Conversations with LEPSN cops, counselors and therapists are confidential and protected by law. You can also help one of your brother or sister officers by being there after a traumatic event. All you have to do is ask them if they are ok, get them something to eat or drink (if appropriate) and listen for what you can do to help. Avoid judgments or advice. Offer support and tell them that you will help them get through this.

One of the most traumatic events an officer can go through is a police shooting. Police Officers Killed in the line of duty and felonious assaults are up dramatically across the country. The frequency of police shootings in Philadelphia is alarming. Our great Police Officers are using sound judgment, good tactics and great restraint. Almost every violent felon that we engage in combat with should not have been on the streets due to their lengthy criminal record. As we all know, we can't control that. That is also another separate issue for another time.

If police shootings are on the rise, what can we do to help ourselves and our fellow officers? One of the things we can do is be kind and supportive to one another after a police shooting. Take the officer away from the immediate scene and give them some time to compose themselves if needed. Get the officer a bottle of water. It won't be long before he or she is on their way to Internal Affairs. The way they are treated immediately after a police shooting is critical. We know the directive and we know that we can't talk to the officer about the discharge. Nothing in that directive prohibits co-workers from offering appropriate

support. One of the things that has angered me the last couple of years is the lack of compassion by some of the supervisors in our department. I assist with the Shooter's Support Group at the FOP and I have heard stories where some of the supervisors have acted inappropriately. I am sure that these supervisors have never been in a police shooting. If they did then they would know that the officer is running the story through his or her mind, second guessing themselves, trying to fill in missing pieces to the puzzle and worried about co-workers. This is normal and is reported in almost every police shooting. Giving an officer a hard time does not help the situation.

Attendance at a Shooter's Support Group (SSG) meeting at the FOP is voluntary and confidential. Many officers have been helped since the group started. We can also assist in Critical Incident Stress Debriefing, referral to appropriate counseling and the FOP often acts as a liaison for officers that need additional help and support. The SSG meets every other Thursday (opposite pay day) at the FOP at 7:00 PM.

I mentioned in my earlier article on Alcoholism in Policing that I worked in a treatment facility for almost two years, exclusively with first responders from all over the country. I have seen the damage that PTSD can do to an officer. Increased Alcohol consumption, mistreating their families due to angry outbursts and lack of communication, the inability to cope or manage stress and leaving police work are some of the things that I have witnessed. Untreated PTSD can also lead to suicide. Every year twice as many cops kill themselves than are killed in the line of duty. Many of these cases involve untreated PTSD. Much of this could have been prevented with early detection and appropriate treatment.

Please visit our website at www.lepsn.org. Please be careful out there and back each other up!

Fraternally Yours,

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