

Emergency Responder Exhaustion Syndrome (ERES): A perspective on stress, coping and treatment in the emergency responder milieu.

Fay, J. PsyD, Kamena, M. D PhD, Benner, A. PhD, Buscho, A. PhD & Nagle, D.

Abstract

Emergency responders, which include police officers, firefighters, correctional officers, emergency medical technicians, and dispatchers, face unique challenges in dealing with critical incidents. In their extensive work with emergency responders, the authors have found that usual treatment modalities are sometimes ineffective. Faulty self-concepts, peer pressure, and the nature of posttraumatic stress contribute to treatment avoidance. Articulating this cluster of symptoms as Emergency Responder Exhaustion Syndrome (ERES) provides a culturally accepted opportunity for the responder to normalize reactions to acute and chronic stress, and for the therapist to conceptualize treatment plans. Assessment, symptoms, education, and treatment are discussed.

Introduction

Inherent in the emergency services profession¹ is the potential for exposure to critical incident stress with the accompanying post-trauma reactions. Traumatic events can cause reactions that affect jobs, relationships and quality of life. Although most responders are able to recover and continue working with the help of friends, debriefings and professional counseling, some responders develop debilitating symptoms and need additional assistance. Police officers reporting high levels of stress have three times greater health problems, three times greater levels of domestic violence, five times higher rates of alcoholism, and are ten times more likely to suffer from depression than other officers (National Institute of Justice. 1999). Sadly, more law enforcement officers kill themselves than are killed by felons or die in an on-duty related accident (Hackett & Violanti, 2003). The purpose of this paper is to discuss the Emergency Responder Exhaustion Syndrome (ERES), a culture-based theoretical orientation and to provide a treatment plan for clinicians working with emergency responders.

Background

Emergency responders risk their lives daily, and must respond to trauma with care, judgment, and professionalism. "Stress arises from ordinary work pressures on the individual and the police family as well as from critical incidents

¹ For the purpose of this paper we are defining an Emergency Responder as a civilian public safety employee, specifically, police, fire, emergency medical services and corrections.

that cause the officer to confront his or her own mortality” (Scrivner & Kurke, 1995, p. 15). Over time, this continual exposure to stress may affect their health, work, family and spirit. This paper will provide information on the nature of critical incident stress as it relates to emergency responders, describe and explain the ERES and discuss treatment utilizing the ERES concept. The authors’ experience with this population comes from a combined 100 years of emergency responder experience, working as sworn officers with various law enforcement agencies and as psychologists specializing in treatment of emergency responders. Data has been obtained by the authors’ work as clinicians and peers at the West Coast Posttrauma Retreat (WCPR) (www.WCPR2001.org), a six-day residential treatment program for emergency responders suffering from critical incident stress, sponsored by the First Responder Support Network, Inc.

At the time of this article, staff at WCPR had treated 99 first responders. Over 60% were law enforcement, 21% were either fire or EMS, and the remainder of the attendees were comprised of corrections, military, probation and other services. At the time of their attendance, 52% of the clients were still 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% had already retired. Approximately one year later, 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 their disability claims were still pending.

Emergency responder work is stressful and unpredictable. Emergency responders must have the emotional resources to perform multiple tasks without losing control in the face of physical threats. 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). They need to exhibit leadership, control and assertiveness; think clearly under pressure; and, adhere to norms of the police sub-culture (Anderson, Swenson, & Clay, 1995). Simultaneously, they must deal with distorted or offensive press reports that detract from their public image; communicate well with the public; and, exhibit restraint and empathy (Brown & Campbell, 1994). “Officers are being called on to make complex, high-risk judgments on the spur of the moment in response to a fluid situation” (Anderson et al., 1995, p. 117). They must be able to complete their tasks despite provocation, ambiguity, and the ever-present threat of psychological or physical injury (Shusman, Inwald, & Knatz, 1987; Silva, 1990).

Common sequelae of police stress include emotional detachment, agitation, alcohol/substance abuse, heart attacks, ulcers, suicide, cynicism, suspiciousness, decreased efficiency, absenteeism, early retirement, marital problems and symptoms associated with posttraumatic stress disorder (PTSD) (Toch, 2002; Bohl, 1995). Personal and environmental factors combine with traumatic events to create stress reactions such as PTSD. Risk factors include isolation, anhedonia, lack of opportunities for expression of feelings, and failure to develop interests outside of the workplace. Symptoms immediately following a critical incident may include shock, nightmares, irritability, difficulty concentrating, emotional instability, and somatic complaints. Recovery may take weeks to months (Carlier, 1999). In addition to PTSD, possible diagnoses include acute stress reaction and chronic stress reaction (American Psychiatric Association, 2000). Acute stress reaction involves symptoms of panic, freezing, disorientation, and agitation, whereas chronic stress reaction typically involves exhaustion, lack of humor, lack of direction, paranoia and isolation (U. S. Department of Defense, 2005). Several criteria from clusters including avoidance, arousal, and reexperiencing must be met to qualify for a diagnosis of PTSD (American Psychiatric Association, 2000).

