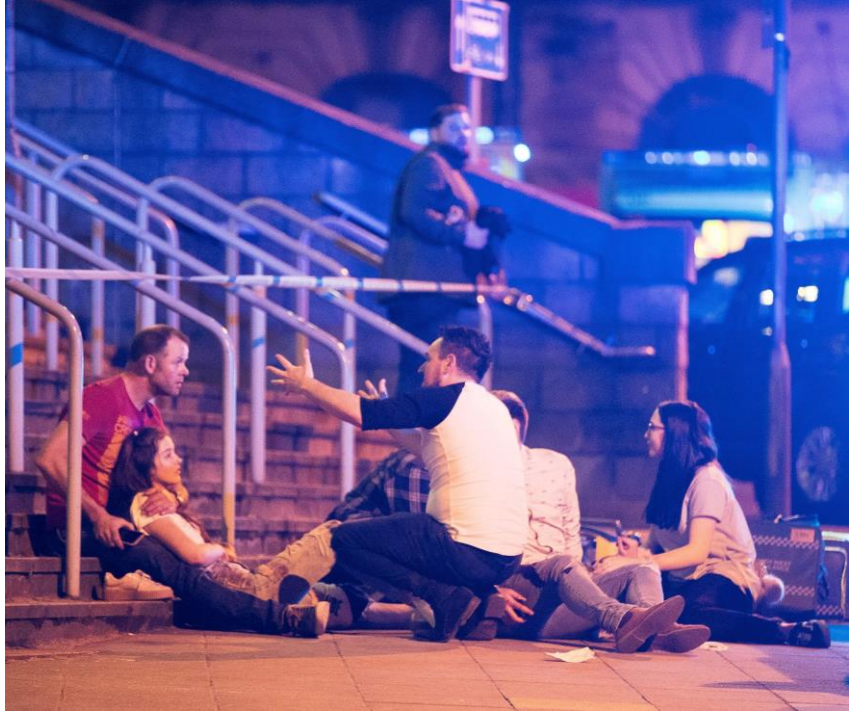
Complex PTSD: Risk Factors, Incidence and Treatment in Policing

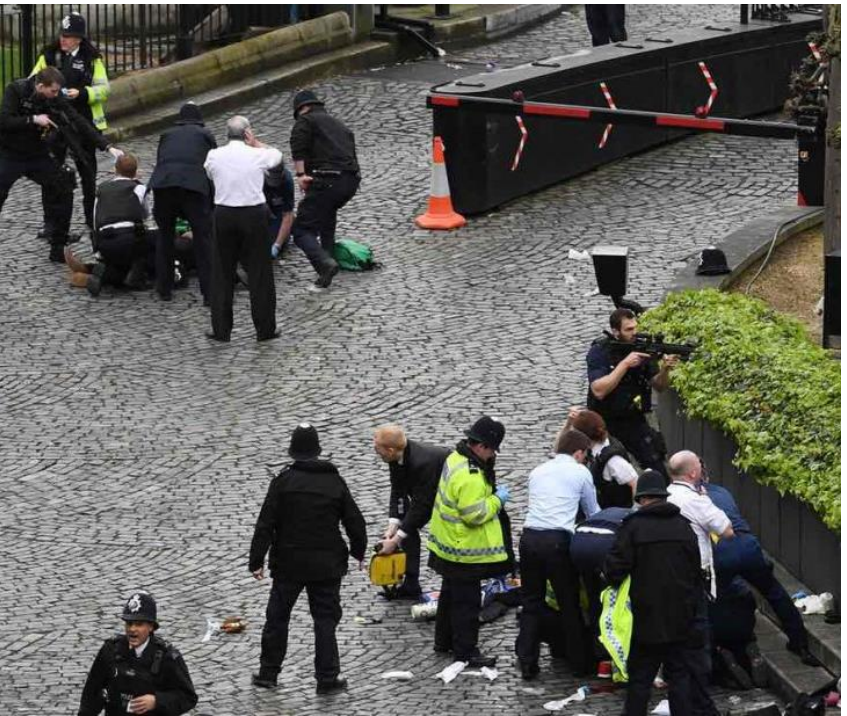
Dr Noreen Tehrani

Clinical Director

Noreen Tehrani Associates

www.noreentehrani.com






Homeland Security Investigations (HSI)
ICE

Symptoms of Trauma and Complex Trauma

There are two bodies that provide frameworks for diagnosis

- Diagnostic & Statistical Manual (American Psychiatric Association
- International Classification of Diseases (World Health Organisation)

