A Residential Milieu Treatment Approach for First Responder Trauma

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Abstract

First responders, which include police officers, firefighters, correctional officers, emergency medical technicians, and dispatchers, face unique challenges in dealing with and recovering from critical incidents. In their work with emergency responders at the West Coast Post Trauma Retreat (WCPR) the authors[1] have found that short-term residential treatment is an effective treatment component. In this article the authors discuss the WCPR residential treatment model.

Introduction

The On-Site Academy[2] was the first residential program devoted to the treatment of first responders. The format for the five-day residential program has since been revised, but the essential elements of the program, which include a true residential setting, culturally competent clinical and chaplain staff and a program that emphasizes peer-support, remained constant. The use of peers throughout the program normalizes a resident's behavior and symptoms, providing hope and encouraging recovery. In 1999, a group of clinicians, peers and chaplains started a similar program in Northern California. Initially, On-Site staff supervised the WCPR team's efforts. Prior to WCPR, there had been approximately six attempts to replicate the On-Site program and all those attempts failed due, in part, to the failure to follow the essential programmatic aspects mentioned above. The authors have written this article in appreciation and recognition of the On-Site staff, without whom, the WCPR would have never started.

Profile of Attendees

Emergency responders who attend WCPR present with clinical symptoms that include depression, posttraumatic stress, anxiety, sleep and substance abuse disorders. The WCPR participant has often received treatment in his/her community but has not responded favorably or sufficiently. Most of the participants have difficulties functioning at work and/or at home as a result of their involvement in one or a number of critical incidents. Others are unable to function at all and are at high risk for suicide. Some attendees have made suicide attempts. The mission of the WCPR program is to help emergency service professionals and retirees regain control over their lives and either return to work with a new perspective on stress and coping, or make career change, including retirement, if that is a more appropriate decision.

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[1] The authors' experience with this population comes from over 100 years of emergency responder experience, working as sworn officers with various law enforcement agencies and as psychologists specializing in treatment of emergency responders.
[2] In 1990, Hayden Duggan, PhD, and Valerie Duggan, LCSW, started the On-Site Academy in Gardener, Massachusetts.

Of the 100+ first responders treated at WCPR, 60% were law enforcement, 21% were either fire or EMS, and the remainder of the attendees were corrections, military, probation and other civil services. Geographically, they came from throughout the United States, Canada, England, Guam, the Caribbean and Mexico. At the time of their attendance, 52% were working but experiencing emotional, psychological and vocational difficulties. The majority of attendees were diagnosed with posttraumatic stress disorder and all attendees were experiencing significant symptomology. Thirty four percent were not working and were pending the result of their disability claims and 13% were retired. At one year follow-up, 92% of the attendees who were working at the time of their attendance at the program were still working. Six percent of the attendees who were not working were able to return to work and the remainder retired or continued on disability.

Background

People who devote themselves to the emergency services profession risk exposure to critical incident stress with accompanying post-trauma reactions. Reactions to these events can affect job performance, social and family relationships and the overall quality of life. For example, police officers reporting high levels of stress have three times greater health and domestic violence problems, five times higher rates of alcoholism, and are ten times more likely to suffer from depression than other officers (National Institute of Justice. 1999). While most responders recover and continue working, some develop problematic symptoms and require additional assistance. Unfortunately, the maladaptive coping mechanisms and cultural norms which discourage officers from receiving help are demonstrated by high suicide rates which cause more deaths than homicide or on-duty related accidents (Hackett & Violanti, 2003).

First responders need to perform complex tasks, under difficult conditions, while maintaining control over their environment and themselves. The complexity of their work requires them to "exercise considerable skill, make delicate decisions with fateful consequences, and solve a wide range of interpersonal problems, with no hard-and-fast criteria about the correctness or incorrectness of solutions. [They] must therefore live with doubts and uncertainty about some of what they have done, which can make them question their own adequacy or competence and undermine their self-esteem" (Toch, 2002, pp. 55-56).

