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Post-Traumatic Stress Disorder (PTSD) and Policing –

Short Guidance Document

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Foreword

Trauma, and its impact on our physical and mental health, has been hidden for decades behind a 'be-strong' culture. This culture may serve us well in times of crisis, but takes its toll when we refuse to acknowledge its presence. Trauma stays with us from the first day we join the job to our last, and beyond.

When I meet new recruits, I start off by stating unequivocally that I am proud to have spent my life dealing with trauma. Usually I see a few raised eyebrows as they try to work out why I'm not standing in front of them, trotting out the usual corporate jargon. I go on to explain why I'm proud: because I believe that the true mark of an exceptional blue light professional is to be able to be at their very best for the victim, the casualty and the bereaved in their time of need.

Quite often, this requires us to deal with some of the most traumatic events imaginable and we do this day in and day out, all of our working lives. To be able to do our best for others we must first look after ourselves and those who lead must work tirelessly to support us. This short guidance is the work of experts in the field, all of whom have given their time freely because they care about the work we do to keep everyone safe.

It is intended to help all of us understand PTSD better so that we can move from denial into taking personal responsibility for our own resilience. It is non-negotiable for us to be competent in whatever role we perform, but that is not enough. To be a true professional we must also be compassionate towards those who need us when they have nowhere else to turn. We must also show compassion towards our colleagues and ourselves. By understanding how trauma affects us we can move from ignorance to awareness, from negativity to positivity, and from pessimism to hope.

Trauma is our job and, whilst we often normalise what is an exceptionally challenging working environment, we can – and should – be proud that we do the things that others never see. Use this short guidance to stimulate reflection about your own experiences and how you process them. If reading it triggers thoughts and feelings that concern you, reach out to your colleagues, your friends or professionals you feel comfortable talking to – because your journey towards understanding how the exceptional work you do affects your health has just begun.

Chief Constable Andy Rhodes
NPCC Lead – Wellbeing and Engagement

Who is this for?

This brief guidance has been designed with a number of different groups in mind, including police officers and staff, occupational health and human resource practitioners, the Police Federation and Police unions as well as the partners and families of police officers and staff. Its goal is to provide some of the essential information needed to understand the kinds of events that can cause traumatic responses, the different kinds of responses that occur, how officers and staff can build their resilience to avoid becoming traumatised, and which interventions may help with treatment.

What is PTSD?

Before the introduction of post-traumatic stress disorder (PTSD) as a diagnosis in 1980, it was not formally recognised that highly stressful events could sometimes have long-lasting psychological consequences. There is no simple definition of a traumatic event, but it usually refers to an event or series of events that cause (or threaten to cause) death, injury, or violation. This may be directly experienced, witnessed, or in some cases viewed on screen (eg repeated exposure to images of dead bodies or child abuse).

PTSD is one reaction to such extreme stress; however, there are other responses, including anxiety and major depression. There are different ways to diagnose PTSD, but in essence the diagnosis requires the presence of three types of symptom: re-experiencing the event or events in the form of vivid and powerful images (flashbacks) or dreams; avoidance of reminders of the event or of thinking about specific aspects of the event; and hyperarousal involving a continuing sense of threat (even though the event is in the past) which is visible in reactions such as being constantly on guard or being easily startled.

Other common symptoms include emotional and physical reactions (like sweating or heart racing) when encountering reminders of the event, avoiding other people, being irritable or having poor concentration, difficulty sleeping, loss of normal concern for others, and taking unnecessary risks.

All these symptoms are normal reactions to an extremely stressful event and usually improve of on their own within a few days or weeks after the event. It is the persistence of these symptoms that signals the presence of PTSD, along with a negative impact on work, home, or social life. If untreated, the condition may last for years. Sometimes other people, such as colleagues or family members notice the signs of PTSD more readily than the person having the symptoms.

PTSD risk factors

The mechanisms that cause PTSD are not fully understood, however, many of the risks have been identified.

The pre-trauma risk factors include a previous history of mental disorders, difficulties in being able to self-calm and a tendency to become frightened and fretful about things that may have gone wrong in the past or may go wrong in the future. PTSD-vulnerable people also tend to have a passive coping style, preferring distraction as a coping mechanism (such as alcohol and avoidance behaviours) rather than an active coping style, which involves identifying the issues and finding resources and support necessary to deal with them.

