

*This article was published in the Fall 2006 issue of "The Command Post" newsletter for Canadian Critical Incident Inc. (newsletter for negotiators, incident commanders, scribes and tactical leaders)*

# PTSD and the Police

*by Dr. Sean P. O'Brien, C.Psych. and  
Det. Cst. James Bremner*

Use of force training has evolved significantly over the past several decades. Indeed, as recent events such as the Dawson College shooting in Montreal illustrate, a focus upon training exercises such as rapid deployment tactics have helped officers to respond safely and effectively to dangerous situations. However, while tactical trainers have helped officers to develop the skills necessary to deal with violent confrontations, they have fallen short when it comes to training officers to cope with the emotional and physical sequelae that often follow a violent incident. If not adequately addressed, such experiences can fuel a posttraumatic stress disorder (PTSD), alcohol abuse, anger dyscontrol, and significant levels of interpersonal conflict and family discord (Fairbank, Ebert & Caddell, 2001; Herman, 1997; McNally, 1999). The authors are currently in the process of developing a training exercise to help officers deal more effectively with the aftermath of a violent confrontation. Unlike other tactical training scenarios, these scenarios begin, rather than end, when shots are fired. The ultimate goal of this program is to prepare officers to handle traumatic mental stress experiences as effectively, and as automatically, as they would handle a gun-toting bandit or a sucking chest wound.

It is important to address PTSD when training police officers because when we ask members of the law enforcement community to protect the public, we are asking them to take on an enormous responsibility. Such responsibility comes with many benefits (e.g., good job security, good pay, great hockey leagues, etc.), but these benefits are often accompanied by many significant costs. Perhaps the most significant of these is the continual exposure to severe forms of physical and emotional trauma.

## **The Risk of Developing PTSD Following Various Forms of Trauma**

We need to accept that the very nature of police work puts officers in harms way, not only physically, but emotionally as well, because they are continually exposed to traumatic events such as physical assaults, homicides, and other brutal crimes. Indeed, the more one is exposed to traumatic events, the more likely it is that a person will develop a posttraumatic stress disorder. Therefore, let's look at the risk of developing PTSD following exposure to certain kinds of trauma (cf. Fairbank, Ebert & Caddell, 2001; Grossman, 1999; McNally, 1999):

- Natural disasters (e.g., flood, hurricane, etc.): 5 %
- Being threatened or attacked by an animal: 5 %
- Being involved in a life-threatening motor vehicle accident: 10 %
- Combat exposure: 30 %
- Being threatened by a weapon: 33 %
- Being a victim of rape: 45-80 %
- Prolonged violent combat: 40-92 %

These events can take an enormous toll on police officers, since almost every officer we've met has been exposed to forms of urban combat and/or have been threatened or assaulted with a weapon. Consistent with this, some experts have suggested that up to 33% of on-duty and retired police officers struggle with unresolved emotional issues associated with traumatic and violent events that they encountered while on the job (Lewis, 2004). Unfortunately, most don't address these issues in any meaningful way and this can be disastrous because untreated PTSD can fuel many of the problems listed above, including police suicide. Indeed, statistics suggest that for every officer who is killed in the line of duty, we lose three officers to suicide (Turvey, 1995). Across North America, it has been suggested that we lose one officer to suicide approximately every 24 hours (Lewis, 2004).

Despite these alarming statistics, most officers are reluctant to seek help because of a fear of appearing weak or being stigmatized. Yet, the reality of this is that stress experiences are common following a critical incident. Failing to address them in an open and direct manner is no different than allowing an officer to reject medical help following a gunshot wound because he believes that: "Real men don't need thoracic surgery." The goal of this article is to review the normal reaction that many officers experience in response to a critical incident and to describe effective interventions that can be used to protect officers from developing debilitating PTSD reactions.

### **Dynamics of Combat**

In order to understand PTSD in police officers, we first need to understand what happens to the human body during a violent confrontation. In our experience, what many officers describe as strange or unusual responses to a traumatic event are not really strange or unexpected at all. Rather, they are normal and adaptive responses that help our bodies and minds cope with trauma. However, if an officer is not adequately trained to prepare for these responses, then when he or she experiences them, they can overwhelm the individual's emotional controls and contribute to frightening symptoms of anxiety.

