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Trauma Observation: Post-Traumatic Stress Disorder and the Agency's Responsibility for Treatment

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ABSTRACT

Post-traumatic stress disorder (PTSD) is a mental health issue that effects as many as one-third of the police officers in the United States (Kates, 2008). Officers afflicted with this disorder experience a decrease in their quality of life through decreased experience of pleasure, declining relationships, and behavioral issues that can impact their personal and professional success (Schnurr, Hayes, Lunney, McFall, & Uddo, 2006). PTSD can manifest after years of seeing the trauma, death, and despair that is common to police officers but alien to the rest of society.

Effective and timely treatment of PTSD can improve the officer's mental and physical health. Mental health treatments improve the officers' ability to have meaningful relationships, deal with stressful situations, and improve interaction with the public. Department's see a benefit in the officers' professional interactions, department image, and a decrease in long-term health care costs. The community the officers serve experiences an officer that is less prone to excessive use of force incidents and can provide a higher quality of service.

PTSD is treatable when the condition is recognized and addressed by proper outreach and professional treatment programs. Departments have a responsibility to provide treatment that is effective and complete. A comprehensive treatment program should consist of critical incident debriefs, a diverse peer support program, and access to professional counseling services. Through effective treatment, departments will increase effectiveness in executing their mission and the officers will experience more rewarding lives.

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INTRODUCTION

Post-traumatic stress disorder (PTSD) and its psychological and physiological effects are an unaddressed epidemic in a vast percentage of the public safety workforce. It has long been believed that the psychological trauma police officers endure is simply part of the job. The reality is that it is an affliction that effects nearly a third of police officers and can have devastating consequences (Kates, 2008).

It has been largely accepted that a single traumatic event such as an officer involved shooting or other deadly force encounter can result in PTSD, and agencies have developed programs to address the stress incurred by such an event. However, law enforcement agencies have been negligent in addressing PTSD that is caused by the day to day traumatic events that officers experience throughout their careers. In multi-trauma observation PTSD, the affliction is caused by years of seeing gruesome and horrific scenes of death and injury.

The physiological effects of PTSD are regularly seen in police officers. Diabetes, heart disease, and cancer are rampant in the law enforcement community, and there are not an abundant amount of studies that link these diseases to law enforcement PTSD. The link between these conditions and the law enforcement profession have only recently been made. However, the causes of these diseases are rampant in the law enforcement community. Police officers become dependent on alcohol, prescription medication, overeating, and other destructive habits that can lead to the above diseases (Marx, 2014).

The psychological effects shown by officers suffering from PTSD are as detrimental to the officers' quality of life as the physiological effects are to the officers'

health. The physiological symptoms are categorized into three groups: those that cause the individual to relive the event, to avoid environmental reminders of the event, and an increased arousal. Examples of symptoms that re-live the event are nightmares and alarming thoughts. Examples of avoidance behaviors are avoiding areas, events, or items that remind the person of the event, emotional detachment, depression, or no longer engaging in activities that once brought the person pleasure. Examples of increased arousal behaviors are being overly sensitive to loud noises, being unusually tense, and insomnia ("Leading Causes", n.d.).

The best example of how PTSD can manifest in a police officer without a single, violent traumatic event in which the officer was involved, such as an officer involved shooting, is the response of public safety workers to the World Trade Center following the terrorist attacks of September 11, 2001. Excluding the New York Fire Department, who had their own required, on-going mental health screening, 40,000 public safety workers responded to the site of the 9/11 terrorist attacks. All of the 40,000 workers were given the opportunity of mental health screening administered through the Mount Sinai School of Medicine. In the three years following the terrorist attacks, over 10,000 of the workers that responded to the World Trade Center recovery site had taken advantage of the services. CDC reports show that a staggering 51% of the public safety workers screened were in need of professional mental health services. While the services were being offered through Mount Sinai, 143 of these responders were contacted by a group of peer outreach professionals from a U.S. agency created to provide outreach and counseling. The findings from this study showed that 13% reported symptoms of depression that were moderate or severe, 40% reported an inability to cope with

environmental triggers, and 22% were diagnosed with post-traumatic stress disorder. However, 70% of those contacted refused all screenings for services and many expressed that they feared the screenings would bring back emotional reactions that they did not want to face. It has been discussed that these members may have been the individuals most severely affected by the traumas observed (Demaria, Barrett, & Ryan, 2006).

