

A Residential Milieu: Update on Treatment of First Responder Trauma

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Abstract

First responders, including police officers, firefighters, emergency medical technicians and dispatchers, face unique challenges in dealing with and recovering from critical incident stress. In their work over the past 20 years with emergency responders at the West Coast Posttrauma Retreat (WCPR), the authors have found that short term residential treatment is an effective component of recovery. Statistically significant results of symptom reduction are evidenced by pre-post analyses.

Keywords: first responders, emergency responders, police, firefighters, dispatchers, residential treatment, PTSD,

In 1999, the founders of what was later to be called WCPR, a program of the First Responder Support Network (FRSN), met in Northern California in response to the suicides of a police officer and a firefighter. Their goal was to create a program to reduce suicides among first responders. The resultant format was a six-day program that includes a week-long true residential setting, culturally competent clinicians, chaplains, and peers, and emphasizes peer-support. The use of peers, trained in peer-support, throughout the week normalizes a resident's behavior and symptoms, providing hope and encouraging recovery (Bohl & Clark, 2017; Kamena et al., 2011). WCPR was modeled after the On-Site Academy in Massachusetts.¹ The overarching non-profit organization, First Responder Support Network (FRSN), was founded and includes three major components: advanced peer support trainings, treatment for Significant Others and Spouses (SOS),

¹ In 1990, Hayden Duggan, PhD, and Valerie Duggan, LCSW, started the Academy in Gardner, Mass. Nancy Bohl-Penrod, PhD, with her colleagues at The Counseling Team offer a public safety trauma recovery and resilience retreat with paid staff.

and WCPR.² All staff used at WCPR retreats are unpaid volunteers.

Profile of Attendees

Emergency responders who attend WCPR present with clinical symptoms that include depression, suicidality, posttraumatic stress, anxiety, sleep disturbances, and addictive and other maladaptive tension reduction behaviors. The WCPR participant has often received psychiatric and/or psychological treatment, but with little or no progress. Most of the participants have difficulties functioning at work and/or at home as the result of their involvement in critical incidents. Others are unable to function at all and are at high risk for suicide (Gulliver et al., 2016; Rufo, 2016; Stanley, Gin, & Joiner, 2016). Some first responder attendees, currently employed or retired, have made suicide attempts. The mission of the WCPR program is to help emergency service professionals and retirees regain control of their lives and return to work with a new perspective of stress and coping, or

² The original Northern California program has expanded throughout the country. FRSN freely encourages and insists on replication of its program. Satellite retreats are currently being held in Oregon, Washington, Arizona, Kansas City, Nebraska, and Indiana. Plans are currently underway to start another satellite retreat in Connecticut.

make a successful career change, including retirement.

WCPR's philosophy is to assist responders in returning to life.

At the time of their attendance (n=1553, 6/2021), approximately 40% were currently working, 11% were retired, 30% were on medical leave, 5% were on light duty, 4% were on administrative leave, and the remainder was composed of those who had been terminated, were off duty, part-time or had resigned. Length of service statistics were: 7% at five years or less; 15% six to 10 years; 59% 11-24 years; and 19% over 25 years as emergency responders. Males comprised 78% of attendees, 22% identified as female along with two transgendered residents.

Sixty percent of attendees were law enforcement, 30% were firefighter/Paramedic/EMS, 4.3% were dispatchers, 3.7% correctional officers, and the remainder consisted of chaplains, probation officers, nurses, clinicians, and others. Approximately 30% of the male attendees had been sexually abused as children. Adverse childhood experiences predispose one to developing posttraumatic stress injury in later life and is evident among the responders who attend WCPR (Crandall et al. 2019).

Background

People who devote themselves to the emergency service profession risk exposure to critical incident stress with accompanying post-traumatic reactions. The sequelae of such stress may affect job performance, social and family relationships and the overall quality of life. Although most responders recover and continue working, some develop problematic symptoms and require additional assistance. Unfortunately, maladaptive coping mechanisms and cultural norms within their work environment discourage help-seeking and encourage pervasive stigma for doing so (Arble, Daugherty, & Arnetz, 2018; Arble et al. (2017). This may be evidenced by suicide rates that cause more deaths than homicide or on-duty-related accidents (Chae & Boyle, 2013; Heyman, Dill, & Douglas, 2018; Kirschman, Kamena, & Fay, 2014; Violanti et al., 2018).

