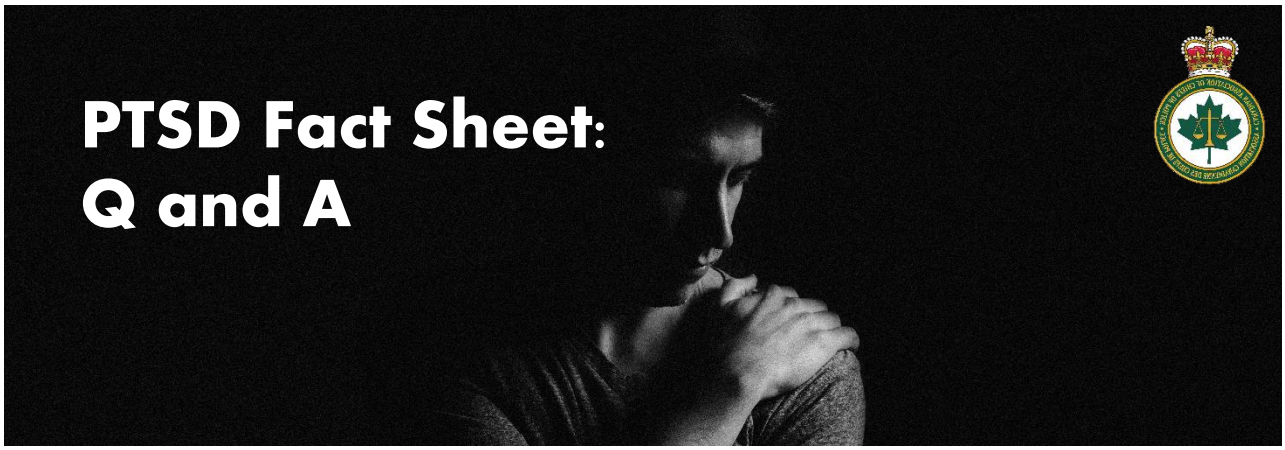

With the upsurge in recent interest in PTSD and related disorders, Human Resources personnel can easily be overwhelmed by conflicting information. There are some questions psychologists very commonly get asked about the assessment and treatment of PTSD. We have attempted to answer some of these questions below.

This reference has been prepared by the Police Psychologists Sub-committee of the CACP Human Resources and Learning Committee.

The issue of post-traumatic stress disorder (PTSD) in the police workplace has garnered significant interest in recent years. Indeed, there are even advances in provincial legislation as part of efforts to better manage PTSD among police. If you were to believe the popular press, you might be left with the feeling that sooner or later, all police personnel will have PTSD, leading inevitably to lifelong incapacitations or significant workplace accommodations. As is often the case, the true picture is a little different from what one might assume based on popular notions. About half of all adults in the general population, and probably nearly all police personnel, may be exposed to one or more potentially traumatic incidents in their lifetime. However, the majority of these people never develop PTSD. Many people may display some post-traumatic symptoms in the early months following exposure to a critical incident, but most will recover fully with no treatment. Some may experience anxiety and depression, but not PTSD. A significant number may experience "post-traumatic growth" following a critical incident, and become more resilient, better copers than they were previously. Clearly, exposure to critical incidents is necessary, but not sufficient, for PTSD. For those who do develop PTSD, the disorder likely results from a complex combination of pre-existing personality characteristics, previous life experiences, social support, and the events that occur immediately after the critical incident. For those individuals (such as police personnel) who encounter workplace critical incidents, organizational structures also likely influence the development of PTSD, as well as in assisting those who do have PTSD with recovery and workplace re-entry.

1. What exactly is PTSD?

Exposure to a potentially traumatic event (e.g., either the actual experience of or witnessing serious injury, actual or threatened death and/or sexual violence) may produce a variety of responses including, but not limited to, negative changes in thinking, emotions, and behaviour. Responses to a potentially traumatic event may differ from one individual to the next but can include distressing thoughts, intrusive images and/or memories (sometimes called "flashbacks"), negative emotional states, irritability, anger, feelings of numbness or detachment, problems concentrating, disrupted sleep, and efforts to avoid reminders of the traumatic event. Such symptoms can cause significant personal distress and may negatively impact daily functioning (e.g., difficulty completing tasks at work, school, or home, problems in relationships). When problematic symptoms persist for longer than one month, an individual *may* meet diagnostic criteria for a mental health disorder referred to as post-traumatic stress disorder. As noted above, exposure to a traumatic event is not the only requirement for such a diagnosis—and many people who are exposed to one or more traumatic incidents will either have no lasting effects—or may indeed develop other mental health problems such as anxiety and/or depression, but not PTSD.

