Traumatology
Volume 12 Number 3
September 2006 255-262

10.1177/1534765606294991
http://tmt.sagepub.com
hosted at
http://online.sagepub.com

A Residential Milieu Treatment Approach for First-Responder Trauma

J. Fay, M. D. Kamena, A. Benner, and A. Buscho

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 have found that short-term residential treatment is an effective treatment component. In this article, the authors discuss the WCPR residential treatment model.

Keywords: first responders; trauma; residential treatment; posttraumatic stress disorder; peer support

The On-Site Academy[1] was the first residential program devoted to the treatment of first responders. The format for the 5-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, have 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 Academy 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 because of, in part, the failure to follow the essential programmatic aspects mentioned above. The authors[2] have written this article in appreciation and recognition of the On-Site staff, without whom 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 or 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.

Of the 100 or so first responders treated at WCPR, 60% were law enforcement, 21% were either fire or emergency medical service, and the remainder of the attendees were part of 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 1-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.

From the West Coast Post-Trauma Retreat, San Rafael, California.

Address correspondence to: J. Fay, San Rafael Police Department, 1400 5th Avenue, San Rafael, CA 94901; e-mail: joel.fay@srpd.org.

Background

People who devote themselves to the emergency services profession risk exposure to critical incident stress with accompanying posttrauma 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 3 times greater health and domestic violence problems, have 5 times higher rates of alcoholism, and are 10 times more likely to suffer from depression than other officers (National Institute of Justice, 1999). Although most responders recover and continue working, some develop problematic symptoms and require additional assistance. Unfortunately, the maladaptive coping mechanisms and cultural norms that 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) lead 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, cardiopulmonary 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; Bohl, 1995; Toch, 2002). 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. Although survival strengths such as psychological toughness, independence, and self-reliance help the responder, recovery strengths such as warmth, compassion, and sensitivity are discouraged. Furthermore, the same survival characteristics that are reinforced on the job can result in negative consequences if taken home (i.e., emotional suppression; 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 or her environment and expectations about the future (Eidelson & Eidelson, 2003). 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 enable the responder to

perform necessary work tasks. These traits and beliefs include the following:

- problem-solving ability,
- action oriented in the service of responding to emergencies,
- an expectation to be in control of the environment and himself or herself,
- command presence and ability to maintain clarity and effectiveness under stress,
- effectively able to control people in crisis,
- 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 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) noted 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. In addition, Wester and Lyubelsky (2005) found that police officers are reluctant to seek psychological help, largely because of their relative distrust of those outside their culture (see also Jones, 1995) and fear of being labeled. Similarly, in a study of U.S. combat soldiers in Iraq and Afghanistan, Hoge et al. (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%), feeling that their peers might have less confidence in them (59%), and perceiving 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 & 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. WCPR provides a secluded 5-day residential retreat setting, which 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 or 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 re-created 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 or 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 facilitates 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 5-day program that combines education, group, and individual clinical

work and peer support. Daily programs start at 8 a.m. and continue until the day's tasks are completed, often 10 p.m. 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 firsthand experience with trauma. WCPR provides additional ongoing 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 reworks his or her 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. 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, nonintrusive 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 although 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

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 do not 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 WCPR 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. Last, 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 Web site at www.WCPR2001.org.

Notes

1. In 1990, Hayden Duggan, PhD, and Valerie Duggan, LCSW, started the On-Site Academy in Gardener, Massachusetts.

2. The authors' experience with this population comes from more than 100 years of emergency responder experience, working as sworn officers with various law enforcement agencies and as psychologists specializing in treatment of emergency responders.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

Benner, A. (2000). Cop docs. *Psychology Today*, *33*(6), 36.

Beutler, L. E., Nussbaum, P., & Meredith, K. (1988). Changing personality patterns of police officers. *Professional Psychology: Research and Practice*, *19*(5), 503-507.

Bisson, J. I., McFarlane, A. C., & Rose, S. (2000). Psychological debriefing. In E. F. Foa, T. M. Keane, & M. J. Friedman (Eds.), *Effective treatments for PTSD* (pp. 39-59, 317-319). New York: Guilford.

Bohl, N. (1995). Professionally administered critical incident debriefing for police officers. In M. I. Kurke & E. M. Scrivner (Eds.), *Police psychology into the 21st century* (pp. 169-188). Hillsdale, NJ: Lawrence Erlbaum.

Breslau, N. (2002). Epidemiologic studies of trauma, posttraumatic stress disorder, and other psychiatric disorders. *Canadian Journal of Psychiatry*, *41*, 923-929.

Briere, J. (1992). *Child abuse trauma: Theory and treatment of the lasting effects*. Thousand Oaks, CA: Sage.

Carlier, I. (1999). Finding meaning in police traumas. In J. Violanti & D. Paton (Eds.), *Police trauma: Psychological aftermath of civilian combat* (pp. 37-53). Springfield, IL: Charles C Thomas.

Chemtob, C. M., Tolin, D. F., van der Kolk, B. A., & Pitman, R. K. (2000). Eye movement desensitization and reprocessing. In E. F. Foa, T. M. Keane, & M. J. Friedman (Eds.), *Effective treatments for PTSD* (pp. 139-154, 333-335). New York: Guilford.

Comille, T. Q., & Meyers, T. W. (1999). Secondary traumatic stress among child protective service workers: Prevalence, severity and predictive factors. *Traumatology*, 5(1), article 2.

Creamer, M., & Forbes, D. (2004). Treatment of posttraumatic stress disorder in military and veteran populations. *Psychotherapy: Theory, Research, Practice, Training*, *41*, 388-398.

Davidson, P. R., & Parker, K. C. H. (2001). Eye movement desensitization and reprocessing (EMDR): A meta-analysis. *Journal of Consulting and Clinical Psychology*, *69*, 305-316.

Eidelson, R., & Eidelson, J. (2003). Dangerous ideas: Five beliefs that propel groups toward conflict. *American Psychologist*, 58, 182-192.

Figley, C. R. (1999). Police compassion fatigue (PCF): Theory, research, assessment, treatment, and prevention. In J. Violanti & D. Paton (Eds.), *Police trauma: Psychological aftermath of civilian combat* (pp. 37-53). Springfield, IL: Charles C Thomas.

Finn, P., & Tomz, J. (1998). Using peer supporters to help address law enforcement. *FBI Law Enforcement Bulletin*, *67*(5), 10.