Stigma resultant from seeking assistance for critical incident related stress and resultant symptoms occurs in one of two ways: Self-stigma results from a perception that certain attitudes and behaviors are not culturally acceptable; and, social or public stigma involves awareness of reactions to

a specific group such as first responders obtaining mental health services (Corrigan, 2004). Wheeler et al. (2021) surveyed 210 law enforcement officers and found that higher self-stigma predicted barriers to seeking mental health treatment and that males had higher levels of stigma than females.

First responders need to perform complex tasks, under difficult conditions, while maintaining control over their environment and themselves. The complexity of their work creates uncertainty and responders may ruminate about their decisions. Revisiting the scene of an incident in their mind creates intrusive thoughts and cognitive dissonance. It may activate a need to be perfect that they learned in childhood and create distorted thinking such as the belief that they should be omnipotent. The message growing up may have been, “If you want anything done right, you’ll have to do it yourself.”

A worksheet entitled Tactical Thinking Errors was developed by one of the authors to demonstrate basic cognitive behavioral theory using terminology familiar to responders. The responder notes the primary emotion that

generates a negative thought. This may be tracked to one of the thinking fallacies (e.g., magical thinking, overgeneralizing or possession of superpowers) which may then create an opportunity to develop a more realistic, rational, and helpful thought or action. These thinking errors may also create burnout (Maslach & Leiter, 1997). In a survey conducted by McCarty et al. (2019), of the 13,146 police officers surveyed, the average officer felt emotionally exhausted one to three times per month and 19% experienced emotional callousness or exhaustion weekly. For 13% of those surveyed, depersonalization that was experienced on the job had emotionally hardened the officers and they became more callous. Law enforcement officers are currently leaving the profession more rapidly than before and morale is at an all time low. Responders deal with riots involving looting, arson, murder, and other crimes perpetrated in response to social unrest.

Symptoms immediately following a critical incident may include shock, nightmares, irritability, isolation, difficulty concentrating, emotional instability including anxiety, panic disorder and depression, and somatic complaints (Brucia,

Cordova, & Ruzek, 2014). Longer term symptoms include feelings of betrayal, embitterment, and moral stress. These responses may result in maladaptive tension reduction behaviors such as driving too fast off duty, disregarding personal safety, eating or substance use disorders, or being unable to control one's emotions and physically hurting someone. Responders suppress normal emotions such as revulsion, empathy, and fear. Denial of these emotions leads to an increase in distress in police officers (Violanti et al., 2017) and firefighters (Boffa et al., 2018; Bing-Canar et al., 2019). Continued suppression may lead to symptoms of emotional detachment, agitation, alcohol/substance abuse, cardiovascular and pulmonary diseases, ulcers, suicide, suspiciousness, absenteeism, marital problems, job and personal impairment, and symptoms associated with posttraumatic stress disorder (PTSD) (Turgoose et al., 2017; Can & Hendy, 2014; Price, 2017; Chopko, 2013; Copenhaver & Tewksbury, 2018). In addition to PTSD, possible diagnoses include acute stress reaction and chronic stress reaction (American Psychiatric Association, 2013).

Vicarious or secondary exposure results from witnessing an event or having knowledge about a traumatizing event that was experienced by another, combined with a desire to help that person. Examples include officers investigating childhood abuse or pornography, 911 operator duties such as dispatching officers and talking with victims, and family members listening to their responder spouse retell a critical incident in which they were involved. These situations create stress, as does compassion fatigue (cumulative stress resulting from heightened caring about victims of criminal acts or caring for emergency responders).

A responder's early life experience, such as perceived abandonment or childhood trauma, may encourage a career choice in emergency services while simultaneously reducing their willingness to access necessary treatment and their reactions to traumatic events. A responder may instead turn to a peer group that discourages treatment and encourages emotional avoidance in the form of alcohol use, engagement in extramarital affairs, and social withdrawal.