During a traumatic event, those who have a strong emotional reaction, such as overwhelming fear of imminent death or injury, extreme horror at what has been witnessed, or extreme helplessness are associated with additional risk. These 'peri-traumatic' responses may be accompanied by dissociative reactions such as experiencing a sense that time speeding up or slowing down, or that oneself or the world is unreal, an emotional numbness, or out-of-body experience.

The risk factors that occur following a traumatic event include self-blame for what happened or the reaction to it, negative reactions from other people, and exposure to additional stress or pressure at a time the person needs all their resources to process and make sense of what has happened.

In addition to the risks associated with a single event in policing there is also a risk of cumulative trauma, where numerous smaller events appear to add up, with the result that they end up having a similar effect. There is an increased risk of cumulative trauma, when the person does not recognise and acknowledge that some events are emotionally demanding and they believe they can simply carry on as though nothing has happened. The likelihood of cumulative trauma increases where stigma makes it more difficult to accept normal trauma responses.

Complex PTSD (cPTSD)

In the past, the term 'complex PTSD' has been used to describe to a severe form of PTSD that is associated with exposure to long-term or repeated trauma from which there was no escape, such as captivity, torture, or intra-familial abuse. The latest version of the International Classification of Diseases (ICD-11), published by the World Health Organisation in 2018, has for the first time published a formal definition that distinguishes it from PTSD.

The new diagnosis states that cPTSD is a combination of PTSD symptoms (Avoidance, Re-experience and Sense of Threat) with three additional symptoms: difficulties in controlling and regulating one's emotions, problems in forming and maintaining relationships with others, and a highly negative perception of oneself or low self-esteem. According to ICD-11, the disorder does not require long-term or repeated trauma to have happened, but such events are risk factors that increase the likelihood of acquiring a cPTSD diagnosis as opposed to PTSD. It is likely that many emergency service workers will be found to be experiencing cPTSD rather than PTSD. The implications of this change in diagnoses will be discussed later in this guide.

The incidence of PTSD and cPTSD in policing

A national screening and surveillance programme involving police officers and staff (n = 14,500) with a response rate of 80 per cent has shown that, whilst there is some variation between roles, the prevalence of clinically significant PTSD in UK policing is 12 per cent[1]. This is much lower than the survey undertaken by the Police Dependants' Trust, where the level of self-reported trauma symptomology was estimated to be 16 per cent (n = 11,000 officers)[2]. The difference between the results is likely to be due to differences in response rates and measures between the two studies.

Are police officers and staff more vulnerable to developing PTSD than other blue light services?

There is no evidence to suggest that police officers are any more vulnerable to developing PTSD than other emergency service workers. In fact, a literature review has shown that PTSD in police is less than 10 per cent, whereas 20 per cent of paramedics and firefighters are thought to have PTSD[3]. However, police officers are under increasing pressure and stress[4]. This increases the vulnerability to developing a range of clinical conditions, which warrants attention.

It is not yet possible to assess how many officers and staff currently experiencing clinical levels of PTSD also have the additional three symptoms, which would give them a diagnosis of cPTSD. To assist clinicians to be able to identify people with cPTSD, a new brief measure has been developed which is based on ICD-11 criteria[5]. There are plans to validate the new International Trauma Questionnaire for the policing population, at which time it will be possible to consider the implications of the introduction of this diagnosis in policing.

Neuroscience and PTSD

In recent years, there has been an increasing interest in neurobiological and neuroendocrinological responses during a traumatic threat and after a trauma has ended[6]. Neuroscience has advanced considerably during the past 15 years, increasing our understanding of how acute and chronic stress affect the workings of the human brain. This has been conducted in a range of occupations, including policing[7 8 9 10 11].

Areas of the brain involved include:

- Hippocampus (which processes memories including traumatic memories).
- Amygdala (from where our stress and threat responses originate).
- Prefrontal Cortex (which helps us to connect with others, to improve our self-awareness and to manage compassion).

All of these brain functions are relevant to policing. Police officers need to process trauma exposure on a regular basis, manage threat perception and the mind and body's stress responses to it. Compassion and the desire to make a difference are often key motivators for those joining the police, and officers and staff strongly value peer support and colleague compassion.

