This article presents the clinical approach developed by a Canadian biofeedback practitioner for the assessment and treatment of police and military clients, especially those with post traumatic stress disorder (PTSD). The author conducted a clinical practice for more than 25 years primarily with male police and military clients. He examines the impact on treatment effectiveness of a number of factors, such as how police and military clients differ from civilian populations, the definition of trauma in this population, Diagnostic and Statistical Manual of Mental Disorders (4th edition; DSM-IV) diagnostic criteria, the assessment of post-traumatic stress disorder, risks and coping factors, consequences of PTSD, DSM-IV conundrums, epidemiology, and other reactions to traumatic events.

Introduction

I have maintained a solo private practice in clinical, police, and military psychology since the mid-1980s with a primary focus on post traumatic stress disorder (PTSD). During this time, I have seen scores of adult civilians who were victims of trauma such as motor vehicle accidents, life-threatening illness, tragic death of a loved one, and physical and/or sexual assault. Additionally, I have seen scores of Canadian combat veterans and peacekeepers as well as hundreds of police officers, usually men, and all suffering from PTSD. Some military personnel served in World War II, Korea, and Kuwait, whereas others were deployed in peacekeeping operations in Gaza, Cyprus, Bosnia, or Rwanda. Although it is not generally recognized, peacekeepers are exposed frequently to incoming fire, are often “detained” by either side in the conflict, and witness many atrocities to civilian populations.

Over the decades, based on the combination of reading professional publications, attending conferences, obtaining feedback from clients, and reflecting on my experiences, I have developed understandings and consequent strategies that are effective for difficult-to-treat populations such as the male police and military clients (PMCs) considered in this article. As will be noted later, a retrospective review of my records since 2005 indicates that all but a few military personnel achieved remission, and this was true also for more than 90% of police officers, rates above those reported in published studies. Also, dropout rates were about 5%, compared with up to 30% in some studies. My consequent conclusion is that I am doing something right. This article distills what I have learned about assessment and treatment of populations with PTSD.

Although I have found the strategies to be discussed helpful with all the populations I have seen, due to some special characteristics of PMCs, the article will focus on this group. PMCs differ from most civilians in a number of important ways: (a) They are exposed to what I have termed duty-related accumulated trauma, rather than to a single traumatic incident; (b) the research evidence indicates that some treatments effective for civilians are much less effective with PMCs; (c) they show a penchant toward personality characteristics or training to not notice/admit symptoms until they are in the severe range of intensity; (d) they tend to stay in control of self and circumstances; and (e) they tend to engage in information gathering that relies less on other peoples’ thoughts (including mine) and more on their own observations. I have learned to accept the latter three characteristics in part because they are critical to PMCs’ survival in the performance of their duties. Also, my view is that it would be a disservice to try changing these characteristics among those still serving. Moreover, for these and other reasons, PMCs relate well to applied psychophysiology and neuroscience methods of assessment and treatment; they can see for themselves what is happening within.

However, the development of useful assessment and treatment approaches clearly is a work in progress; I make
continuous changes as I learn and explore more. For example, when I began writing my PTSD treatment manual for clients and colleagues 25 years ago, it numbered about 10 pages; as of August 2008 it was about 100 pages, and this does not include my current recommendations for stabilization or my structured clinical interview, which also continue to evolve. Also, there is much potentially important information we do not yet have, such as bidirectional changes with PTSD symptoms in respect to sleep architecture, event-related potentials, and startle reflex. Investigation of these aspects would constitute useful research or dissertation topics.

**Trauma Defined**

Some events/situations/stressors are so significant that they are considered to be traumatic. As defined by the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition; *DSM-IV*) diagnostic classification system (American Psychiatric Association, 1994), a trauma is one in which

- (A-1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others, and
- (A-2) the person’s response involved intense fear, helplessness, or horror.

I obtain information about the A-1 and A-2 criteria through what the client tells me. Research has demonstrated a close relationship between self-report and military records. So for PMCs I ask “Tell me about your traumatic experiences” and usually follow up with questions about experiences I know are common, for example: “What about dealing with suspects who are HIV positive?” By their in-office deportment alone, usually it is not difficult to conclude that the experiences exerted a significant impact.