Symptoms immediately following a critical incident may include shock, nightmares, irritability, difficulty concentrating, emotional instability, and somatic complaints (Carlier, 1999). First responders often deny and suppress normal emotional responses, such as revulsion, empathy or fear (Wastel, 2002). Denial of emotions and the appearance of the need to be *tough* (Stephens, Long, & Miller, 1997) leads to significantly related higher levels of psychological distress in police officers (Progrebin & Poole, 1991) and firefighters (McFarlane, 1988). Continued suppression can lead to symptoms of emotional detachment, agitation, alcohol/substance abuse, cardio pulmonary disease, ulcers, suicide, cynicism, suspiciousness, decreased efficiency at work and at home, absenteeism, early retirement, marital problems and symptoms associated with posttraumatic stress disorder (PTSD) (Toch, 2002; Bohl, 1995). In addition to PTSD, possible diagnoses include acute stress reaction and chronic stress

reaction (American Psychiatric Association, 2000). Vicarious or secondary exposure (i.e., behaviors and emotions resulting from witnessing an event or knowledge about a traumatizing event that was experienced by another person and the desire to help that person) can also create stress (Comille & Meyers, 1999; McCunn & Pearlman, 1990; Harris, 1995) or compassion fatigue (i.e., cumulative stress resulting from heightened caring about victims of criminal acts) (Figley, 1999).

A responder's early life experience, such as childhood trauma, may encourage a career choice in emergency services while at the same time reduce his or her willingness to access necessary treatment when needed. "It is a paradox that those early life experiences that may lead a person to choose police work as a career might be the very elements that undermine it" (Kirschman, 1997, p. 89). A responder may instead turn to a peer group that discourages treatment and encourages emotional avoidance in the form of alcohol use, affairs, and social withdrawal.

To treat responders effectively, one must understand the cultural factors at work in the emergency services. Generally, the emergency service worker has a strong need for the acceptance, respect and approval of peers (Benner, 2000; Finn & Tomz, 1998). Peers reinforce traits necessary for emotional survival in a first responder career. While survival strengths such as psychological toughness, independence and self-reliance help the responder, recovery strengths such as warmth, compassion, and sensitivity are discouraged. Further, the same survival characteristics that are reinforced on the job can result in negative consequences if taken home (i.e., emotional supression). (Wester & Lyubelsky, 2005). Even when physically alone, behavior and decisions are strongly influenced by the expectations of peers and may discourage a responder to seek necessary treatment.

A responder's self-concept evolves during training and throughout his or her career (Stradling, Crowe, & Tuohy, 1993) and affects the individual's interpretation of his/her environment and expectations about the future (Eidelson & Eidelson, 2003). Benner (2002) described a responder's self-concept as consisting of traits and beliefs which are modified through experiences. A responder's reliance and trust in these beliefs enable the responder to perform necessary work tasks. These traits and beliefs include:
- o Problem solving ability
- o Action oriented in the service of responding to emergencies
- o An expectation to be in control of the environment and his/herself
- o Command presence and ability to maintain clarity and effectiveness under stress
- o Effectively able to control people in crisis
- o Unaffected by gruesome events
- o An expectation to affect positive outcomes regardless of the circumstances.

In the aftermath of a critical incident a responder's self concept may be challenged and in the subsequent psychological void a responder is often filled with self-doubt, guilt, second guessing and self-blame. The responder may isolate from friends, peers and family to avoid confronting the negative beliefs.

Hackett and Violanti (2003) note that the stigma associated with help-seeking behaviors involves not only the possibility of negative impact on the responder's career, but also the possibility of fitness for duty evaluations, mistrust by peers, and a view of oneself as being weak or inferior. Additionally, Wester and Lyubelsky (2005) found that police officers are reluctant to seek psychological help, largely due to their relative distrust of those outside their culture (see also Jones, 1995) and fear of being labeled. Similarly, in a study of US combat soldiers in Iraq and Afghanistan, Hoge, Castro, Messer, McGurk, Cotting, and Koffman, (2004) found that concern about stigma and how the soldier would be perceived by peers and superiors was related to resistance to seeking mental health interventions. The most significant barriers to soldiers seeking mental health services were being seen as weak (65%), feeling that their superiors would treat them differently (63%), that their peers might have less confidence in them (59%), and the perception that it might harm their career (50%).

Why Residential Treatment within a Retreat Setting?

Emergency responders who experience emotional discomfort are prone to engage in avoidance behaviors and seek distractions to mask psychological symptoms (Levson and Dwyer, 2003). Such avoidance behaviors include excessive work, substance abuse and high risk behaviors including adrenalin- inducing "sport" activities which contribute to higher rates of psychological distress (McFarlane, 2002). Whatever the behavior, the objective is to avoid thinking and processing the issues and feelings underlying their psychic pain. The WCPR provides a secluded five-day residential retreat setting prevents the responder from engaging in avoidance behaviors and encourages the resident to focus on the psychological and physiological symptoms that have combined to overwhelm him/her. The residential setting combined with an intensive treatment process that supports peer cohesiveness and multiple therapeutic alliances has been an effective treatment tool. It provides a milieu and process that has not been recreated outside a residential retreat format. However, the WCPR program is not a "stand alone" program. Upon graduation we encourage and assist participants to transition into mental health treatment in their community to continue their recovery work.