### **Physiological Effects of Urban Combat**

First, we have to acknowledge that hundreds of thousands of years of evolution have provided us with valuable tools to deal with danger. When we are involved in a critical incident, our heart rate can accelerate to over 200 beats per minute (bpm; Laur, 2002). Indeed, with prolonged exposure to an incident, our sustained heart rate can be well over 200 bpm for a lengthy period of time (Hole, 2001; Siddle and Grossman, 1998). As most people are well aware, the normal heart rate is in the 60 to 80 bpm range. However, during a critical incident, this acceleration in heart rate is accompanied by a number of hormonal changes in the body.

First, the heart rate increases because three specific parts of our brain, the hypothalamus, the amygdala, and the pituitary gland, set off an alarm response (Hole, 2001). It is as if our brain says, "Holy crap, we're in trouble." The brain then sends a signal that activates our sympathetic nervous system – the part of the body that is charged with keeping us alive during threatening situations. What occurs when this system is activated is an epinephrine and norepinephrine dump from our adrenal glands. Our brain also sends a signal to the heart via the 10th cranial nerve to speed up the heart rate and increase the force of each heart contraction. Then, once our heart rate hits about 115 bpm, vasoconstriction occurs (Siddle and Grossman, 1998). This pushes our blood pressure higher and it concentrates our blood in our body core and our brain

where it's needed most during a confrontation. Our airways also dilate and we breathe more rapidly, and this increases our oxygen saturation. This is adaptive, because if we are stabbed or shot, we won't bleed to death as quickly and the remaining blood in our system will have higher levels of oxygen. Coupled with this, we get an increase in muscle tension which makes our bodies stronger, faster, and more resistant to penetrating wounds (Hole, 2001).

Our pupils also dilate and this helps us to identify threats, especially in low light situations. At the same time, our stomach stops digesting food because it will take far too long to get nourishment into our system. Consequently, our body begins to increase the level of blood sugar and blood cholesterol because they will provide us with fuel in a timely manner.

Our body also increases the level of cortisol, which not only helps to process various energy sources, but it also travels through our blood vessels to make them less permeable. Consequently, these blood vessels bleed or leak less easily when we become injured (Hole, 2001; McNally, 1999).

However, while these effects are beneficial because they increase our ability to survive a violent encounter, there is no such thing as a free lunch. Chronic and prolonged stress causes our blood sugar and blood cholesterol level to remain high. Cortisol also damages the walls of our blood vessels, and over time, this can cause blockages in our arteries. Tight muscles and dilated pupils can cause headaches. Interference with our stomach enzymes causes diarrhea and constipation. Hyperventilation causes light-headedness, and chronic stress also causes our white blood cell count to diminish – leaving us vulnerable to various forms of infection (Cunningham, 2002; Hole 2001).

Another of the effects that occur when we get reduced blood flow to the extremities is a loss of muscle control. At heart rates of 115 bpm, our fine motor control begins to diminish. However, heart rates between 115 and 145 bpm prime our systems for survival, and while we lose a bit of our fine motor skills, our cognitive functions, our gross motor functions, and our visual processing skills are heightened (Siddle and Grossman, 1998). Unless we are a sniper shooting at long range, we should welcome this.

However, as our stress response increases, and as our heart rate begins to exceed 145 bpm, hyper arousal begins to occur and our complex motor skills begin to deteriorate. What this means is that we can't load a magazine easily, it gets harder to change channels on a radio, and we have trouble finding the transmission button on a mitre.

At a heart rate of 175 bpm and above, our body begins to prepare for a catastrophic reaction. At this point, the only things that really work well are our gross motor functions. We can run, we can grapple, and we might be able to strike somewhere on a person's body with a baton, but shooting with any accuracy will be extremely difficult because our hands begin to tremble involuntarily. In fact, when the heart rate exceeds 175 bpm, most people would be lucky to hit the side of a barn. Keep in mind that these reactions take place once our heart rate hits 175 bpm, but during a violent encounter, our sustained heart rate can remain over 200 bpm for an extended period of time.

It is important to note that these effects don't generally occur when we exercise or engage in simulations training because the stress hormones are not secreted, even though our heart rate may be elevated. However, when we are in a life and death struggle, and our stress hormones begin to flow, these characteristic responses begin to occur. However, most officers are not aware that this will take place. Therefore, when they experience it, they often perceive that they are losing control and this can fuel an overwhelming sense of shame or a perception that one has failed.