To effectively treat first responders, it is necessary to understand the role that cultural factors play. Generally, the

emergency service worker possesses a strong need for the acceptance, respect, and approval of peers (i.e., co-workers) (Benner, 2000; Kirshman, Kamena, & Fay, 2014). Peers reinforce traits necessary for emotional survival during their career. Although survival strengths such as psychological toughness, independence, and self-reliance help the responder cope, recovery strengths such as warmth, compassion, and sensitivity are discouraged. Further, the same survival characteristics that are reinforced on the job may result in negative consequences if taken home. Such emotional suppression may result in family discord in the form of disputes, divorce, or domestic violence (Kirshman, 2021). Even when physically alone, behaviors and decisions are strongly influenced by the expectations of peers and may discourage help-seeking behavior.

A responder's self-concept evolves during training and throughout their career and affects the individual's interpretation of their environment and future expectations (Biggs, Brough, & Barbour, 2014). Benner (2000) described a responder's self-concept as consisting of traits and beliefs that are modified through experiences. A responder's reliance and

trust in these beliefs facilitates performance of work-related tasks. These traits and beliefs include problem solving ability, action orientation when responding to emergencies, ability to control themselves and their environment including people in crisis, command presence with the ability to maintain clarity and effectiveness under stress, be unaffected by gruesome events, and 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 psychological void they may be filled with self-doubt, second guessing, and self-blame. Expectations of the need to be perfect, often learned in childhood, create unrealistic scenarios and negative beliefs. The responder may isolate from friends, peers, and family to avoid confronting these beliefs. This may be accompanied by increasing anger, embitterment, and moral distress.

Stigma associated with help-seeking behaviors not only involves the possibility of negative impact on the responder's career, but also the possibility of incurring a fitness for duty evaluation, mistrust by peers, and a view of oneself as being weak or inferior (Schlosser & Kudrick, 2019). Wester and

Lyublesky (2005) found that police officers are reluctant to seek psychological help, largely due to their relative distrust of those outside their culture (see also Haugen, 2017; Pennington et al., 2021) and fear of being labeled. U. S. combat soldiers have also been concerned about stigma and fear that help-seeking behavior would be negatively perceived by peers and superiors, thus contributing to their resistance to seek services. The most significant barriers to soldiers seeking mental health services have been being seen as weak, feeling that they will be treated differently by their superiors, having peers feel less confidence in them, the perception that it would hurt their career, and the perceived lack of organizational support (Hoge et al., 2004; Graziano & Elbogen, 2017; Kelly, Britt, Adler, & Bliese, 2014; Sharp et al., 2015).

Residential Treatment

Emergency responders who experience emotional discomfort are prone to engage in avoidance behaviors and seek distractions to mask psychological symptoms (Chopko, 2013). Such avoidance includes excessive work, substance abuse, and high-risk behaviors that include adrenalin-seeking

sport activities, and that typically leads to higher rates of psychological distress (Kirschman, Kamena, & Fay, 2014). The objective is to avoid thinking and processing the issues and emotions that underly their psychic pain. WCPR provides a secluded six-day residential treatment setting that prevents responders from engaging in avoidance behaviors and encourages their focus on the psychological and physiological symptoms that have combined to overwhelm them. The residential setting allows for an intensive treatment process that supports peer cohesiveness and multiple therapeutic alliances that are formed. This milieu has not been recreated outside of the residential format. The residential setting is referred to as a retreat, with an emphasis on education. This labeling helps to overcome the emotional barrier against “treatment” and “therapy” and projects a safer image to the first responder who may be more willing to attend.

WCPR is not a “stand alone” program. Upon program completion, participants are encouraged to attend follow-up meetings, participate in mental health treatment in their community and continue to receive peer support. Residents

are provided with a list of attendees, with their contact information, and are assigned an individual peer who follows them for a minimum of 90 days following their attendance.

WCPR residents are often referred by their clinicians, employee assistance, workers' compensation plans, employers, unions, and others when individual therapy stalls. Many are encouraged to attend by their spouse or significant other, or by previous attendees. Fear, avoidance, and denial collude to prevent responders from seeking help and they need individual encouragement to attend. Potential residents are matched with peers, who have previously attended WCPR, to alleviate their anxiety and doubt. Efforts are also made to ensure that peers who will attend the retreat share similar demographics, such as sex or gender, occupation, military history, and other factors. Confidentiality is also a constant focus. Thus, peers from the same department or agency will not attend, and if the peer discovers that a resident is known to them, the peer would be replaced should the resident feel uncomfortable. First responder spouses or partners are also available to talk with the potential attendee's significant other or spouse.