The model adopted by many police agencies in the 1970s and later refined by the Mitchell/Dyregrov model called for a critical incident debrief following a major incident. The personnel involved in the incident would discuss their role and specifics of the event. A review of six studies involving the single instance psychological intervention technique found that the results showed no significant benefit to the subjects who participated in the debrief method. Therefore, the single debrief method has shown to be ineffective in adequately addressing the effects trauma can inflict upon an officer (Rose & Bisson, 1998).

The purpose of this paper is to establish, through research of related books, articles, studies, and academic publications, the importance of psychological support for law enforcement officers. With the high frequency of police officer psychological trauma experienced in the workplace, it is the employing agency's responsibility to prevent the onset and treat established PTSD. Such treatment should be through a comprehensive program of continuous support and multiple easily accessible resources. Psychological support programs must be constructed to protect the anonymity of the officer as to avoid the negative stigma of weakness that a psychological issue can bring when viewed by members of the tough law enforcement culture.

Departments should implement programs to address post-traumatic stress disorder affecting officers through the peer level support and professional psychological treatment services. With effective programs in place, departments can improve the quality of life of their officers, improve the physiological well-being of their officers, and reduce long-term medical costs incurred by the employing municipality and the officers themselves.

POSITION

Proper treatment of PTSD and intervention after traumatic events can improve the quality of life of an officer. A study of how PTSD effects quality of life has shown that 59% of PTSD patients experienced severe impairment of quality of life. PTSD can lead to deterioration in the quality of the officer's personal life by causing an inability to maintain relationships, declining mental stability, and prevent the ability to experience pleasure. These coping deficiencies can lead to higher divorce rates, avoidance of crowds or social situations, inappropriately resorting to violence, anger issues, irritability and even suicide (Schnurr et al, 2006).

These symptoms can have a devastating effect on the officer's life, both professionally and personally. An officer who has increased irritability or is unable to control violence can very easily find that the condition is detrimental to his career. A use of force incident that is unwarranted or unreasonable can not only be a career ending event, but can lead to incarceration for assault charges or worse. Even if the aggression issues do not end in termination of employment, they can lead to a reputation of being difficult or impossible to work with. Whereas the officer may still keep his job, the

reputation garnered could lead to loss of promotional opportunities, denial of lateral transfers or removal from specialized assignments that bring the officer pleasure.

Of course, most would consider the professional effects PTSD can cause as secondary to the effects on the officer's personal life. Avoidance of groups of people could be detrimental to an officer or spouse who has previously enjoyed a healthy social life. When crowds are a source of anxiety, the officer would not be inclined to attend concerts, parties, group dinners, clubs, and any number of other social pastimes. Feelings of being trapped and not having a social life could easily lead to deterioration of an intimate relationship and the end of a marriage. Possibly a greater threat to family are the anger, irritability, and a higher propensity for violence associated with PTSD. Anger, irritability, and especially violence could end a marriage, but would have an especially devastating effect on children. Violence can end a lifelong relationship with the officer's children and can even cause children to be psychologically harmed themselves.

There is also a passive symptom of post-traumatic stress that effects some sufferers. Officers who are exposed to dead children or disturbingly maimed adults can associate the traumatic events to everyday interactions with family members. When an officer looks at his wife or children of similar age to those he has seen deceased or maimed, his family members can trigger an environmental response to the traumatic event. This can lead to the officer emotionally detaching himself from family members to protect himself from the emotional trigger, leaving the family members alienated and himself isolated from those he loves (McFarlane & Bookless, 2001).

Implementing an effective psychological treatment program for officers suffering from PTSD could improve their quality of life. Relationships with co-workers, family and

friends can be improved and the officer will find these relationship more rewarding. Officers who have previously seen a deterioration of their careers can have an improved chance of professional success and a brighter future.