One other critical experience that occurs when our heart rate exceeds 175 bpm is that our mature thinking brain begins to shut down and our reflexive brain begins to kick in (Siddle and Grossman, 1998). Our forebrain is the civilized, rational, and sophisticated part of our brain that can engage in logical problem solving behaviour. However, when the forebrain shuts down, our midbrain begins to take over. This brain area controls our reflex centres, and it is the more primitive system. This is the part of the brain that is activated when we deal with someone who is in a drunken rage. As any officer knows, one can not reason with someone in this state because, as Grossman states: "No one is home" (Grossman, 1999).

Good use of force trainers know that we use the midbrain when we are in a violent confrontation, that's why they train us repeatedly until things are reflexive. You pull your weapon and shout: "Police. Don't move!" over and over again until it is automatic and you can do it in your sleep. That's important, because when our heart rate hits 175 bpm and above we don't think, we just react with reflexive behaviour.

Other things happen, though, when we are in this state. First, our peripheral vision begins to disappear and we get tunnel vision. The actual shape of the eye begins to change and our depth perception begins to alter. This can make the bad guy look extremely close, and we often tune-out other stimuli, such as fellow officers who are responding alongside us during a critical event.

This can also be accompanied by auditory exclusion processes. Use-of-force trainers (Bremner, 2006) repeatedly emphasize this phenomenon and it is often experienced by officers during a critical incident. It has great survival value because when we are faced with a serious threat we channel the majority of our energy to the senses that are needed most. During a violent encounter, the primary sense that is needed is vision. Therefore, our brains process visual stimuli well, but this often occurs at the expense of our remaining senses. That is why gunshots sound loud when we observe an encounter, but they seemingly disappear when we are the one who is involved in a shooting. Other senses, such as the sense of touch, often diminish as well. This explains why we often feel as though we hardly struck a perpetrator when in fact we may have broken their arm during an arrest. This is because our muscle feedback may be lost during such an event. During a critical incident, our brains may cause us to exclude auditory, tactile, and other sensations, but we may not be aware that this is happening.

Similar perceptual distortions can take place involving memory. It is not uncommon for police officers to experience Critical Stress Amnesia following an event (Laur, 2002). Because our brains are focused upon survival, and not upon accurately capturing memories, we may find that an officer will lose the ability to recall significant parts of an event immediately after it occurs. In many instances, the memory for parts of the event will be lost forever.

These experiences can alter our perceptions of an event significantly. For example, in a recent study by Kevin Siddle (2006), officers were exposed to a simulated violent encounter. The officers were lead to believe that they could be injured during the experiment and they were asked to sign a waiver releasing the experimenters from liability in the event of their accidental death. This was done to increase the officers' stress level. The officers were then confronted with a violent offender and their responses to this encounter were recorded while various aspects of the encounter were manipulated (e.g., a loud air horn was set off during the experiment in order to assess for auditory exclusion, etc.). The experimenters asked the officers to evaluate their performance and this was compared to objective data that was gathered during the experiment. Some of the data that was obtained is illustrated in the table below.

	<i>Perceived</i>	<i>Actual</i>
Shots fired	8.26	12.71
Targets hit	4.38	3.30
Accuracy	53.00%	24.41%
Hesitation	26.19%	10.42%
Fear / Panic	4.76%	16.67%
Auditory Exclusion	23.81%	58.33%

As this data illustrates, an officer's perceptions of an event can differ dramatically from the objective event. It is interesting to note that the officers fired 50% more shots but hit less targets than they had thought. They also appeared to display more fear and panic than initially perceived, but even though more than one in four officers felt that he or she hesitated to react, the data suggest that this did not occur as often as perceived. It was also interesting to note that more than half of the officers failed to hear the loud horn during the confrontation, but only one in four recognized that auditory exclusion had taken place.

A failure to recognize and cope with these hormonally-induced events can contribute to a stress reaction following a violent confrontation. We recently dealt with one young officer who was nearly beaten to death by an emotionally disturbed person who had escaped from a local hospital. During the incident, the officer called for backup, but he perceived that no one had responded to his call. He was also upset because he felt that he had failed to respond appropriately to the attack (e.g., he had struck the attacker lightly with his baton, had failed to pull his weapon, and had stood by idly as the attacker began his assault). However, when we obtained additional data from the 911 call centre, fellow officers, witness reports, and photographs taken following the assault, a very different picture emerged. It appears that the officer's calls for help were answered immediately and at least ten other officers marked onto the call within seconds. Indeed, the event lasted less than two minutes from the start of the attack to the arrest of the subject by fellow officers. Witness reports and photographic evidence also suggested that the young officer responded quickly, decisively, and appropriately (e.g., he struck the attacker repeatedly with his fists and baton, he drew his firearm, and despite the fact that the attacker was much larger than the officer, he suffered numerous serious injuries during the confrontation). However, the officer continued to berate himself for hesitating to react and he harboured much anger toward his colleagues because he perceived that they had abandoned him during the assault. As we processed this with him, it became apparent that his reaction was one that was marked by auditory exclusion (i.e., he could not hear responses on his mitre), critical incident amnesia, and numerous other