The most widely used criteria for diagnosing PTSD in North America is included in the newest version of the *Diagnostic and Statistical Manual - DSM-5*. *DSM-5* requires the presence of several types or clusters of symptoms including:

a) repeated, intrusive and distressing memories of the traumatic event,
b) efforts to avoid reminders of the event,
c) negative thoughts or feelings than began or worsened following the incident,
d) heightened levels of physical arousal (e.g., exaggerated startle reaction,hypervigilance), and
e) symptoms must persist for more than 1 month and cause significant distress and/or impairment in functioning.

2. Is an "occupational stress injury" the same as PTSD?

The phrase "occupational stress injury" (OSI) was originally coined to describe a group of symptoms that some members of the Canadian Military were experiencing as a result of their service. Part of the intention behind the new phrase was to better recognize that the symptoms were caused, at least in part, by experiences associated with service, rather than by a failure of the individual. The phrase and associated acronym remain relatively new but have increasingly been used by non-military persons for similar purposes. Within that context, PTSD has been referred to as an OSI. Within that same context, PTSD would be one of many mental disorders that could be referred to as an OSI, including, but not limited to, major depressive disorder, generalized anxiety disorder, and panic disorder. In summary, PTSD may be an OSI, but not all OSIs are PTSD.

3. Do most/many/all police officers end up with PTSD?

The research on how common PTSD is among Canadian police officers remains relatively limited. Results from a recent study[1] suggest that about a quarter of Canadian police officers *screen* positively for PTSD (meaning that they self-report symptoms that may be consistent with PTSD). About 40% self-report symptoms consistent with any mental health challenge, including PTSD, but also including depression, anxiety, and related symptoms. However, the results were based on self-report screening tools and the sample included only about 5% of Canadian police officers, which means the results are only estimates. Canadians continue to wait for a full interview-based epidemiological study to understand the actual diagnosed levels of PTSD among our police. Some sources suggest as few as 10% of police may meet interview-based diagnostic criteria—which is still slightly higher than the percentage of people in the general population who have PTSD.

Regardless of the exact numbers, the evidence is clear that mental health issues are not uncommon among police officers. Given what we know about the cost of mental health problems in the workplace in general, there is a clear need and justification to develop evidence-based prevention and intervention strategies in the police workplace.

4. How is PTSD assessed? And who assesses it?

PTSD is best assessed and diagnosed by trained medical and/or mental health professionals, and there are effective treatments.

There is no blood test to determine if someone is suffering from PTSD. Instead, PTSD is assessed using a combination of clinical interviews and psychometric testing. The examiner will try to determine not only if the person meets the criteria for PTSD but will also work to rule out other possible diagnoses such as depression, anxiety, or substance use. As noted, not all OSIs or mental health problems are PTSD. It is important to arrive at the correct diagnosis so that the appropriate treatment is provided. For example, providing a PTSD-focussed treatment to a person whose problem is actually anxiety or depression is less likely to provide the best possible outcome.

Interviews can involve an assessment of current symptoms as well as a person's past history, personality characteristics, and the nature of the trauma(s). In some cases, assessments can also involve interviews with family members or significant others. Interviews are helpful but generally not sufficient for diagnosing PTSD. Accordingly, additional tests and measures are often used. Some of these may be general measures of personality (e.g., the MMPI-2, the Personality Assessment Inventory), but other are specific to PTSD (see below). Common tests that measure symptoms of PTSD include:

[1] http://journals.sagepub.com/doi/full/10.1177/0706743717723825

Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)

The CAPS-5 is the 'gold standard' psychometric test for the evaluation of PTSD. Developed by the Department of Veterans Affairs (USA) National Center for PTSD, the CAPS-5 assess PTSD symptoms that include the onset and duration of symptoms, subjective distress, impact of symptoms on social and occupational functioning, and improvement in symptoms during treatment.

PTSD Checklist (PCL)

The PCL is a self-report questionnaire that can be given out to officers to answer. This self- report questionnaire takes very little time to complete and can help officers and their care givers determine if a more comprehensive assessment is required.

Structured Clinical Interview of DSM-5 Disorders (SCID)

The clinician-administered SCID has been shown to provide valid and reliable diagnostics for PTSD, but it also tests for other psychological disorders that frequently occur together with this illness (e.g., depression, substance abuse/dependency).

5. Can people recover from PTSD?

Recovery is the primary goal for officers who have experienced PTSD, their families, and their care providers. Recovery does not necessarily mean complete freedom from post-traumatic effects. Recovery is an individual experience and can look different for everyone. In general, recovery from PTSD is the ability to live in the present without being overwhelmed by the thoughts and feelings of the past. Recovery from PTSD is best looked upon as a process that is worked on over time and in stages. The re-establishing of safety is the first and most central step in recovery from this illness. There is limited research about how many people with a diagnosis of PTSD actually return to full employment, but the available information suggests that most do. This of course depends on the severity of the disorder, the person's own history, the nature of the trauma, and significantly, the nature and level of support from the workplace. In general, people who engage in and persist with evidence-based treatment approaches, and who perceive good support from their employer, do better in the long term.