Neuroendocrinology and PTSD

The body is finely tuned to respond to threatening situations. Central to this response are the hypothalamus, pituitary and adrenal glands (HPA system) which orchestrate the regulation of stress response and bring about the restoration of calm and normality[12]. The deregulation of the HPA system, which occurs in extreme stress, is associated with several disorders including major depression, post-traumatic stress, panic disorder and chronic anxiety. Where the stress occurs in early life there is mounting evidence that this brings about a change in the structure of the brain[13] and affects the way genes create complex proteins. This change is associated with an increased vulnerability to psychological trauma in later life[14]. The autonomic nervous system's responses to threat are well known as Fight, Flight, Freeze and Appease. These responses are outside personal control with the fight/flight responses being associated with the Sympathetic Nervous System and the Freeze/Appease with the Parasympathetic System[15]. However, in policing these automatic behaviours may be interpreted negatively and can create feelings of shame and guilt which tend to increase the magnitude of the trauma response[16].

The development of proactive skills to reduce the impact of trauma

So, we can see that healthy brain function in policing (just like in the military) is something to acknowledge, understand and support. The term 'the policing brain' is useful because it reminds us that policing can involve impactful experiences that shape the way our brains adapt and manage over time. Sometimes our brains adapt well, and sometimes our brains develop less healthy coping mechanisms that can go unnoticed until the damage from those behaviours affects us and those around us, and we seek help.

> " I have led quite a positive career and always put myself forward for any challenges and policed in a robust manner and not been scared to tackle some large problems….I have always taken pride in how as a service we deal with traumatic incidents and support the people affected by them – and I have done this without much thought to the effects on me. "
>
> **Response Officer, 40s, 18 years in service (2018).**

Modern neuropsychology gives us a chance to be more proactive and to improve our awareness of what our brains need to do to adapt to the demands of the job. For example, contemporary research in the UK is investigating new ways to support new recruits and those in high-risk policing roles in learning simple cognitive skills to apply on an everyday, operational basis to boost trauma processing and resilience.

> " Trauma can affect any of us at any time and to have an understanding of what is happening in our brains and simple proactive techniques available to support it is invaluable in modern policing. I'm now able to talk to colleagues with confidence about the benefits of putting an incident into perspective and the fact that what they are experiencing is normal ."
>
> **Response Inspector and trainer, 20 years' service (2018).**

> " It's great to see how the brain works. It helps us to understand and feel better when thinking of incidents. The techniques help thinking and memory."
>
> **New recruit with police trauma exposure, 26 years old (2018).**

Getting perspective

Managing threats and being able to successfully commit events to memory is an integral part of policing. Being able to respond effectively to an incident or case, and being able to remember, evidence and explain that response is essential to everyday life on the job for many officers and staff.

Neuropsychology tells us that one part of the brain – the hippocampus – is particularly useful in helping us to contextualise trauma (or threat) and file the memories of it[17]. Ironically, the hippocampus can become damaged by stress, so it finds it increasingly difficult to provide context to the experiences we have, and so we find them harder to file away[18 19 20]. This can happen to any of us at any time, and may fade over days and weeks. However, if we try to ignore this, it can have a cumulative effect and lead to burnout, PTSD or cPTSD. Science indicates we need to make time to process the impact an incident has on us before we move on to the next.

> "Together with my counsellor I discovered I was not broken- everything that was happening to me was pretty normal. I had been accepting and filing traumatic experiences for years and not giving myself time to work through and process what I had actually been doing. Like all cops, I had conditioned myself to go to from job to job without thinking what my brain needed from one moment to the next."
>
> **Response Officer, 18 years' service (2018).**

There are techniques we can use to boost trauma processing, and some of these techniques are already used in policing and trauma therapy. Creating maps (sketch plans) and timelines of incidents is an accepted part of the investigative process, particularly when it comes to interviewing witnesses[21 22]. Looking back at traumatic experiences from an observer or overhead perspective is also used in therapy[23 24 25] and has been trialled in the military to boost the hippocampus in cases of cPTSD[26]. Ongoing research is looking at using paper-based mapping and timeline techniques with new police recruits. Initial results suggest that learning to shift viewpoints and create timelines of any traumatic incident improved how at ease individuals felt about the experience and improved their recall of it. Officers reported that broadening their view of what happened 'gave themselves more space and time' to make sense of it, lowering their stress response and allowing them to move on.