DSM 5 (2013) has four criteria for PTSD

- Avoidance
- Arousal
- Re-experience
- Negative cognitions and mood

ICD 11 (2019) has three criteria for PTSD and a further three for CPTSD

- Sense of Threat (Arousal)
- Avoidance
- Re-experience

ICD 11 Complex PTSD (Disturbance of Self Organisation)

- Affect dysregulation
- Negative self concept
- Interpersonal problems

Difference between PTSD and Complex PTSD

- Many traumatic events (e.g. car accidents, attacks or natural disasters are time-limited
- Some traumas are continuous or repeat for months or years
- The current PTSD diagnosis does not fully capture the severe harm that can occur with prolonged or repeated trauma
- People who experience chronic trauma report additional symptoms such as a change in self concept
- Traumas that can lead to complex PTSD include
  - Child Abuse
  - Domestic Violence
  - Sexual exploitation
  - Military or Emergency Service engagement
- Complex PTSD takes longer to treat and recovery can be more difficult

Risk Factors for complex posttraumatic stress disorder in UK police (Steel, Tehrani, Lewis & Billings, 2021)

- NPWS offers psychological surveillance for twelve high risk roles (e.g. POLIT, MOSOVO, CSI, SCIU)
- In 2019 the ITQ was introduced into the surveillance and referral programmes
- 2171 Officers completed surveillance
  - Prevalence rate of PTSD = 3%
  - Prevalence of C-PTSD = 2%
- 273 personnel were referred for psychological screening
  - Prevalence rate of PTSD = 14%
  - Prevalence rate for c-PTSD = 41%

(Brewin et al 2022; Prevalence of PTSD was 8.0% and CPTSD was 12.6%)

Hazards and Resilience Differences between PTSD & C-PTSD

Complex PTSD

1. For every 1-point increase in Compassion Satisfaction the odds for C-PTSD decreased by 8%
2. For every 1-point increase in Burnout C-PTSD increased by 1.06 times
3. C-PTSD was 3.91% higher in officers exposed to high levels of stress
4. C-PTSD 77% lower in officers with excellent manager support
5. Getting less than 5 hours sleep increased by 13.5 times
6. Every 1-point increase in anxiety increased C-PTSD by 1.88 times
7. Every 1-point increase in depression increased C-PTSD by 2.08 times

PTSD

1. No change in PTSD from increased Compassion Satisfaction
2. No change in PTSD from increased burnout
3. No change in PTSD from higher exposure to stress
4. No change in PTSD related to excellent manager support
5. No change in PTSD related to getting less than 5 hours sleep
6. For every 1-point increase in anxiety PTSD increased by 1.39 times
7. Every 1-point increase in depression increased PTSD by 1.29 times

Discussion

Why were the levels from the Brewin et al., (2020) survey higher?

Why is manager support so important to officers with C-PTSD?