6. What kinds of treatment work for PTSD?

Police employees affected by PTSD have a variety of effective treatment options to help recover from this disorder. The popular literature includes everything from yoga to diet to self-help programs. However, recognized evidence-based treatment approaches, by which we mean treatments that research suggests improved symptoms for most people, include:

Prolonged Exposure Therapy

In this type of treatment, a therapist guides officers to recall traumatic memories in a controlled and incremental fashion so that they eventually regain mastery of their thoughts and feelings around the incident. While exposing officers to the traumatic events may seem counterintuitive, it is done in a gradual, controlled, and repeated manner, until the officer can evaluate their circumstances realistically and understand they can safely return to their usual activities. Virtual reality technology is now increasingly being used in Prolonged Exposure Therapy sessions.

Cognitive Therapy

A form of cognitive behavioural therapy, or CBT, this treatment includes an exposure component but places greater emphasis on cognitive strategies to help change erroneous thinking that has emerged because of the traumatic event. For example, a psychologist may work with an officer on distorted ideas or assumptions that the world is no longer safe or that they are incompetent because they have 'let' a terrible event happen to them.

Eye Movement Desensitization and Reprocessing Therapy (EMDR)

In this type of treatment, the psychologist guides officers to make eye movements or follow hand taps at the same time they are recounting traumatic events. There is ongoing debate about the mechanisms by which EMDR works, which can make the therapy appear controversial. Nevertheless, there is research supporting the use of EMDR.

Interpersonal Psychotherapy (IPT)

IPT is a novel therapy for PTSD when compared to the other therapies listed above. Unlike the Prolonged Exposure, Cognitive, or EMDR therapies, IPT does not require 'exposure'. Rather than attempting to reconstruct the traumatic events, IPT is designed to repair the damage trauma does to interpersonal trust and social functioning. Trauma can isolate officers from the social supports that help in recovery from PTSD. By helping officers identify their emotions and to recognize them as helpful social signals (rather than as bad or dangerous) they can put them to use to handle relationships better, deciding whom they can and cannot trust.

Medications

There is research supporting the use of selective serotonin reuptake inhibitors (SSRIs) for PTSD. Specifically, paroxetine (Paxil) and sertraline (Zoloft) have been approved for use in treating PTSD. Other medications may be useful in treating PTSD as well, particularly when the person has additional disorders such as depression, anxiety, or psychosis. Medications typically attempt to treat the symptoms of PTSD and not the psychological cause(s). Nevertheless, they can be effective therapies on their own or as a supplement to psychotherapy.

7. As an organization, are there things we can do to help prevent PTSD and to facilitate recovery and return to work?

Given the huge costs—both financially and in human terms—of incurring PTSD in the workplace, employers have a vested interest in preventing PTSD in the first place and in treating/remediating PTSD that does occur. Some common organizational solutions include:

- Employee Assistance Programs (EAP) and Family and Employee Assistance Programs (FEAP),
- education related to prevention and early intervention, such as the R2MR program,
- crisis intervention/management teams,
- "Safeguard" type programs for people in higher risk job categories, and
- peer support.

Importantly, simply having programs such as these is not sufficient. Having a program does not necessarily mean that it is working. Services offered must meet current "best practice" standards. For example, FEAP and EAP programs should utilize skilled mental health professionals with knowledge and experience in treating PTSD (not simply "counselling"). Crisis intervention services should be designed and be mindful of the potential damage that some interventions may cause. Peer support programs reflect careful selection and training of peers and should not be seen as a substitute for professional help when needed.

Research also suggests that the incidence of PTSD increases when the following workplace characteristics are present:

- job insecurity,
- dysfunctional interactions between colleagues, and
- poor support from the organization.

In general, people who feel that their organization does not support them, who hold negative attitudes toward their employer, who experience interpersonal discord in the workplace, experience low work satisfaction, and who have negative attitudes toward their employment in general are less likely to be able to return to work successfully.

Given the role of organization factors in the occurrence, maintenance, and recovery from PTSD, one of the single most useful things a police employer can do is address organizational inconsistencies and develop front-line supervisors in such a way that they are able to support their staff. In addition, employers can work to educate everyone on their team about identifying potential signs of trauma early on and how to address such signs. Finally, employers can work to determine sources of organizational dissatisfaction and perceived unfairness, all of which can contribute to stigma and negatively impact mental health.