Another benefit of proper treatment of PTSD in police officers is to improve the officer's physical health. The psychological effects are the means of diagnosis for the condition and, therefore, are the most prevalent and identifiable symptoms. However, the multi-event PTSD that formulates in police officers builds up over time. This is further exacerbated by the police culture that makes officers feel that seeking help for mental issues is not okay for fear that it will be seen as a sign of weakness. As a result, the self-destructive behavior that the psychological symptoms cause eventually lead to health issues.

When officers start in police work, many are healthy, strong individuals in good physical shape. Healthy young people with a strong sense of community are drawn to police work and the result is an applicant pool of driven young people with high fitness levels. As the officers are exposed to the worst of society and all of the death and violence that comes with the profession, many officers develop undiagnosed PTSD. When self-destructive behavior becomes a norm in the officers' lives, many start to see a decline in physical health. Alcoholism, overeating, and a lack of exercise can all be symptoms of the officers' reaction to observation of trauma. According to van der Kolk (1987) increased exposure to trauma can lead to a lessened level of motivation. Van der Kolk assimilated this phenomenon to a decline in occupational performance, but the argument could easily be made that this could also lead to a decline in other aspects of motivation, such as the desire to exercise or maintain prior activity levels.

The decrease in activity levels coupled with the need to self-medicate through alcohol, drugs and excessive eating can lead to devastating health effects. Type 2 diabetes is referred to by physicians as the cop's disease. Many outside law enforcement view obese officers as lazy or slovenly when the real culprit is the job itself. Proper treatment of existing PTSD in officers and, more importantly, adopting a system to treat officers after they experience a traumatic event, could greatly improve existing health effects and in some cases prevent the health effects from manifesting.

The two positions outlined above concentrate on the effects of PTSD on the officer; however, there is also a great benefit to the departments when treatment to the officer is administered. The officers' employing municipal, federal, state, or county agency would see a financial benefit to implementing a program to treat psychological injury to its officers. The health effects of diabetes, alcoholism, heart disease, and cancer have been hypothetically linked to PTSD (Schnurr et al, 2006). These conditions consume a vast amount of the costs of health care in the United States and are so prevalent that heart disease, cancer and diabetes are in the top six leading causes of death in the United States ("Leading Causes," 2015).

Agencies that implement programs to combat PTSD in its officers could see a sharp decline in the amount of money the governing body spends on health care. Agencies that address its officers currently suffering from PTSD and implement intervention procedures for those that are exposed to trauma could improve the agency's overall health. With improved health, the agency could also see a healthier bottom line.

COUNTER POSITION

A counter position to the validity of this theory is the validity of PTSD as an illness. There are psychological theorists that resist the categorization of symptoms into the diagnosis of post-traumatic stress disorder. PTSD was formally recognized as a condition in 1980 and has come to the forefront of media and social consciousness after the September 11, 2001 terrorist attacks and the ensuing wars in Iraq and Afghanistan. But there are those who feel that the systematic treatment approach to PTSD as a generalized diagnosis can have a more detrimental effect to the officer than concentrating on traditional diagnosis treatments. One of the theories offered in Brewin's book (2003), suggests that PTSD is not caused by an individual's reaction to trauma, but rather that the exposure simply exacerbates pre-existing hereditary or psychological disorders. This suggests that mentally healthy individuals do not get what practitioners are labeling as PTSD, but instead, the traumatic event simply triggers the symptoms of pre-existing disorders such as schizophrenia, major depressive disorder, and hereditary predisposition to alcoholism. If this theory were to be believed, treatment centered on the traumas experienced in police work may be inappropriate as they would be treatments that are centric on the event itself. It would suggest that the treatment should be centered on the underlying condition that the traumatic event triggered, not the traumatic event itself.

To rebuke this theory one must consider the percentage of police officers that potentially suffer from PTSD which was cited above as possibly being as high as 33%. In a study mentioned above, 51% of rescue/ recovery workers at the site of the 9/11 terrorist attacks suffered a psychological injury that required treatment. In the same study,

40% showed an inability to cope with psychological triggers (Kates, 2008). By comparison, the general population has a rate of approximately 25% of the population experiencing some kind of mental illness with 5% experiencing a serious mental illness (Duckworth, 2013). The theory that PTSD is non-existent and the underlying cause is a preexisting psychological condition does not explain the prevalence of a severe inability to cope manifesting in PTSD diagnosed patients compared to the psychological health of the general population.