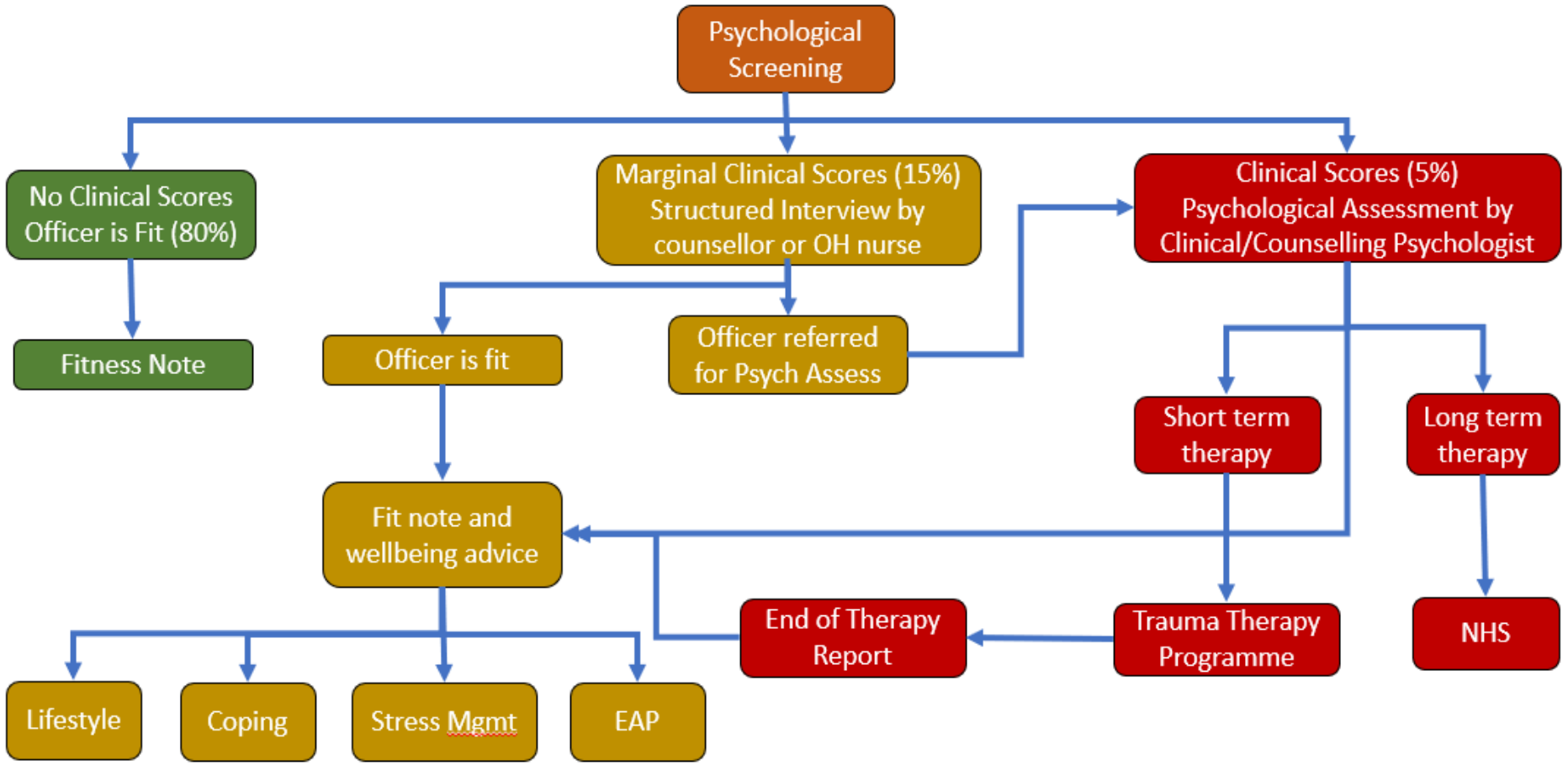
What is it about getting compassion satisfaction that builds resilience?

Two studies looking at treatments for PTSD and Complex PTSD

- The need for introducing trauma therapy programmes
- Benefits of organisational models
- First study examined treatment for PTSD pre formal recognition of CPTSD
- Second study took place in 2020 when surveillance programme included ITQ which identified CPTSD
- Results from both studies will be presented

An Integrated Support Approach

Screening, Assessment & Referrals in UK Policing (Tehrani, 2019)



Short Term Trauma Therapy

- Psychologist's assessment, referral and oversight
- Therapists provided with screening results, assessment and management guidance
- Therapists trained in TF-CBT and most have training in EMDR
- Six sessions lasting 1.5 hours (option to two additional sessions where necessary)
- Mean number of sessions 6.4
- Mid-therapy report
- Closing report and management advice

Trauma Interventions

TF-CBT and EMDR are both recognised by NICE (2005)

Trauma Focussed CBT

- Psycho-education
- Self soothing techniques
- “Debriefing” of traumatic incident(s)
- Skills to deal with:
  - Re-experience
  - Arousal
  - Avoidance
- Re-engagement