Significant Others and Spouses Retreat (SOS)

A parallel program to WCPR is also offered for first responder romantic partners. The SOS program follows a similar format in that it is a six-day residential treatment program but focuses on issues of living with an emergency responder. These issues include problems living with someone suffering from posttraumatic stress injury, co-dependency, affairs, intimate partner violence, prior abuse, addictions, maladaptive tension reduction behaviors, somatic symptoms, anger/hostility, and other psychiatric symptoms. FRSN is only able to offer five SOS retreats are offered per year, for six residents per retreat. The waitlist is two years.

Treatment Format

As of 2021, WCPR has six satellite locations with its main treatment facility located in a rural area of Napa County in the city of Angwin, California. It is approximately 90 minutes from the Oakland and San Francisco airports. Volunteer peer support members typically pick up residents from area airports and escort them back after graduation. All staff and residents sleep in dormitory type accommodations. During COVID protocols, staffing has been reduced, not normally

staff may outnumber the residents as much as 3:1. Meals are provided by volunteers who also reside at the facility for the week of the retreat. Satellite locations are rented and some of these are governed by their States and the facilities provide meals. Residents and staff share meals together which provides opportunities for informal clinical observations and interventions. This facilitates relationship building between attendees and staff. The programs are designed to reduce the hierarchy between staff and attendees by having staff members, including clinicians, self-disclose when appropriate.

These retreats employ a highly structured format that combines education, group and individual clinical work, as well as peer support. Daily programs start at 8:00 AM and continue until the day's tasks are completed, often not until 10:00 PM. Some "down time" allows for informal conversations between peers, clinicians, chaplains, and fellow residents. There are few outside distractions that would allow a resident to avoid interpersonal interaction and peers have been trained to interact with and "pursue" individuals who are not engaging in activities. The retreat schedule is tight. The chaplains hold morning meetings at 7:30 for those who wish

to attend. Exercise may be done before breakfast at 7:00. Specific aspects of the programs are described below.

Staffing

All clinicians, chaplains and peers donate their time to the retreats. FRSN, the non-profit parent organization, employ paid administrative support staff. The authors believe that while clinicians and chaplains provide useful services to those responders emotionally injured during their employment, that assistance is made more credible when it includes peer counselors. Peer support also emerges among the ad hoc resident bonding process. That is, the residents become peers for each other. Resident recover is facilitated by a peer/clinical alliance that offers the greatest amount of support 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, enabling peers, chaplains, and clinicians to work together as a team.

Clinicians

Licensed mental health providers who have been trained to work with emergency responders include psychologists,

social workers, marriage and family therapists, and licensed professional counselors. They are considered culturally competent and have been vetted through their prior work with this population. Many are either former or current first responders who have experience with trauma. Advanced peer support training is offered through the First Responder Support Network (FRSN), and those serving in leadership roles have been trained by observing a retreat for an entire week. Ongoing training is offered to interns and students who participate in a practicum through their graduate school. One of the founding members gathered a group of psychologists and formed the First Responder Psychology program at the Wright Institute in Berkeley, California, where doctoral and masters' level students take four specific courses and earn a certificate upon completion. These courses include: Introduction to First Responder Psychology; Consultation and Operations; Intervention; and, Assessment. This is the only doctoral level training program in the country and utilizes the 55 proficiencies that form the foundation for earning board certification in police and public safety psychology. FRSN

also offers accredited continuing education courses for clinicians, as well as for chaplains and peers.

Peer Support

Program objectives are enhanced by the involvement of highly trained peers who themselves have experienced circumstances similar to those of the residents. These peers offer intense and frequent contact throughout the week. Most have attended the program themselves and pay it forward through their volunteer participation. The peer role in the treatment process provides acceptance, validation, and empowerment as the resident reprocesses their past experiences. Advanced peers also participate in the debriefing process, also known as the group therapy component of the treatment program. They often provide educational trainings and help maintain a clean environment. Peers may work individually with residents as well, assisting in taking detailed personal histories and with helping residents' completion of their exit plans of action.