Another counter position is that the responsibility for treatment lies with the officer and not the department. With on-duty physical injuries, such as injuries sustained in a car wreck or resulting from gunfire as a result of police action, there is a clear moment the injury is inflicted and specific injury sustained by the officer. With psychological injury, especially injury that in inflicted over time, the distinction is not so clear and can occur over an extended period of time. It may take five years or more of seeing the accident victims, dead children, victims of industrial accidents and gruesome homicide scenes for PTSD to manifest. The argument can be made that the officer's diagnosis was the deterioration of mental health over time and place the responsibility of treatment on the officer instead of the department. If the expectation exists that the officer maintain his physical health as a routine course of life, the argument can be made that the officer must maintain his psychological health as well.

The numerous sources describing the stressors a law enforcement career have on the officers' emotional and psychological well-being rebuke this theory. Marx (2014) discusses the increased stress on law enforcement and the difficulty in identifying when it takes its toll on an officer. Increased stress and constant observation of trauma is the

norm in law enforcement, yet they are considered events that are outside the normal human experience for the rest of society. Psychological injury from such events must be considered an on-duty injury. Just as a broken leg sustained in a foot pursuit with a suspect is considered an on duty injury, psychological injuries are a direct result of law enforcement duties.

RECOMMENDATION

Departments should implement progressive programs to address post-traumatic stress disorder and emotional stress in their officers by providing multiple means of assistance. Stressors encountered while executing the law enforcement mission are outside of the normal human experience and observation of trauma can lead to the manifestation of PTSD. Symptoms such as irritability, increased susceptibility to violence, sleeplessness, insomnia and other self-destructive behaviors are indicators of the manifestation of PTSD. Left untreated, these conditions can lead to heart disease, diabetes, cancer or even suicide in those it effects. The symptoms can have extremely detrimental effects on the officer's quality of life. Relationships can suffer, careers can be destroyed, and loved ones can be driven away leaving once healthy officers sick and alone. Departments that implement effective programs to combat the effects of PTSD in its officers can improve the officer's quality of life and the overall effectiveness and financial future of the organization.

The theories that PTSD is a pseudo-illness or not the department's responsibility do not stand up to statistical or logical arguments. As many as one third (33%) of police officers may suffer from PTSD that creates a significant impairment (Kates, 2008).

However, the general population has a rate of one in twenty (5%) suffering from a serious mental illness that creates a significant impairment (Duckworth, 2013). Comparing these two statistics rebukes this theory. Analysis of these statistics also shows that the rate of mental illness, specifically PTSD, is higher in police officers than the general population; therefore, the cause can specifically be linked to the stressors of the law enforcement profession which places the responsibility for treatment as solely the burden of the department.

The solution to this epidemic is not a complicated one. Departments have been doing mandatory counseling for officers involved in on-duty shootings for years. The difference between the officers involved in on-duty shootings and the officer that is having difficulty dealing with PTSD brought on by trauma observation is that the latter is more difficult to identify. Departments must institute a multi-optional program to reach these officers while allowing anonymity to the officer. The recommendation of this paper is to institute a program of a critical incident debrief by a licensed psychologist coupled with multiple avenues to access available resources for officers to seek help. The available resources should consist of access to a staff psychologist, a contracted employee assistance program and a diverse peer support team. The peer support team should consist of officers and civilians throughout the department in order to increase the chances of having a trained peer support professional that is available to speak to an officer that is showing symptoms of difficulty coping. Peer support officers dispersed through an organization will also be able to monitor their peers and offer assistance when a need is identified. To ensure the success of a broad support program, the department must alter its culture to remove the stigma of weakness mental health issues

have with members of the police culture. With multiple options for assistance in place to combat the stressors upon an officer's mental health, departments can improve the lives of its officers, officers' families, and the departments' effectiveness.

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