> " Taking myself out of situation and remembering it from other perspectives has helped me normalise and overcome the feelings I had towards the experience."
>
> **New recruit with previous personal trauma exposure, 29 years old (2018).**

Sharing experiences

Another way of being proactive is simply not ignoring what has happened and talking about it instead. Evaluation of post-incident management interventions refers to peer support as being one of the best predictors of managing trauma exposure[27]. This shows that being able to 'put things in context' with others and sharing perspectives really helps the brain file an incident to memory. When we recognise others' perspectives, this activates the prefrontal cortex and makes us feel connected and helps lower our stress response[28].

Waking up and tuning in

Staying aware of what the mind is doing is increasingly understood as vital to wellbeing and resilience overall[29]. This is not always easy in jobs like policing, which create strong memories and which require forethought and preparation for whatever comes next. Extreme experiences can seem to pull us away from the present, often taking us back to particularly vivid moments. Sometimes these are referred to as 'flashbacks' or 'intrusions'. Deliberately calling to mind moments from when an experience becomes 'safe' again, or has passed, can offer individuals a sense of safety. Such moments are called 'safety cues' and can help calm the amygdala and overall stress response.

> " My brain, as a survival instinct, had progressively put everything into the back of my head…I later realised that all these fragments of traumatic incidents needed to be sorted and that I had to give myself time to do this, not distraction. I began to plan my mental health and strength like we do our physical wellbeing as police officers. I now believe it is possible to give people the tools to not just process and deal with trauma but to feel really healthy again and prevent ongoing damage."
>
> **Response Officer, 18 years' service (2018).**

Finally, practising techniques of improving awareness and attention improves moment-to-moment awareness in general. Such skills can help to keep us in the present, so we can make clear decisions and take appropriate action. These techniques have been shown to improve the function of many areas of the brain and can give us a solid starting point to improve cognitive function and maximise our resilience to the experiences that come our way, in policing and beyond.

Value of peer support

Peer support is a means of creating a safe and confidential place where employees can help each other with workplace issues that impact on their lives. It is predicated on active listening, is non-judgemental and supportive. The value of peer support lies in the simplicity of the concept. It is not about solving or fixing things, nor is it therapeutic. It is about actively listening, caring and supporting each other in times when our ability to cope may be tested.

Role of supervision

The role of the supervisor is critical in terms of PTSD and cPTSD. Supervisors have an important role in engaging, informing and supporting employees who are experiencing mental health issues. Supervisors should never do nothing, however it is important that they take evidence-based approaches. Supervisory good practice is to have regular one-to-ones with employees to see how employees are and how they are feeling. It encourages employees to talk about their health and wellbeing and helps to create a safe environment for employees to discuss their own feelings.

Good supervisors give employees the opportunity to ask questions and keep employees informed of organisational or team changes, seeking views where possible. Great supervisors avoid micromanaging and give employees as much control as possible over how they deliver their work, while ensuring they have the right skills for the job. They create the right working environment for a meaningful and purposeful life, and monitor workloads to ensure what individuals are expected to deliver are realistic within the timescales and resources available. They lead by example, role model good behaviour and encourage work-life integration.

Excellent supervisors know enough about their employees to spot when things are not right and have the skills to intervene quickly and effectively. They are aware of where to access help, what is available for their employees and how to make it happen should the need arise.

Role of Occupational Health/EAP

The occupational health service provides a safe and clinically confidential space for police officers and staff to talk about their health. This might be describing symptoms or how they are coping or not coping with work. It is probably the only place in the force where a holistic assessment of health can take place. Using a bio-psycho-social model of assessment, an occupational health practitioner will ask about symptoms with a view to making a diagnosis that will inform future management of an illness. This will take into account any pre-existing health conditions and other past medical problems. Occupational health practitioners are able to liaise with other treating clinicians to ensure a connected care pathway and, in many cases, to refer for specialist treatment. Employee Assistance Programmes may be able to provide generic mental health support. However, they often do not provide the specialist psychological interventions necessary to assess and treat PTSD. Forces will need access to either in-house or external therapists for trauma-focused CBT or EMDR. Occupational health practitioners will advise on making workplace adjustments to support either continuing at work, possibly via temporary redeployment, or phased return to work at the appropriate time.

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