8. What kinds of workplace accommodations are appropriate for people with PTSD?

There is no "one size fits all" type of accommodation for employees with PTSD. Accommodations will vary depending on the severity and nature of the symptoms. As noted above, people with PTSD may experience concentration problems, distractibility, over-reactivity, slowed response time, sleep problems and thus fatigue, interpersonal problems, to mention just a few. Accommodations should be suited to the symptoms and the individual's own limitations, rather than simply being related to a diagnosis. Some of the links provided later on in this document connect to suggestions about the possible range of accommodations in the workplace for PTSD.

9. What can workers do to support co-workers with PTSD?

Support them and 'walk the talk'.

Many police agencies have programs in place to promote resiliency and to help officers with occupational stress related injuries. However, we all need to work effortfully and consistently to continuously improve the culture of policing with respect to mental health. There are several opportunities for change, not the least of which include reducing the pervasive stigma associated with experiencing emotions in the face of incredibly challenging events, and the stigma that can accompany mental injuries. Stigma continues to be one of the biggest challenges faced by police officers, limiting their opportunities for recovery and their capacity for recovery. Indeed, many officers continue to describe colleagues across ranks stigmatizing those with mental illness as weak or unfit to wear the uniform. Reducing stigma associated with mental health remains challenging in no small part because, unlike physical health injuries, mental health injuries remain largely invisible. In addition, changing stigma will require more than instructions, policies, and training. Change will require individuals to adopt what for many will be very different beliefs. Such changes may be extremely difficult if the beliefs are longstanding or fundamental to a person's identity. There may also be occasions where persons making change need to step out of their comfort zone by challenging their own biases, by working to include ostracized colleagues, and by challenging others to support real change. We can best support those courageous steps by helping police leaders to 'walk the talk', therein modeling the changes needed to reduce stigma and improve mental health. The changes start with a sincere desire to help, engaging evidence-based best practices wherever possible, and genuine efforts to change a challenging culture for the better – all of which we can do if we tackle the challenges of change together.

Welcoming back a colleague who has experienced an occupational stress injury including PTSD is no different than welcoming back a colleague who is returning from surgery or a broken bone or the flu. We know they may need a little extra support, they may not be completely back to their former state right away, and they may eventually achieve a different "normal" compared to before. They may have good days and bad days. This the normal process of recovery. The co-workers' job is to help their affected colleagues progress to the extent possible, and to continue to 'have their back'.

10. Useful Links for Further Information

The links below connect to a few of the many sources readily available on the internet in regard to PTSD. A note in regard to internet sources: there is a lot of misinformation out there, particularly in regard to the epidemiology of PTSD and how prevalent it is in first responders. If you see statistics, look for reliable sources (rather than an author's opinion). Generally speaking, check the credentials of any source before deciding how much weight to put on the information.

Canadian Institute for Public Safety Research and Treatment

https://www.cipsrt-icrtsp.ca/

CIPSRT is a national network operating within the governance structure of the Collaborative Centre for Justice and Safety at the University of Regina that responds to the urgent needs of the tri-services and public safety sector to provide the best practical scientific evidence that will lead to a real and imminent positive impact on the mental health of all public safety personnel.

Mental Health Commission of Canada

https://www.mentalhealthcommission.ca

The MHCC helps build capacity to advance the mental health of first responders and improve their interactions with people living with mental health problems and illnesses. Through stakeholder collaboration, the MHCC develops and adapts training tools and resources to enable first responder organizations to adopt comprehensive mental wellness strategies, focused both internally and externally.

Badge of Life

http://badgeoflifecanada.org

Badge of Life Canada is a peer-led, charitable volunteer organization committed to supporting police and corrections personnel who are dealing with psychological injuries diagnosed from service.

Public Safety Canada

https://www.publicsafety.gc.ca/cnt/mrgnc-mngmnt/mrgnc-prprdnss/ptsi-en.aspx

This page contains very basic information about PTSD in public safety personnel along with links to a few government and related documents.

Canadian Center for Police & Emergency Services Resilience

http://911resilience.ca/

The CCPESR was created to promote psychological health and resilience in police officers, soldiers, veterans, and emergency responders including fire – rescue, EHS, medical professionals, social workers, and corrections.

Providing Reasonable Accommodations to Employees with Post-Traumatic Stress Disorder

https://askjan.org/modules/ptsd/upload/PTSDInteractiveModuleTranscript.docl

Post-traumatic stress disorder (PTSD) and how an individual with PTSD can effectively work with job accommodations is often misunderstood. Employers and employees with disabilities can greatly benefit from exploring successful accommodation ideas and how they benefit the workplace.