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Fighting the Enemy Within the Fortress

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Abstract. *Posttraumatic stress disorder (PTSD) is a debilitating psychological health condition that jeopardizes the wellbeing, holistic health and functioning of police officers following exposure to traumatic, stressful, and life-threatening experiences. While resiliency is expected of officers, the recurrent encounter to traumatic incidents eventually influences the expression of symptoms that collectively constitutes PTSD. In addition to exploring the definition of PTSD and how it affects officers, this paper intends to inform police officers suffering from PTSD of the availability of effective treatments (e.g., prolonged exposure therapy, cognitive processing therapy) and to explain major parts of PTSD treatment to ensure officers are able to understand the processes involved in the treatment. This article hopes to clear up any skepticism about the efficacy of PTSD treatment and help officers become more informed about PTSD treatment.*

Keywords: *police trauma, police mental health, posttraumatic stress disorder, prolonged exposure therapy, cognitive processing therapy, cognitive-behavioral therapy*

Police PTSD: Fighting the Enemy Within the Fortress

Exposure to critical incidents is inherent to police work. Police officers are not only mandated to respond to violent crimes, but they must also make split second decisions, often in order to save the lives of civilians, as well as to defend themselves from imminent harm. In addition, police officers are often the ones who respond to critical incidents before other frontline professionals, and thus find themselves in situations where they also need to provide emotional support to the victims of crimes. Considering that officers are mandated to act as "street fighters" as well as "social service workers" while on duty, the role of the police officer is versatile and complex (Manzella & Papazoglou, 2014), prompting Chopko (2011) to describe police officers as "compassionate warriors." In addition to being exposed to multiple critical incidents over the course of their career, they are also expected to be more resilient compared to the general population (Galatzer-Levy et al., 2013; Marmar et al., 2006). The authors refer to Bonanno's (2004, 2005) definition of resilience as the human capacity to flourish during exposure to adverse situations and to recover (bounce back) after exposure to deleterious stress and potential trauma. All the above findings are not surprising considering that during the recruitment process, police organizations exclude applicants whose profiles indicate severe forms of psychopathology or other personality disorders that would prevent them from performing their police duties effectively (Cochrane, Tett, & Vandecreek, 2003; Reaves, 2010; Sarafino, 2010). In addition, police officers attend

intense training (e.g., realistic, classroom type) that promotes their resilience and job performance in critical situations (Andersen, Papazoglou, Arnetz, & Collins, 2015; Andersen, Papazoglou, & Collins 2016). Nonetheless, long-term and frequent exposure to extreme stress or the experience of unprecedented catastrophe (e.g., 9/11 attacks) may entail negative consequences for police officers' mental and physical health (Joseph et al., 2009; Violanti et al., 2006).

Posttraumatic Stress Disorder (PTSD)

The American Psychiatric Association (APA) (1980, 2013) defines a traumatic incident as a horrific type of incident that is extended beyond the limits of normal human experience. Due to the severity of the impact of the event, parts of the brain become over-activated and affected in a way that forestalls logical thinking processes and certain normative behavioral patterns (Lansing, Amen, Hanks, & Rudy, 2005; Yehuda, 2002). Greenwald (2013) notes that in addition to the sense of helplessness and life-threat, one's feeling of horror, panic, or disgust qualifies the experience as being traumatic. Further, the severity of the incident, the proximity to the event, the person's reaction to the event, and the impact of the event on a person's physical, emotional and psychological health, well-being, and functioning are additional parameters entailed in traumatic experiences. In the APA's (2013) Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the diagnostic criteria for PTSD are concisely defined as the following: a) experience of the stressor or traumatic event (e.g., direct or indirect exposure), b) re-experiencing symptoms (e.g., intrusive memories; nightmares), c) avoidance (e.g., trauma-related external reminders), d) negative alterations in cognition and mood (e.g., persistent distorted blame of self or others), e) alterations in arousal and reactivity (e.g., hypervigilance, sleep disturbance). The aforementioned symptoms need to persist for more than a month to qualify as diagnostic criteria for PTSD. It should be noted that only licensed health professionals (e.g., psychiatrists, clinical psychologists) are entitled to perform clinical assessments and diagnose PTSD. It is estimated that the prevalence of PTSD among the general population is 1.5%-5.5% (Frans, Rimmo, Aberg, & Fredrikson, 2005; Helzer, Robins, & McEvoy, 1987). Taken together, it is not surprising to find that unlike among the general population, the prevalence of PTSD among police is estimated to vary between 7%-19% (Haugen, Evces, & Weiss, 2012).

How Can We Defeat the "Enemy"?

The aim of the current paper is to serve two purposes: i) to inform police officers that PTSD can be treated effectively and ii) to elucidate major parts of PTSD treatment in plain language so that police officers may comprehend the different components that PTSD treatment entails. In this way, the authors hope to help police officers become cognizant of the major components of PTSD treatment and to reverse any skepticism about the efficacy of PTSD treatment. To date, psychological science offers multiple evidence-based interventions that treat PTSD efficiently. For the sake of parsimony, in this paper, the authors discuss two scientific-based interventions that have shown to be the most effective treatment for PTSD (Harvey, Bryant, & Tarrier, 2003; Koucky, Dickstein, & Chard, 2013); that is, prolonged exposure therapy and cognitive processing therapy. In addition, Papazoglou and Tuttle (2018) emphasize that police officers suffering from PTSD seeking psychological relief should seek help with the mindset that treatment occurs in an empathetic and egalitarian context where officers are not considered to be inferior to the clinician and perceived as experts in their field; that is, clinicians also learn from officers about the challenges and unique nature of police work.