Eye Movement Desensitisation & Reprocessing

- Psycho-education
- Self soothing techniques
- Identification of target(s)
- Evaluation of strength and validity of the cognition
- Bi-lateral stimulation
- Processing of body sensations
- Re-evaluation

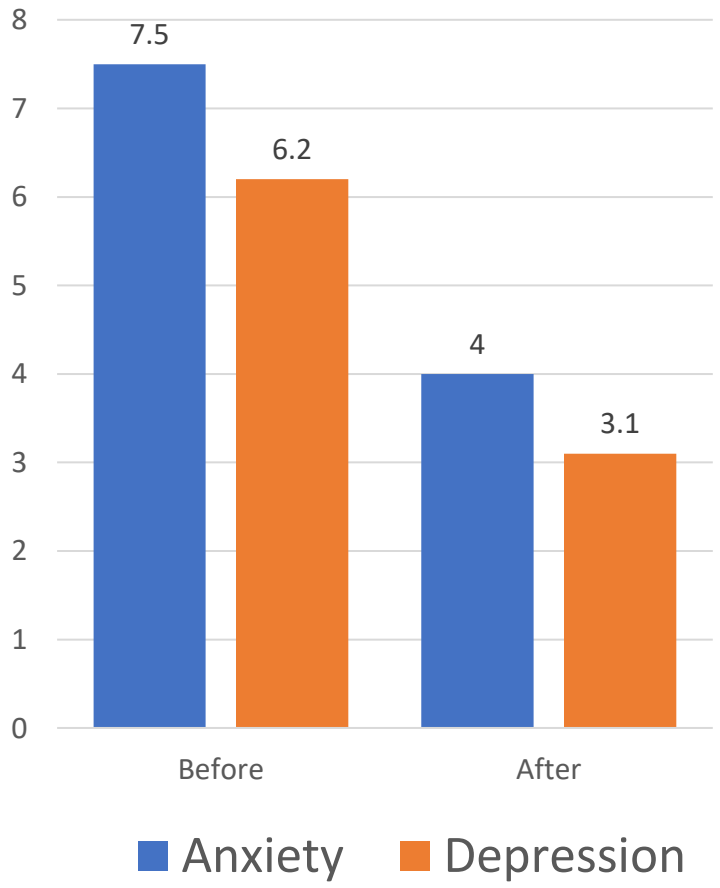
Study 1: Evaluation of a trauma therapy programme within emergency service organizations (Tehrani, 2019)

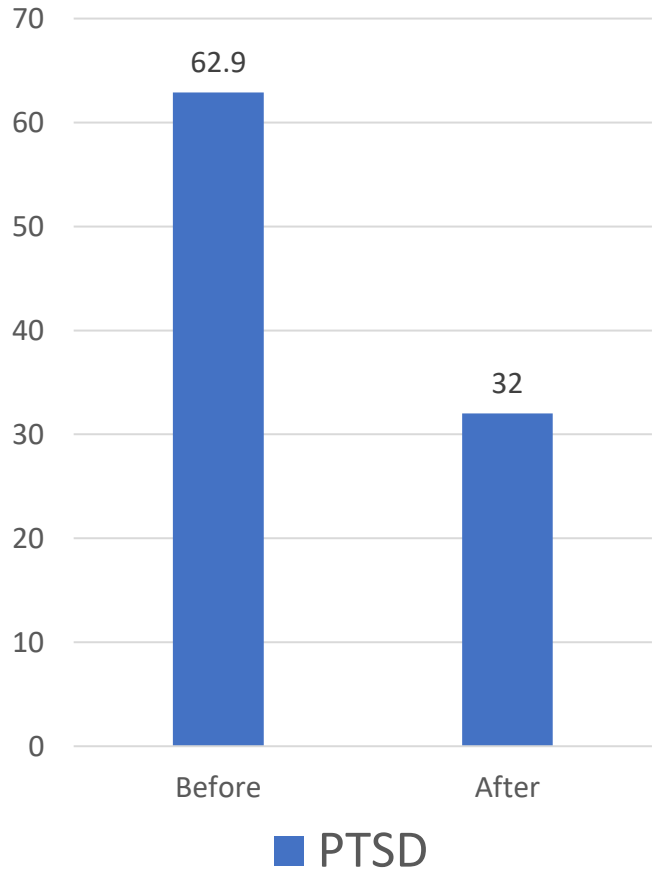
- 329 Emergency Service Professionals met the referral criteria
  - Anxiety/Depression (Goldberg, et al. 1988)
  - Traumatic Stress (Tehrani, Cox, Cox, 2002)
  - Compassion Fatigue (Stamm, 2010)
- 172 Female mean age 38.2 years, 148 Male mean age 42.8 years
- Roles
  - 74% Police Service
  - 14% Ambulance Service
  - 2% Fire and Rescue Service
  - 10% Other groups