Approximately 50% of WCPR residents are referred by clinicians or worker's compensation organizations, often after individual therapy had not been effective. Many are encouraged to attend by their spouse, significant other, or are referred by a prior WCPR program attendee. Because of fear, avoidance or denial potential residents often need to be individually encouraged to attend a residential program. WCPR matches potential residents with peers who have been through the program to alleviate anxiety and doubt. First responder spouses/partners are also available to talk with the potential resident's spouse or significant other.

Treatment Format

WCPR is located in a rural area of west Marin County overlooking Tomales Bay and approximately 45 minutes from San Francisco. Volunteer peer support members pick up clients from area airports and escort them back after they graduate. Clients sleep in dormitory type accommodations, as do all staff members. Meals are provided by

volunteers; participants and staff all eat together which provides opportunities for informal clinical observations and interventions as well as facilitating relationship building between attendees and peers. The program is designed to reduce the hierarchy between staff and attendees, by having staff members self-disclose when appropriate.

WCPR is a highly structured five day program that combines education, group and individual clinical work and peer support. Daily programs start at 8 AM and continue until the day's tasks are completed, often 10 PM. There is some "down time" that allows informal conversations between peers, clinicians and fellow residents. There are few outside distractions that would allow a resident to avoid interpersonal interaction and the peers are trained to interact with and "pursue" individuals who are not engaging in the program. Specific aspects of the program are described below.

Staffing:

Clinicians:

WCPR clinicians are licensed mental health providers who specialize in the treatment of first responders. Many of the clinicians are past or present first responders who have first-hand experience with trauma. WCPR provides additional on-going training and support to clinicians as well as chaplains and peers.

Peer Support:

WCPR program objectives are enhanced by the involvement of highly trained peers who themselves may have experienced circumstances similar to those of WCPR residents. Trained peers often outnumber residents by a 3:1 ratio. This allows intense and frequent peer contact throughout the week. The peer role, in the treatment process provides acceptance, validation and empowerment as the resident reprocesses and re-works their experience.

Emergency responders are resilient; that is, they may focus on positive outcomes of having survived a critical incident. They may engage in a process of self-enhancement and growth (Higgins, 1994), and exhibit qualities of altruism, forgiveness, strength gained from surviving, and self-knowledge (Carlier, 1999). As a result, they may share their experience with others by becoming peer counselors themselves. For example, at WCPR attendees often return as peer counselors. This enables them to continue their recovery work while helping others. As one peer counselor stated, "The first time I came back I was half resident and half peer counselor; the next time I returned I felt more like a peer counselor than a resident."

Peers have an ability to break down the fallacy of uniqueness or the belief that the resident is the only person experiencing the stress symptoms. The goal is to demonstrate to residents that they are not alone in what they are experiencing and that what the resident is experiencing is normal. The fallacy of uniqueness has the potential to paralyze a responder's natural resiliency because it is closely associated with shame. They often believe, *"Since I am the only one feeling this bad, I must be a bad person."* On the first day, WCPR residents interview each other in a semi-structured format to begin challenging this belief. The results of these peer-to-peer interviews are then shared with the entire group to further reduce the stigma and promote conversation.

Peers help residents cope with the myth of invulnerability, which may have been shattered, and work closely with residents to develop a more rational and healthy perspective of their experience. Peers serve as role models, provide hope and assist in the development of appropriate coping skills in residents. Peers validate and normalize the clinical process and make it acceptable to seek help. Peers also work in conjunction with clinicians to help residents develop their own long-term wellness program. Peers diligently commit to follow-up with residents and help validate emerging, healthy coping strategies.

Chaplains:

Chaplains who participate in the program are members of the International Conference of Police Chaplains (ICPC). Chaplains also provide help for those who are in need of spiritual guidance. They do not evangelize or promote their individual faith tradition; instead, they provide a calming non-intrusive presence for both residents and staff. Often, the chaplain will act as an observer. At other times, the chaplain provides an empathic connection for residents and assistance in reconnecting them with their faith community. Not all residents seek the support of the chaplain but all seem to be reassured by the presence of a spiritual resource.