Most emergency responders are resilient. 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, posttraumatic growth, and self-knowledge (Carlier, 1999; Kamena & Galvez, 2020). As a result, they may share their experience with others by becoming peer counselors (Kamena et al., 2011). When former residents return as peers, they are afforded the opportunity to continue their recovery while helping others. One peer remarked, “When I returned, at first, I felt that I was half peer counselor while remaining half client. The next time I returned I felt more like a peer and that continues to grow each time I come back.”

Peers can break down the fallacy of uniqueness or the belief that the resident is the only person experiencing the stress symptoms. Self-disclosure by a peer counselor gives residents permission to share their own innermost secrets. The goal is to demonstrate that the resident is not alone in their experience and that what they are experiencing is normal. The fallacy of uniqueness has the potential to paralyze a responder’s natural resiliency because it may be closely associated with shame. Their belief may be, “Since I am the only one feeling bad, I must be a bad person.” On the

first day, 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 stigma and promote discussion.

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 experiences. Peers serve as role models, provide hope, and assist in the development of adaptive coping skills for 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 personal wellness program. Peers diligently commit to follow-up with residents and help validate emerging, healthy coping strategies (Can & Hendy, 2014).

Chaplains

The role of chaplains in the emergency responder environment has been a time-honored tradition. In the field, they provide comfort and counseling to responders, families, and crime victims. They accompany responders during death notifications and officer spiritual services when appropriate.

Those who participate at retreats are members of the International Conference of Police Chaplains or the Federation of Fire Chaplains. Chaplains do not evangelize or proselytize. They provide a calming, non-intrusive presence for both the residents and the staff. They often act as an observer but at other times may provide an empathic connection and may offer residents assistance in reconnecting with their faith community, deal with existential issues, or focus on posttraumatic growth. With their keen observation and intuition, they often assist in the therapeutic insight gained by residents.

The chaplain's religious order is often unknown to the residents as they view their role as providing a spiritual presence when needed. Grace before dinner is offered and may follow the faith traditions expressed by the residents. For example, Native American tradition may be followed one evening, Jewish the next, Christian or Buddhist traditions may be followed on other evenings.

Chaplains also work with individual residents who may have lost an unborn child, had an abortion, or who are grieving the loss of someone special in their lives. A specific

ritual has been established involving the dedication of a brick as a form of remembrance; the brick is placed in a secluded area of the property on a steel rack specifically designed to hold them a permanent memorial. The attendee designs and paints the brick, the process of which in and of itself is healing. Not all residents seek support from the Chaplain, but all seem to be reassured by the presence of a spiritual resource. They consistently receive high regard in exit surveys.

Psychoeducation

Various forms of psychoeducation are used 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 (van Dam et al., 2013; Hackett & Violanti, 2003; Creamer & Forbes, 2004; Kirschman, Kamena & Fay, 2014; Conn, 2018). Education modules are provided in a group format that is designed to promote feedback, reduce stigma, and encourage residents to make connections between their current symptoms and the information provided. The module Psychophysiology of Stress teaches clients to recognize their personal somatic

experiences as a normal reaction to an abnormal event. Residents are provided with education about sleep, self-care, and adaptive health behaviors such as the benefits of physical exercise, mindfulness, and meditation. The Emergency Responder Exhaustion Syndrome[®], characterized by anger, isolation, depression, and exhaustion, normalizes the first responder culture and the way responders react to stress. The Rescue Personalities module helps responders understand what brought them to choose a first responder career and how the personality factors that protect them during their career could also work against them when dealing with stressful situations. The Relationships module explains the impact of trauma on family, friends, and children. The Forgiveness or Letting Go of a Grudge module provides a template for the release of resentments that have built over the years. A discussion about addictions is accompanied by a 12-step meeting hosted by responders in recovery. And modules concerning cognitive processes, including dealing with emotional triggers and on resilience, allow better understanding of the mechanisms at work and ways to overcome their symptoms. The book Emotional Survival for

Law Enforcement is provided and discussed throughout the retreat (Gilmartin, 2002).