Prolonged Exposure Therapy (PET). Initiated by psycho-education about reactions to extreme stress, trauma, and PTSD symptoms, prolonged exposure, considered part of the behavioral component of evidence-based cognitive-behavioral therapy, involves graduated exposure to trauma-related memories (e.g., thoughts and feelings) and the systematic confrontation of the trauma-related stimuli (i.e., situations, objects, places) which are otherwise safe or have low probability of causing harm to the trauma survivor (Foa, Gillihan, & Bryant, 2013; Foa, Hembree, & Rothbaum, 2007). Prolonged exposure encompasses two components: imaginal exposure whereby the goal is to imagine and directly confront feared or traumatic thoughts, memories, activity or situations (e.g., visualizing about the incident and what happened). It includes providing a detailed account of the feared or traumatic event, encompassing details related to, for instance, thoughts, feelings, behaviors, and sensory information. Often imaginal exposures are used when in-vivo exposures are not practical and certainly when predominant symptoms include recurrent re-experiencing symptoms of trauma, imaginal exposures help to minimize the frequency and intensity of the symptoms. The goal of the imaginal exposure is to reduce feelings of fear associated with memories. In turn, frequency and intensity related to the feared memories decrease over time.

In-vivo exposures, where the individual gradually approaches anxiety provoking places, objects, situations, or activities relative to the traumatic incident. For instance, a police officer shot in the line of duty and suffering from PTSD symptoms might visit the place where the shooting occurred and which s/he had been avoiding for years. At that juncture, the clinician will support the officer through the application of different techniques meant to help him or her realize that by visiting the shooting-related place, s/he is now safe.

In addition, as part of the PET, specifically imaginal exposure, a police officer is often asked to audiotape the description of the traumatic incident and later requested to listen to it over in the therapy context. That way, officers who suffer from PTSD are guided by clinicians to process their traumatic thoughts and emotions effectively and within a safe context; this process is repeated until officers realize and understand that the traumatic incident occurred in the past and that they are currently safe. Moreover, prolonged exposure entails relaxation techniques, cognitive therapy techniques, and breathing techniques among other skills and strategies that help officers to better cope with PTSD symptoms. In addition, officers engaging in prolonged exposure treatment complete various types of cognitive therapy related exercises such as journaling in between the sessions to help them identify any unhealthy or distressing thoughts or beliefs, reframe the thoughts, and adopt a more balanced outlook including arriving with balanced alternative thoughts and beliefs that allow to better process the information, better control and cope with emotions, make healthier decisions, and create a proactive and adaptive plan of action and problem solving. For instance, a distressing thought such as "*I am a bad cop*" an officer could say "*I am a good cop that had a challenging moment which may happen to everybody*."

Cognitive Processing Therapy (CPT). CPT is a specific type of evidence-based cognitive behavioral therapy and Resick, Monson, and Chard (2014) elaborated on components of the CPT treatment manual for veterans and military personnel suffering from PTSD. CPT usually initiates with psychoeducation where officers suffering from PTSD are informed about PTSD symptomatology, recovery, and fight-flight stress-related response. Officers learn ways of identifying, questioning, and modifying distressing and unhealthy beliefs about self, others, and the world related to the trauma. The beliefs include areas related to safety, trust, power, control, esteem, and intimacy. The goal is to form a new and more balanced understanding of the traumatic or upsetting event, in turn, helping to reduce PTSD symptoms and improve overall functioning, quality of life and well-being. Clinicians encourage officers to identify and write a brief essay about automatic (distorted) thoughts, feelings, and behaviors (so-called "stuck points") akin to the traumatic incident that is most directly affecting the officer's health, life, and wellbeing. Over the sessions, the clinician applies Socratic questioning, that may include clarification, questioning of the officer's viewpoints (e.g., "*Why is it better than…?*"), and probing assumptions (e.g., "*How did you come to this conclusion*?"). The officers are encouraged to complete a worksheet between the sessions where trauma-related (problematic) thoughts, beliefs, and feelings are identified, reviewed, and processed during the treatment session. Moreover, affective expressions about the event are addressed and the clinician encourages the officer to express his/her sentiments. For instance, officers may falsely self-blame themselves (e.g., "*I could have saved the hostage*") or feel angry with themselves; hence, the clinician facilitates the officers' ability to distinguish the difference between responsibility and blame, since the latter, as opposed to the former, encompasses the intentionality of the action. Other issues that are addressed and modified during CPT therapy include the sense of safety, self-control, balanced view of power/control, self-esteem, intimacy, and trust towards one's self and others. PTSD often leads people to believe that the world is not safe and that nobody should be trusted. Therefore, certain values that are important to police work (e.g., trust, intimacy with partners), which may have been jeopardized due to trauma effect, are re-installed or re-established in the context of PTSD treatment.

Conclusion

PET and CPT have both been applied to military and police personnel and both are found to be successful in helping them overcome PTSD. Further, such treatment supports the recovery of police officers and helps them to improve their overall functioning including personal and occupational functioning, including returning to meaningful work, returning to service, and being prepared to perform their duties efficiently. Threat and extreme stress are omnipresent in police work. However, both PET and CPT help officers modify problematic thinking and, in turn, transform their behavioral patterns in ways that help them better function in the challenging environment of police work. What is noteworthy is that psychology currently provides the necessary tools to support police officers recovering from PTSD, armoring them against the future challenges of police work; that is, helping those who protect us and maintain peace and order.

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