All clinicians, chaplains and peers donate their time to WCPR. There is only one part-time paid administrative support staff. The authors believe that while clinicians and chaplains provide useful services to those injured "on the job," that assistance is made more credible when it includes peers. Peer support also emerges among each session's residents as they become "ad hoc" peers for one another. Common sense and experience have taught us that a collective clinical understanding, facilitated through a peer/clinical alliance offers the most support for residents as they sort through their past experiences and make decisions about their future. Part of the clinical function is to interpret the phenomenon observed during the sessions in an understandable and useful way so that peers and clinicians work together as a seamless team. As such, this process is referred to being "peer-driven and clinically guided."

Psychoeducation

Psychoeducation is utilized to reduce concern about treatment and prognosis, reduce self-blame over symptom development, enhance the credibility of the therapist and provide a framework for recovery (Bisson, McFarlane, & Rose 2000; Carlier, 1999; Creamer & Forbes, 2004; Flack, Litz, & Keane, 1998; Hackett & Violanti, 2003). At WCPR, education modules are provided in a group format that is designed to promote feedback from residents, reduce stigma, and encourage them to make connections between current symptoms and the information presented. The module on psychophysiology of stress teaches clients to recognize their own somatic experiences as a normal reaction to an abnormal event. Clients are educated about better sleep protocols, self-care and adaptive health behaviors. The module on Emergency Responder Exhaustion Syndrome© normalizes the first responder culture and the way responders react to stress. The module on rescue personalities helps responders understand what brought them to choose a first responder career and how the personality factors that

protect them during a career as a first responder could work against them when dealing with stress. A culturally competent psychiatrist (who donates her time to WCPR) educates clients about symptoms, brain function and medications. The module on relationships explains the impact of trauma on family, friends and children. Video tapes are also used to provide information on emotional survival (Gilmartin, 2002), dynamics in alcoholic families, and on negative/positive cognitive processes and resilience.

Group Process

WCPR groups provide an opportunity for the retelling and reprocessing of traumatic events. Each group is facilitated by two clinicians who are assisted by a chaplain and peers specifically trained and selected to assist in the group process. Peers can challenge negative beliefs and provide a non-clinical perspective that can be accepted by the residents. Staff and peers also challenge residents' unrealistic expectations and encourage them to adopt realistic goals (Foy, Glynn, Schnurr, Jankowski, Wattenberg, Weiss, Marmar, & Gusman, 2000). The goals of group therapy are to normalize the responders' experiences, reduce isolation and symptoms, increase a feeling of community and support, and allow for the responders to feel understood (Talbot, Manton, & Dunn, 1992).

A modification of the International Critical Incident Stress Foundation's debriefing model (Mitchell & Everly, 1997) has provided a culturally acceptable framework to begin the discussions. During this modified debriefing, fact, thought and reaction phases are used to engage the responder. However, the transitions among these three phases are somewhat flexible; for example, a responder who starts emoting during the fact phase would not be told to wait until the reaction phase (Bohl, 1995).

Substance Abuse

One of the most common maladaptive coping mechanisms among responders is the increased use of alcohol as a means to manage their emotions (Beutler, Nussbaum, & Meredith, 1988; Breslau, 2002; Briere, 1992; Tucker, Pferrerbaum, Doughty, Nixon, Jordon, & Jones, 2002). In addition to education on the effects of alcohol and other drugs, residents are required to attend a 12 step meeting hosted at the WCPR facility by other first responders who are in recovery. Staff participants share their experiences and model substance abstinence and recovery.

Addressing Earlier Traumatic / Unresolved Issues

Many responders present with unresolved childhood issues or previous work-related or personal traumas. For example, many attendees have a history of early traumatic experiences, which is consistent with research on stress disorders (Briere, 1992; Ford, 1999; Yehuda & McFarlane, 1995). In addition to helping a responder reveal and discuss early traumatic experiences, it is beneficial to help the responder understand how those early experiences affect current responses to stress. An educational piece on the impact of early trauma is presented to residents, who then discuss a significant or problematic relationship and ways in which current symptoms and coping styles are affected and shaped by these earlier experiences.

Goal Setting

Responders are usually experts at identifying a problem and working toward a resolution. This trait, if not already a part of their personality, is instilled in them in the academy and throughout their career. Goal setting at WCPR includes specific steps a responder will take to improve his or her current situation. Attendees are encouraged to articulate and commit to steps that are specific, concrete and measurable (e.g., "I'm going away with my spouse for the weekend" vs. "I am going to improve my relationship"). The goals address all aspects of the responder's life, including work, family, physical and mental health, and spiritual wellness (where appropriate). The goal setting plan is written by the responder and provided to peers who follow-up with the resident, monitor progress and encourage compliance with treatment.