perceptual disturbances. Once this became apparent, his stress reaction diminished significantly.

Teaching officers to anticipate these effects and training them to use autogenic breathing techniques can help to reduce the negative effects associated with a critical incident. As noted earlier, many officers are unaware that these hormonally induced effects take place because they do not generally occur during training exercises, even though heart rates can be elevated. However, when they do occur, they can be reduced by using autogenic breathing -- a simple technique has been used by military and tactical trainers for years to reduce the heart rate by up to 30% (Laur, 2002). For example, if the heart rate accelerates to a level between 175 and 200 bpm, then using autogenic breathing techniques can help to reduce the heart rate to a more appropriate target range of 115-145 bpm. Unfortunately, these simple techniques are often taught only to officers on tactical units, despite their potential to save lives. In order to use autogenic breathing, we merely have to slow our breathing pattern by using "belly breaths" or diaphragmatic breathing. You can do this simply by breathing in for a count of four, holding your breath for a count of four, breathing out for a count of four, and then holding your breath for a count of four. Continue to repeat this process and you will notice that your heart rate and muscle tension will begin to diminish, and this can be done even in a very stressful situation. It is important to note that we must remember to hold our breath for a count of four when we breathe in, and then again when we breathe out. This allows the oxygen and carbon dioxide levels of balance and this prevents many of the stress-related effects associated with hyper-arousal and hyper-ventilation.

### **Psychological Effects of Combat**

In addition to these universal physiological effects, there are also a number of important cognitive behavioural effects associated with exposure to a violent encounter. The first is fear. Once again, through hundreds of thousands of years of evolution, we have developed fear structures that cause us to develop a fear response to anything that threatens us (Fairbank, Ebert & Caddell, 2001; Levitt, 1967; McNally, 1999). But, not only that, through a process of conditioning, we begin to fear other forms of stimuli that were present at the time of a violent encounter. And then, through the process of generalization, this fear can spread to a variety of other things as well.

Let us explain this through an example. If a woman is raped late at night at a bar after she has been drinking alcohol, and she is raped by a large man with a beard and long hair, she may come, not only to fear that man, but all men with beards and long hair, the smell of alcohol, being alone late at night, being around parties, etc. We are biologically programmed to do this. But, over time, the fear that develops can begin to generalize to other stimuli. So, now this woman begins to fear, not only tall men with beards and long hair, but all men, pictures of alcohol, social contact, and so on. It is as if she has a little voice in her head that says, "Be careful, these things can kill you." Indeed, her heart rate will accelerate, her stomach will feel sick, and she will experience hyperventilation and sweating when exposed to these feared situations because her body is trying to keep her alive.

This fear can then be maintained through avoidance. For example, if this woman avoids all these scary scenarios, she will reduce her fear, and the relief that she obtains will teach her that her avoidance is a good thing.

If we translate this to the work of a police officer, we can see that an officer who is attacked by an emotionally disturbed person may come to fear, not only the original attacker, but all emotionally disturbed people. This may also generalize to hospitals, television programs involving hospitals, or to sounds or smells that remind the officer of emotionally disturbed people, hospitals, or related stimuli. The officer may also come to have a fear response when he or she puts on a police uniform, straps on a duty-belt, or socializes with colleagues. For the officer who is attacked on duty, close contact with another human being may become fear-inducing. It is as though the brain says: "Be careful because something bad is going to happen." This may contribute to an uncontrollable urge to avoid sleeping with one's spouse or to an urge to avoid displays of affection when with family members. This can cause the officer to conclude that he or she is losing control and "going crazy." It can also contribute to high levels of familial discord because family members don't understand what is happening.