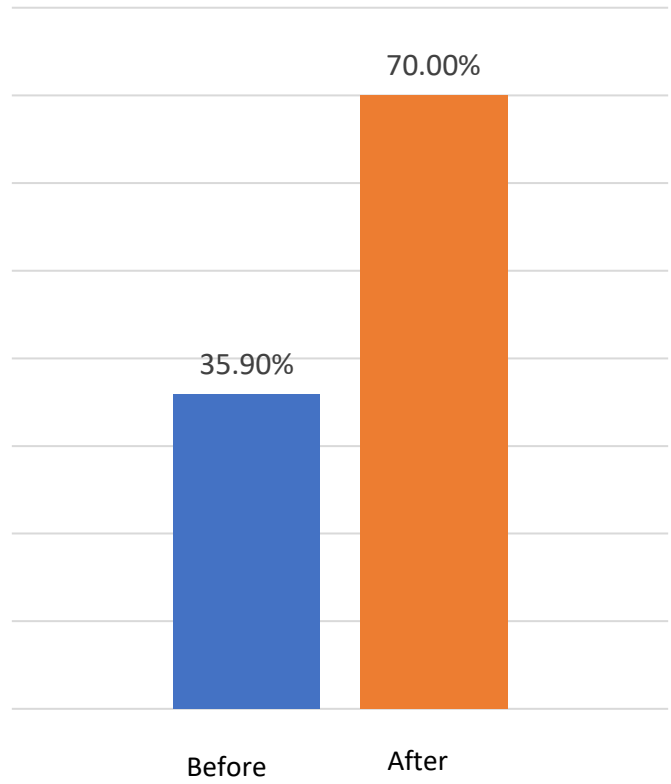
Sources of Trauma

		Childhood			Adult			Work		
	n	Trauma	Abuse	Loss	Trauma	Relationships	Sexual Abuse	Primary	Secondary	Relationships
Male	144	33%	22%	16%	35%	26%	2%	76%	54%	24%
Female	136	46%	35%	31%	41%	43%	16%	62%	62%	28%
Statistical Significance		.05*	.05*	.005*	NS	.05*	.001***	.01*	NS	NS

Before and After Therapy





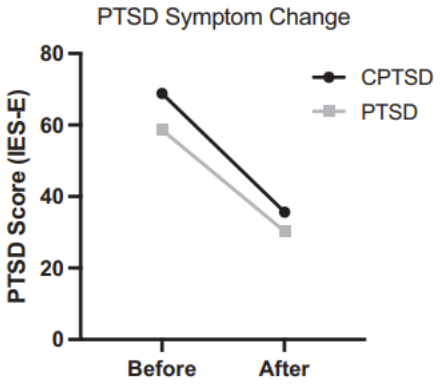


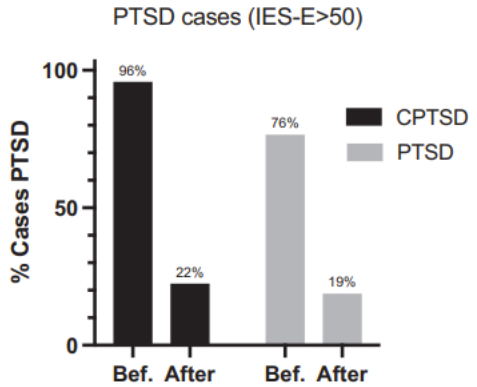
Capacity to Work

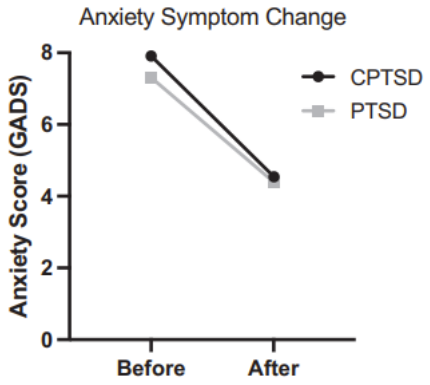
Study 2: Brief trauma therapy for occupational trauma related PTSD/CPTSD in UK police (Biggs, Tehrani & Billings, 2021)