One of the things I have learned in working with PMCs is to not delve much into details of their traumatic experiences. I do not need this information for purposes of treatment planning, and it is unnecessarily upsetting to the clients; PMCs are seeing me because they do not yet have effective methods for managing symptoms. Retelling the story in detail may exacerbate the individual’s neural fear circuitry. PMCs have experienced far too many traumas for full discussion of each, and obtaining full details of one trauma serves only to open the door to reexperiencing one “forgotten” traumatic experience after another. There are no data to suggest that full or repeated telling of the tale(s) is therapeutic. This is a major departure from psycho-dynamic approaches modeled after steam boilers. However, often PMCs will talk about their traumas spontaneously without emotional upset once their regulation of autonomic and central nervous systems has improved.

Similarly, I have not found cognitive therapy effective until after PMCs learn to regulate autonomic nervous and other systems. In addition, I have found exposure-based interventions to be both rejected by PMCs and unnecessary for positive outcomes. Furthermore, the few times I tried exposure therapy while simultaneously monitoring psychophysiology, the observed pattern was so alarming to me that I discontinued the procedure. Ignoring these two groups of interventions represents yet another departure from generally recommended treatment. Moreover, my clinical experience is that once PTSD symptoms are in remission following biofeedback training, usually cognitive anomalies resolve without much therapeutic intervention.

**Remaining DSM-IV Diagnostic Criteria**

According to the *DSM-IV*, PTSD can be diagnosed if a sufficient number of symptoms are present when they were not there before the traumatic event, if they have been present for at least 1 month, and if they cause significant distress in the person’s life. To meet the diagnostic criteria, clients must have at least one of five symptoms from cluster B (reexperiencing), three or more from seven symptoms in cluster C (avoidance/numbing), and two or more from five symptoms in cluster D (anxious arousal). Clinicians should be very familiar with *DSM-IV* symptoms for each cluster. Additional symptoms are common among those with PTSD, including survivor guilt and memory impairment.

Also, symptoms can emerge at various times after trauma: within days, only after multiple experiences, following an unrelated stressor, and/or decades after the event(s). For example, many of my World War II clients led productive lives until their 80s, when PTSD symptoms came to the fore as activation slowed. One veteran police officer got through hundreds of traumatic experiences without symptoms until his daughter became pregnant, which cued memories of the many dead children he had attended.

**Assessing PTSD**

I assess PTSD symptoms in multiple ways, in part because usually a report from me is required so that agencies such as Veterans Affairs (VA) Canada can determine whether or not PMCs qualify for disability benefits. Because it is viewed by VA as the gold standard for PTSD assessment, I begin with the Clinician Administered PTSD Scale (Blake et al., 1997), a structured interview of symptoms. Then three standardized psychological tests with good psychometric properties are administered: the Trauma Symptom Inventory (Briere, 1995), which is readministered from time to time so as to
monitor progress; the Multiscale Dissociation Inventory (Briere, 2002) to obtain scaled scores for specific numbing/dissociative symptoms; and the MicroCog (Harcourt Assessment, 2004) to prescreen cognitive functioning.

Subsequently, clients participate in a structured psychophysiological protocol wherein autonomic nervous system (ANS) variables—including blood pressure, blood oxygen saturation, heart rate, heart rate variation, skin conductance, finger temperature, and aspects of respiration—and both frontalis and upper trapezius muscle tension levels are recorded during baseline, during recall of traumatic events, and following a recovery period.

It has proven helpful to show PMCs their psychophysiological results on the monitor immediately after recording. Viewing the physiological data changes further affirms client beliefs that the traumas have a continuing impact. Because psychological test responses are based on a client’s cognitive awareness of symptoms, not infrequently these test results will be in the normal range, whereas ANS responses will be elevated into clinical significance. The body reveals what the client has cognitively concealed from himself. For these and other reasons, I consider psychophysiological assessment essential, and publications by others support the value of this aspect of PTSD assessment.

Risk and Coping Factors
I have found it helpful to discuss risk factors for PTSD with PMCs after the review of their psychophysiology, because it helps to answer their unspoken question of why they developed symptoms, whereas some of their colleagues appear not to have done so. Among the risk factors supported by some experimental evidence are: (a) exposure involving multiple events; (b) long exposure times; (c) exposure to purposeful violence, death, or dismemberment; (d) exposure to child victims; (e) resulting chronic pain to the PMCs; and (f) lack of system support afterward.