However, while the rape victim may be able to avoid some anxiety provoking situations fairly easily, it can be much harder for the officer to utilize avoidance strategies to remain safe. Avoiding some work situations might be extremely difficult, and if attempts at avoidance begin to falter, some officers may turn to drugs or alcohol in order to calm their inner torment and to turn off the alarm reaction.

However, quite simply, the brain is programmed to set off the alarm reaction whenever it encounters anything that it believes might be harmful, and fighting this reaction is impossible. It would be much easier to hold one's breath for six minutes than to turn off the alarm reaction. We must keep in mind that the alarm is inherently adaptive. The only thing that has gone wrong is that the brain has become far too sensitive to threat, and this is extremely common following a serious critical incident. Psychological treatments, such as cognitive-restructuring exercises and systematic-desensitization procedures, are designed to normalize these experiences and they can help to return the officer to his or her normal level of adaptive daily functioning fairly quickly.

### **Diagnosing PTSD**

Diagnosing PTSD itself is important because, while a high level of physiological and psychological stress in response to combat is normal, if we aren't prepared to deal with our reactions appropriately, then we can fight these reactions, and this can lead to the development of PTSD. PTSD is a severe set of symptoms that can develop following a critical incident, but in many cases, officers who suffer from it go untreated for lengthy periods of time because the symptoms are not recognized. PTSD can be treated with brief forms of intervention if it is detected early (Fairbank, Ebert & Caddell, 2001; Foa and Rothbaum, 1998). If it is not, then it may take years to fix it, and in some cases of severe untreated trauma, the problem will never completely resolve.

So, how do we diagnose PTSD? According to the DSMIV-TR (our diagnostic manual for stress reactions), we must first have exposure to a traumatic event that involved actual or threatened death or serious injury. The person's response to this event must involve intense fear, helplessness or horror.

Next, we see the development of symptoms that come together in three clusters. First, the traumatic event tends to be re-experienced in one or more of the following ways:

1. Intrusive and distressing recollections of the event.
2. Recurrent distressing dreams of the event.
3. Acting or feeling as if the traumatic event were recurring (e.g., illusions, hallucinations, dissociative flashbacks, etc.).
4. Intense psychological distress upon exposure to internal or external cues that resemble the traumatic event.
5. Physiological reactivity upon exposure to internal or external cues that resemble the traumatic event.

Next, there are three or more symptoms that represent a persistent avoidance of stimuli that are associated with the traumatic event. Such symptoms include:

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. An inability to recall an important aspect of the trauma.
4. Markedly diminished interest or participation in significant activities.
5. Feeling detached or estranged from others.
6. A restricted range of emotions (e.g., unable to have loving feelings, etc.)
7. A sense of a foreshortened future (e.g., person does not expect to have a career, marriage, children, or a normal life span).

Finally, there are two or more symptoms of increased arousal, as evidenced by:

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

If the symptoms last for more than one month, and if they cause significant distress or impairment, then a Posttraumatic Stress Disorder can be diagnosed.

### **Other Problems Associated with PTSD**

PTSD not only causes the difficulties that we've listed here, but there are a number of other serious problems, what psychologists call co-morbid disorders, that can accompany PTSD. In fact, of all of the people who are diagnosed with PTSD, an astounding 80.0 to 98.8% also struggle with at least one other clinical issue (Fairbank, Ebert & Caddell, 2001; McNally, 1999).

The most common co-morbid problems that accompany PTSD include:

1. **Panic Attacks.** The characteristic symptoms of increased arousal that we described earlier can occur daily, and the person who experiences them can fear that they are dying or losing complete control of their mind. The symptoms of panic are usually adaptive responses to stress, but they often get misinterpreted because they begin to occur in response to seemingly innocuous stimuli.
2. **Depression.** An inability to cope with PTSD can cause feelings of depression, and this is significant, not only because it makes the person unhappy, but because it causes structural and chemical changes in the brain that interfere with daily functioning.