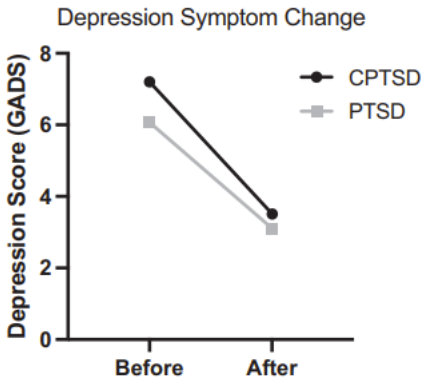
- 162 Police personnel (51% male 49% female)
- Age range 23-65 (mean 42)
- Mean amount of treatment 6.1 sessions
- Type of Therapy: TF-CBT 44%, EMDR 40%, Combined 16%
- 78% exposed to more than one type of trauma and 61% more than one area of trauma (childhood, adulthood and work)
- 56% met criteria for CPTSD and 44% for PTSD, 95% Anxiety, 88% Depression

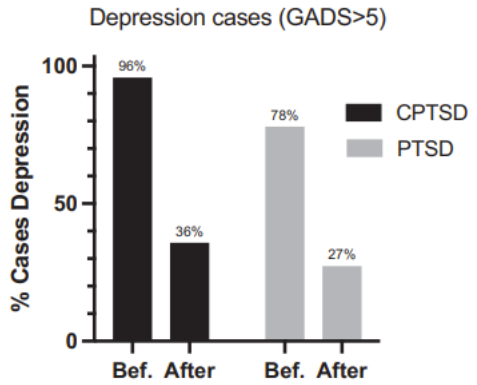
Study 2 Results











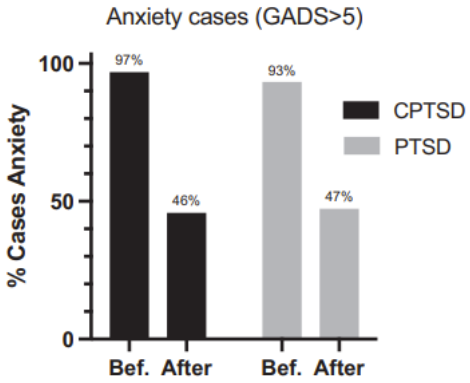


Table 3. Difference in treatment effectiveness between CTPSD and PTSD groups assessed through simple linear regression analysis with the change of symptoms score as outcome variable and PTSD/CPTSD diagnostic group as exposure variable

	Change in score				
Variable	CPTSD, mean (SD)	PTSD, mean (SD)	Difference in means	95% confidence interval	*P* value
PTSD (IES-E)	34.11 (21.80)	28.93 (22.99)	5.18	−1.85 to 12.21	NS
Depression (GADS)	3.69 (2.75)	3.01 (2.95)	0.68	−0.22 to 1.57	NS
Anxiety (GADS)	3.43 (3.07)	3.07 (2.93)	0.36	−0.59 to 1.31	NS
Sense of coherence	13.96 (19.68)	8.99 (16.63)	4.97	−0.83 to 10.77	NS
Perceived management	9.84 (4.74)	9.79 (4.79)	0.05	−1.52 to 1.62	NS

Discussion

Why was there so little difference in the recovery rates for PTSD & CPTSD?

Is CPTSD in policing different?

The future: Establishing the Organisational and Financial Benefits

- Proactive psychological surveillance and identification of police personnel with clinical symptoms
- Individual reports and organisational data
- Rapid psychological assessments and referrals for therapy
- Updates and closing reports to facilitate rehabilitation
- Reduced time off sick
- Economic evaluation of programme to be undertaken 2022/3

Thank you

Any questions?

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