Group Process

WCPR retreats provide an opportunity for the retelling and reprocessing of traumatic events . During each 6-day retreat, two clinicians assisted by a chaplain and two peers, specifically trained and selected, participate in the debriefing process with the residents. Peers can often challenge negative beliefs and provide a non-clinical perspective that can be accepted by the residents. Staff and fellow residents challenge unrealistic expectations and encourage adoption of more realistic goals (Kirschman, Kamena, & Fay, 2014). The goals of group therapy are to normalize the responders' experiences, reduce isolation and symptoms, increase feelings of community support, and allow them to feel understood (Sloan, Bovin, & Shurr, 2012).

A modification of the International Critical Incident Stress Foundation's debriefing model has provided a culturally acceptable framework for discussions (Mitchell & Everly, 1997). During this modified debriefing, fact, thought, and reaction phases are used to engage residents. The transition

among these phases is often flexible. For example, a responder who starts emoting during the fact phase would not be told to wait until the reaction phase (Bohl, 1995).

Addictions

One of the most common maladaptive coping mechanisms among responders is the increased use of alcohol to manage their emotions (Conn, S., 2018; Prochniak, 2019). Other addictive behaviors include abuse of pain medications, gambling, use of internet pornography, excessive physical exercise, use of steroids, excessive caffeine intake, and gaming via the internet. These behaviors often lead to family discord and interfere with their ability to work and function in society. All residents are required to abstain from alcohol for a minimum of 30 days prior to their attendance. Residents are encouraged to take medications as prescribed but are cautioned about medications that are prescribed as needed (PRN) to ensure their alertness and ability to fully experience distressing emotions. The use of alcohol, marijuana, and vaping are prohibited at the facilities. Use of tobacco products are limited to designated locations outside of buildings.

Addressing Earlier Traumatic or Unresolved Issues

Many responders present with unresolved childhood issues or previous work-related or personal traumas. For example, many attendees have a history of childhood abuse and abandonment. In addition to helping responders to uncover and disclose early trauma, responders benefit from developing an understanding of how these early experiences affect their current response to stress. An educational module on the Impact of Early Trauma is presented and residents discuss a significant problematic relationship in group debriefings. This segment increases an understanding of the connection between current symptoms and coping styles that evolved earlier in their life. Residents frequently choose a parent for the problematic relationship that they discuss.

Goal Setting

Responders are typically experts in identifying problems and working toward resolutions. This trait, if not already part of their personality, is instilled in them in the academy and throughout their careers. Goal setting at the retreats includes specific steps a responder will take to improve their current situation. Attendees are encouraged to identify and commit to

steps that are specific, concrete, and measurable. For example, “I’m going away with my spouse this weekend” instead of “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. The goal setting plan is written by the resident, with the assistance of an assigned peer, and a copy is prepared for the peer who follows-up with the resident, monitors progress, and encourages compliance. Residents are asked to complete assessments of the program following their attendance.

Eye Movement Desensitization and Reprocessing (EMDR)

Research on the use of EMDR to treat individuals who have been involved in traumatic incidents has been significant and its efficacy has been widely recognized (Shapiro, 2017). EMDR is a therapeutic technique that quickly uncovers deeply held negative beliefs and is efficacious for short term residential treatment settings. This information enables the responder to replace negative cognitions with more realistic and other possible perspectives (Kirschman, Kamena, and Fay, 2014; Kamena & Galvez, 2020). Should EMDR not be

effective, another technique, Brain Spotting or the Flash Method, have been effective at the retreats. On rare occasions, clinicians may employ psychotherapy with which they are most familiar.

On arrival at the retreat, each resident meets with an individual clinician to reduce their anxiety and to provide tools that they may use during the week to help them accomplish their goals. Breathing, relaxation, and grounding exercises are reviewed. Bi-lateral stimulation is used to reinforce the establishment of a calm place through visualization, an inner resource such as skill, trait or belief that has been used in their past to help them through difficult situations, a “back-up” or protective figure (real, imaginary, living or dead) that can provide advice via their imagination; and, the use of an imaginary container to temporarily store disturbing thoughts or memories. Assistance is also provided to responders who use dissociation as a defense which prevents them from attending to information provided at the retreat. Toward the end of the retreat, EMDR is provided by to each resident individually by a trained clinician. Considerable success in symptom reduction has been

demonstrated following preparatory work that was completed during the debriefing and psychoeducational components of the program, when compared to a waitlist control group (Kamena & Galvez, 2020).