3. **Substance Abuse.** When someone with PTSD can't control his or her symptoms they can shut down and become severely avoidant, or they can turn to alcohol and drugs to numb their torment. Some people can't sleep without drugs or alcohol, and while they obtain symptomatic relief on a short-term basis, over the long run, this only serves to make a bad problem much worse.
4. **Anger and Irritability.** Anger and irritability can occur when the officer believes that he or she has been mistreated by his or her coworkers and supervisors, but it can also occur as a response to excessive internal stimulation. Officers who become aggressive and argumentative with their colleagues, their family members, or with members of the public following a critical incident should be routinely screened for signs of PTSD.
5. **Further Traumatization.** When the officer struggles with PTSD, depression, substance abuse, and anger or irritability, this leads to a series of events that can increase the likelihood that they will put themselves in harm's way. We have seen many traumatized officers who struggle with shame and guilt, and in order to cope with these symptoms, they put themselves in harm's way in order to prove to themselves and their peers that they are not weak.
6. **Vicarious Traumatization.** This refers to PTSD symptoms that develop in spouses and children of officers involved in a traumatic event. These symptoms can mimic those seen in the officers themselves, and in many cases, they are worse. Left untreated, these problems can lead to divorce, domestic violence, and other serious difficulties.

### **Risk Factors for PTSD**

It is difficult to predict who will get PTSD, but we can describe three specific types of risk factors that will increase the likelihood that an officer will get PTSD (Fairbank, Ebert & Caddell, 2001; Herman, 1997; McNally, 1999). The first risk factor consists of pre-trauma risk factors. These are factors that we bring to the critical incident and they include such things as:

1. A pre-existing psychological problem. This is important because this represents a vulnerability factor that can make someone more susceptible to getting PTSD. This may not seem like a critical issue, until you realize that between 17-20% of the general public will have struggled with depression alone. Those who have a pre-existing history of psychological stress will be at twice the risk of getting PTSD.
2. Family history of psychiatric illness. Once again, this can predispose individuals to PTSD because it may reflect an underlying predisposition toward getting the disorder.

The second group of risk factors are things that we call peri-traumatic risk factors. This refers to risk factors that exist at the time that the trauma takes place. Such risk factors include:

1. A perceived life threat. This is a subjective experience that can differ between officers who attend the same call. The higher the perceived life threat, the higher the risk of PTSD. This can double your risk of PTSD.

2. Actual injury or death. This is an objective risk factor. Suffering a physical injury or witnessing a serious injury or death taking place increases the risk of getting PTSD. Estimates are that 45% of those who perceive that their life was threatened and/or who suffer an injury during an assault will develop PTSD.
3. Proximity to the trauma. The closer you are to the event and the more involved you are in it, the greater your risk of getting PTSD. Close proximity to the traumatic event can increase your risk of getting PTSD by five- fold.

Finally, the third types of risk factors that can predispose one to getting PTSD are what we call post trauma risk factors. The most consistently studied factors that predispose officers to PTSD are a lack of social support and a lack of unit cohesion following exposure to a traumatic event. Officers who are provided with social support and who are members of a cohesive unit tend to respond better when they develop PTSD.

Unfortunately, many officers are subjected to something that we call the “Just World Hypothesis” (Lerner & Miller, 1978). This term refers to the process by which fellow officers respond to the critical incident by blaming the person who was involved in it. This occurs because many people believe that the world is a just place where good things happen to good people and bad things happen to bad people. This doesn’t reflect reality, but it is a self-protective mechanism that allows us to believe that people get what they deserve. Therefore, if a colleague is traumatized, it is because they are weak, were poorly trained, or “froze.” As a result, “What happened to them can’t possibly happen to me.” This makes us feel safe, but it is truly an illusion. Furthermore, using the Just World Hypothesis only serves to alienate those who are traumatized and it increases the likelihood that they will suffer from PTSD.

### **Preventing and Treating PTSD in Police Personnel**

PTSD can be treated (cf. Fairbank, Ebert and Caddell, 2001). However, in order to do so effectively, we need to pick it up early. If we don’t, then the condition can be very difficult to resolve, and in some cases, the officer will never recover. If we get to the symptoms early, then we may be able to resolve the condition within 12 to 16 hours of treatment. However, if the traumatic stress response is severe, then we may be looking at a year or more to resolve it.

The first thing that we can do to reduce the effects of PTSD is to take it out of the closet. We need to demystify it. It is not a sign of weakness or evidence that one is a “mental.” People do not have to have their guns taken away because they have PTSD.

The second thing that we can do is to create programs that provide for Stress Inoculation Training (SIT). Ideally, these programs teach recruits what is normal when one deals with a violent encounter, since a lack of knowledge can lead to traumatic stress symptoms. The SIT programs help recruits to identify these normal reactions, and they also help them to identify signs of the more serious PTSD response so that they can access treatment services while they can still benefit from treatment. By learning how to respond to critical incidents, we can greatly reduce the emotional and physical impact on our officers.