Eye Movement Desensitization and Reprocessing (EMDR)

Research on the use of Eye Movement Desensitization and Reprocessing (EMDR) to treat individuals who have been involved in traumatic incidents has been significant and its efficacy has been widely recognized (Parnell, 1997). EMDR is a therapeutic technique that quickly uncovers deeply held negative beliefs. This information enables the responder to replace negative beliefs with more realistic/positive perspectives (Figley, 1999; Shapiro, 2001).

Shortly after arrival, residents meet with a clinician who uses EMDR to facilitate a "resource installation." The installation includes developing internal strengths: visualizing a safe place, internalizing a desired trait (courage, patience, hope, etc.) and/or protector figure (e.g., role model). Toward the end of the retreat, attendees meet individually with psychotherapists who often use EMDR as a tool to confront traumatic memories. About 90% of residents receive EMDR as a treatment intervention. The authors have had considerable success using this technique, after the preparatory work that the responder completed in the debriefing and the psychoeducational components of the program.

Research

Research is being conducted regarding the efficacy of this program and its long-term effects. Several instruments are used to establish pre-post data as follows:

1.) Trauma Symptom Inventory (TSI) – Permission was obtained from the publisher (Psychological Assessment Resources, 1995) to modify the item booklet instructions to capture current experiences. The 100 questions take less than 10 minutes to administer and the report provides 16 T Scores (3 validity scale scores, 3 summary scale scores and 10 clinical scale scores) and a list of critical items. It is administered twice during the retreat: Once at the beginning (Sunday evening) and again at the end of the program (Thursday evening or Friday morning).

2.) Detailed Assessment of Posttraumatic Stress (DAPS) (Psychological Assessment Resources, 2003) – The value of the DAPS is that it not only provides validity and clinical scales to measure distress, but also because it provides information on substance abuse and suicidality. It is administered on Monday morning and

the 15 page interpretive report is used by the clinician conducting the responder's detailed intake interview later that day. The report provides two validity scales, two scales regarding an indexed event, and six scales regarding PTSD clusters, levels of dissociative experiences and an index on their level of impairment. The information generated is often shared with the resident and further inquiry or clarification may be made at that time. In general, residents score at very high levels on the reexperiencing, avoidance and hyperarousal scales. The DAPS is readministered 90 days following the retreat.

3.) Posttraumatic Growth Inventory – As an outgrowth of the work done by the American Psychological Association on resilience, the Posttraumatic Growth Inventory was modified for attendees at WCPR. It is completed at the end of their stay and again 90 days later.

The purpose of collecting this data is to conduct statistical analyses to determine whether there is any immediate benefit of attending the program (by examining TSI pre-post scores), whether there are any long-term benefits (by comparing DAPS' scores) and whether resilience factors are stable over time (by comparing Posttraumatic Growth Inventory scores). The goal is to obtain a sample large enough to generate sufficient power and effect size. Currently, we are in our fifth year of operation and hope to have the data available at the end of the year.

Every person who has attended a session, whether as a participant, staff member or observer, has seen the dramatic change in the residents. It is what keeps the volunteers coming back. One seasoned clinician said that he kept coming back as a volunteer, session after session, because he found the work to be "seductive." Veteran first responders are often amazed at the metamorphoses. A comment was overheard that the person who arrived on Sunday could not have been the same person who left on Friday; "I had to see it to believe it." Spouses often call WCPR to thank the staff for "giving them back their loved one." All staff participate because they want to give something back, to let fellow responders know that they don't have to kill themselves and that they matter. All staff participate with no compensation other then the satisfaction of knowing that they helped a suffering responder.

Conclusion

The West Coast Post-Trauma Retreat and the On-Site Academy are two examples of a residential treatment program specifically targeted to emergency responders. Additional research is needed to further develop effective treatments for emergency responders who have been involved in a critical incident. Specifically, additional confirmation and statistical support of the efficacy of the WCPR treatment model would be useful. Factor analysis of each program element would also provide useful information. Although gains appear to be immediately realized in terms of symptom reduction, additional research is necessary to demonstrate long-term efficacy. Analysis of long-term gains, maintenance of progress made and relapse prevention should be ongoing. Lastly, it will be important to measure changes in relationships and issues regarding quality of life.

WCPR, a division of the First Responder Support Network, Inc., may be reached through their website at www.WCPR2001.org

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