Research

Research has been conducted regarding the efficacy of WCPR (Kamena & Galvez, 2020; Dunnigan, 2012; Cantrell, 2010). Several assessments have been used including the Detailed Assessment of Posttraumatic Stress (Psychological Assessment Resources, 2003), the Trauma Symptom Inventory (TSI) (Psychological Assessment Resources, 1995), TSI-2 (Psychological Assessment Resources, 2011), and the Post-Traumatic Growth Inventory (Tedeschi & Calhoun, 2004). These and other published assessments had used the general population to establish a normative base. Individual administrations are compared to this base to establish symptom severity. However, no assessment tool had been developed using emergency responders as the base comparison group. So called validity questions did not apply to first responders and areas of frequent distress had not been addressed. To rectify this, a new instrument was created

called the Symptom Assessment For Emergency Responders (SAFER) and has subsequently been revised (SAFER-2[©]).

The original SAFER was normed on 500 responders from throughout the United States and Canada. Responders were randomly selected and represented varied but related occupations. The sample contained a representative sample by race, sex, age, and length of service. The revision is currently being re-normed but baseline comparisons are used in a clinical evaluation that uses criteria from the DSM-V (APA, 2013) and collective clinical experience. SAFER-2 contains 19 clinical scales, two validity scales and two summary scales. Hyperarousal, avoidance, negative alterations in cognitions and mood, intrusive symptoms (reexperiencing), depression, dissociation, anxiety, and panic disorder follow DSM-V criteria. The remaining clinical scales are anger/hostility, (with sub-scales of internalized and externalized), betrayal (with sub-scales of administrative/organizational/peer betrayal plus adverse media attention versus embitterment/moral stress), discrimination, impairment, isolation, sexual concerns,

somatization, addictions, suicidality, and maladaptive tension reduction behaviors (Kamena & Galvez, 2020).

Data collection began with the first retreat. The purpose of collecting this data is to conduct statistical analyses to determine the immediate benefit of attending the program by examining pre-post scores. Program information is regularly updated, and lessons are learned from every retreat. Each person who has attended a session, whether a participant, staff member, or observer, has observed a dramatic change in the residents. It keeps the volunteers coming back. One volunteer clinician stated that the results observed were the reason that she initially became a psychologist. Veteran responders are often amazed at the metamorphoses. It is often said that the person who arrived on Sunday is not the same person who left on Friday; “I had to see it to believe it.” Spouses often call to thank staff for “giving me back my partner.” 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 know they matter. All staff participate without compensation other than the satisfaction of know that they helped a suffering responder.

WCPR utilizes no advertising. Referrals are typically made by word of mouth. WCPR has consistently had a six-month waitlist.

Conclusion

Research has consistently found that WCPR provides a guide to future treatment and emphasizes a way of life that, if maintained, can help recovery from PTSD and other psychological disorders, thereby reducing the possibility of suicide. Although gains appear to be immediately realized in terms of symptom reduction, additional research is necessary to demonstrate long-term efficacy. Analyses of long-term gains, maintenance of progress made, and relapse prevention should be ongoing. Future research may include factor analyses of each program element that would provide useful information. Lastly, it will be important to measure changes in relationships and issues regarding quality of life.

WCPR and SOS may be reached through their website at www.FRSN.org.

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Drs. Kamena and Fay are board certified in police and public safety psychology, licensed psychologists, have worked as police officers, are co-founders of FRSN, and volunteer as lead clinicians at retreats. Dr. Kamena is the chair of the First Responder Psychology Certification program at the Wright Institute, Berkeley, CA, and is the Director of Research for FRSN. Dr. Fay is the Clinical Director and past President of FRSN, and teaches responders peer support and counseling, working with citizens experiencing clinical symptoms (crisis intervention), and wellness at police academies.

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