Third, we need to embed mental health professionals within police units. The United States military has done a great job with this because they have embedded psychologist within fighting units and it is much easier to have soldiers access proper treatment services because they are already familiar with the psychologists from training exercises and social situations. We've personally had officers contact us because we've been involved with them in hockey leagues, through tactical training exercises, or through social activities organized by police associations. These officers come to trust that they can count on our support long before they encounter a traumatic incident, and they are more likely to contact us if they know us personally and can access us at any time.

Finally, when PTSD does develop, we need to access a trained mental health professional quickly. It is important to note that untreated PTSD can lead to chemical and structural changes in the brain. These problems can be treated effectively through the use of a three-stage model that was developed by Judith Herman (Herman, 1997). Essentially, this model teaches officers to use safety strategies to control seemingly overwhelming symptoms (e.g., depression, panic attacks, nausea, etc.). Safety can be achieved through breathing strategies, relaxation, education regarding PTSD and the recovery process, and possibly even the use of anxiolytic medications. In the next stage, officers learn to recall their trauma in a safe and effective manner while remaining calm and relaxed. This is a specialized process that allows the officer to learn that thinking about, dreaming about, or talking about the incident is quite different from experiencing it. In essence, this helps to reset the brain's alarm system so that it does not activate when confronted with innocuous stimuli. Over time, and with the help of a trained professional, this can lead to the return to a healthy and normal lifestyle.

*Dr. Sean P. O'Brien is a registered clinical psychologist who currently maintains a private practice in Whitby, Ontario. The majority of his work involves the provision of clinical services to policing organizations throughout Canada. He has more than 10 years of experience in dealing with high-profile critical incidents, including police-related shootings, traumatic homicides, suicides, and criminal investigations into police conduct.*

*Det. Cst. James Bremner has over 20 years experience with the Toronto Police Service. He has served in uniform patrol, and as a member of the Emergency Task Force as a gun team member, team leader, explosives technician, and tactical trainer. He is currently assigned as tactical trainer to the Gun and Gang Task Force. For contact information see [www.bremnerassociates.com](http://www.bremnerassociates.com)*

## **References**

Bremner, J. (2006, Sept). Use of force and marksmanship in Ontario. Paper presented to the Toronto Police Service, Toronto, Canada.

Cunningham, A. (2002). The healing journey: Overcoming the crisis of cancer. Toronto: Key Porter Books.

Fairbank, J.A., Ebert, L. and Caddell, J.M. (2001). Posttraumatic stress disorder. In P.B. Sutker and H.E. Adams (Eds.), *Comprehensive Handbook of Psychopathology* (pp. 183-209). New York: Kluwer Academic/Plenum Publishers.

Foa, E. and Rothbaum, B.O. (1998). Treating the trauma of rape. New York: Guilford Press.

Grossman, D. (1999). On Killing: The Psychological Cost of Learning to Kill in War and Society. New York: Little, Brown and Co.

Herman, J. (1997). Trauma and recovery: The aftermath of violence – from domestic abuse to political terror. New York: Basic Books.

Hole, J.W. (2001). Human anatomy and physiology. Dubuque: Wm. C. Brown.

Laur, Darren. (2002). The anatomy of fear and how it relates to survival skills training. Portland: LWC Books/ Integrated Street Combatives.

Lerner, M. J., & Miller, D. T. (1978). Just world research and the attribution process: Looking back and ahead. Psychological Bulletin, 85, 1030-1051.

Levitt, E.E. (1967). Psychology of anxiety. New York: Bobbs-Merrill.

Lewis, C. (2004). Police Suicide is an Alarming Problem Rarely Discussed Publicly. Tears of a cop. 01 Sept. 2004.

McNally, R.J. (1999). Posttraumatic stress disorder. In T. Millon, P.H. Blaney, & R.D. Davis (Eds.), Oxford Textbook of Psychopathology (pp. 144-165). New York: Oxford University Press.

Siddle, K. (2006). Bio-psychological responses to simulated firearms events. Paper presented to PPCT Management Systems.

Siddle, K. and Grossman, D. (1998). Effects of hormonal induced heart rate increase. Post-Traumatic Gazette, 4(4), pp. 6-7.

Turvey, B. (1995). Police Officers: Control, Hopelessness, & Suicide, Knowledge Solutions Library, Electronic Publication, URL: <http://www.corpus-delicti.com/suicide.html>, April, 1995

\*\*\*