Also, when present, I point out client aspects related to the probability of a successful treatment outcome, such as higher versus lower IQ, stable and supportive relationships, good health practices, adaptive coping skills, and consistent lifelong implementation of the treatment recommendations we find helpful.

Consequences of PTSD
In addition, especially for PMCs who tend to downplay the seriousness of their condition, I communicate to them the known consequences of PTSD: decreased satisfaction with life; increased family and other interpersonal struggles; failure to engage in preventative health strategies; compromised physical health; increased risk of cognitive decline/dementia; and increased mortality including by suicide. Because most PMCs have already experienced some of these consequences, it is useful to confront these realities openly, for they often become more willing than otherwise to address their condition seriously.

Conundrums for DSM-IV
Whether clinicians like the system or not, the reality is that diagnoses as defined by DSM-IV are important in obtaining assistance for the client from various agencies and in respect to court proceedings. Nevertheless, it is important to realize that DSM-IV is fraught with conundrums for the clinician.

Given space limitations, I can only hint at some of the issues and will do so in question format. Is PTSD a discreet condition or a continuous one with symptoms ranging from mild to severe? Is it a specific condition or a spectrum of conditions/symptoms? Do symptoms cluster around the current three “factors” or the four or more detected by factor analysis? Because by their training, PMCs often do not show the A-2 characteristics, should their other common distressing reactions be substituted? What about studies showing very different brain processes among those with PTSD who do or do not have the numbing/dissociative symptoms? What about studies showing at least two different biological systems in PTSD, an adrenergic one and a serotonogenic one?

Epidemiology
For personnel involved in military combat, the rates of PTSD are high. Depending on the study and the conflict, rates vary from 19% to 60%. Moreover, rates remain high long after returning home; for example, 50 years after World War II, between 12% and 32% of veterans continued to have PTSD. For prisoners of war, PTSD rates vary between 50% and 70%. Again the effects can be long lasting: 20% of Canadian POWS still had PTSD 40 years after World War II. Clearly, as one U.S. Marine Corps colonel noted seriously in a seminar I attended, “War is not good for you.”

Many of those deployed to peacekeeping missions do not escape PTSD. Between 2% and 20% meet the diagnostic criteria once home. In one study the rates doubled for service personnel in Bosnia who were there for 9 months compared with a stay of 2 months, thereby providing some evidence of a dose-response relationship.

The few studies available indicate that between 12% and 35% of police officers will qualify for the diagnosis of PTSD at some time. Other studies have indicated that an unknown percentage of officers who leave police work, or who move to “safer” or nonoperational assignments in the unit, who develop medical or alcohol problems, or who become...
identified by their colleagues as “slugs” (low performers) are in fact suffering from PTSD. Most of my police clients had between 15 and 25 years of frontline policing, during which time they were assaulted, under constant threat of bodily harm and death, attended innumerable scenes of gory death and dismemberment, and so on. Clearly, frontline police work is not good for you either.

**Other Reactions to Traumatic Events**

Although PTSD is the most common psychological condition that can result from trauma, other DSM-IV conditions can be produced by trauma as well. These include major depressive episode/disorder, nighttime panic disorder, sleep disorders, and psychophysiological conditions.

In addition, when PTSD follows a traumatic event, more often than not it is accompanied by symptoms of one or more of the above disorders as well as other conditions. About 80% of those with PTSD will have a at least one co-occurring DSM-IV diagnosis. For example, about 50% will meet the criteria for major depression. PMCs I have seen usually have between two and four co-occurring diagnoses. The more co-occurring conditions, the longer treatment will take. On the other hand, if the co-occurring conditions are not addressed successfully, treatment effectiveness is compromised and increased relapse rates can be expected.

I assess co-occurring symptoms or conditions through a structured clinical interview that I have revised over the years, through administration of the Personality Assessment Inventory (Morey, 1991), a standardized psychological test with good psychometric properties, and with the use of other tests as required.

**Conclusions**

In closing, I will emphasize the value of a thorough assessment, using a structured clinical interview, psychometric testing, and a psychophysiological stress profile, to provide the comprehensive understanding of the police and military client’s condition, and to assist treatment planning. Discussion of the client’s physiological response patterns with the client provides a useful educational tool to graphically show the client the evidence of the effect of trauma on his body. Discussing the known consequences of PTSD with the client is also worthwhile, because many clients will recognize that they are already suffering these consequences, and it serves to mobilize their motivation for treatment.

**References**