Emergency responders respond to and immerse themselves daily into the chaos and confusion of other people's lives and by doing so put themselves at risk of becoming victims of traumatic incidents. One needs only to stand back and watch officers responding to a call of a "man with a gun" or fire fighters responding to and entering a structure fire to appreciate their coping abilities. Responders comfort trauma victims and operate in the wake of negative events. Responders need not directly experience the exposure to trauma to be affected. Rather, constant vicarious or secondary exposure (i.e., behaviors and emotions resulting from 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). For example, in a study of child protective service workers, Comille and Meyers (1999) found that up to 37% experienced significant levels of vicarious emotional distress.

In the emergency services occupations, stressful or traumatic events are often referred to as critical incidents. Traumatic stress symptoms will be experienced by over 86% of officers involved in a critical incident (White & Honig, 1995). Because of the varying effects an incident has on different responders, it is important to keep the definition of a critical incident flexible (Federal Bureau of Investigation, 1996). A critical incident is any situation faced by a responder that causes unusually strong emotional or physical reactions. These reactions may have the potential to interfere with the responder's ability to function either at the scene or later in life (Mitchell (1983), as cited in Clark & Friedman, 1992).

Kirschman (1997) believes that 85% of emergency responders experience symptoms of critical incident stress which may include impaired job performance, difficulty concentrating, short-term memory loss, tardiness, loss of interest in work and/or pleasurable activities, loss of motivation, absenteeism, and physical health problems (see also Brown & Campbell, 1994). However, as a result of emergency responders' training, beliefs, experience and culture, they may believe the opposite to be true that a minority experience such symptoms. It is important to point out and explain to responders the differences between normal job-related stress and critical incident stress because responders may experience inappropriate guilt if they are unable to handle what they believe is typical job stress (Davis, 2002).

Mitchell and Bray (1990) initially developed a list of critical incidents that affect the emergency responder. This list was later modified and expanded as follows²:

1. Line of duty death
2. Serious injury in the line of duty
3. Suicide of a working partner
4. Injury to or death of a child
5. Prolonged exposure to a victim who dies
6. Multiple injury / fatality accident
7. Victim is known to the responder
8. Any incident where one's personal safety is in peril, including deep undercover work
9. Exposure to infectious diseases
10. Unusual media attention
11. Administrative and/or co-worker betrayal

Self Concept and Culture

An individual's self-concept, which is developed through childhood and is informed by subsequent adult experiences, is comprised of the beliefs people have about themselves and their world. A self-concept template is developed through cultural consensus and allows individuals to interpret their environment and establish expectations about the future (Eidelson & Eidelson, 2003). When people are involved in critical incidents, three basic assumptions or beliefs about the self and the world are challenged. They are the belief in personal invulnerability, a belief that one is a good person, and the belief in a meaningful and orderly world (Janoff-Bullman, 1985). When a person faces a loss, as in the loss of the feeling of invulnerability, there must be some adjustment in order to continue functioning effectively. The interval between the recognition of the loss and the adjustment can be problematic.

Critical incidents may give rise to psychological crises which violate or contradict the beliefs people have about the world and their place in the world.

² Hayden Duggan, Ph.D., personal communication (2003).

For example, police officers may develop a distorted view of the world (i.e., loss of a belief in a just world) because of their exposure to crime and violence (Brown & Campbell, 1994). Exposure to critical incidents may challenge the evaluation of one's competency, contribute to self-doubt (Everly, 1995) or shatter the responder's assumptions regarding the world as a safe place. During a critical incident responders' expectations about their ability to handle stressful situations are called into question (Mitchell, 1990; Ryan & Brewster, 1994).

An emergency responder's self-concept is informed by cultural beliefs and enables the emergency responder to perform on the job. In this paper, "culture" refers to the underlying beliefs, values, practices, norms or the expectations of the emergency responder subculture (Anderson et al., 1995). Responders are action-oriented problem-solvers who can be depended upon by peers to control themselves and the environment. Responders value honesty, morality, bravery, compassion, clarity and effectiveness under stress. They expect positive outcomes regardless of the circumstances. Retired NYPD Sgt. Daniel Rudoffosi Ph.D. (personal communication, 2003) refers to this process as "Adaptive Dissociation." The responder self-concept is both necessary and unrealistic and can prove to be a psychological trap. For example, police officers responding to a call of a robbery in progress or firefighters entering a burning structure have to assume that they will be successful. When success is not achieved, the responders may blame themselves. Some of the beliefs held in this subculture are influenced by socially constructed expectations of the public. For example, the public would question a firefighter or paramedic who cries at the scene of a traffic accident.

To treat responders effectively, one must understand the cultural factors at work in the emergency services. Generally speaking, the emergency service worker has a strong need for the acceptance, respect and approval of peers (Benner, 2000; Finn & Tomz, 1998). Police peers reinforce psychological toughness, the failure to show emotions, independence, self-reliance, aggression, and quick reactions to danger; on the other hand, qualities such as warmth, compassion, and sensitive child rearing are shunned. Expressions of fear might be viewed as weakness. These characteristics that are reinforced on the job can result in negative consequences if taken home (Wester & Lyubelsky, 2005). Even when physically alone, behavior and decisions are strongly influenced by the expectations of peers. The very reasons a responder may go into danger are "peer-driven." A belief that the responder failed to meet culturally derived expectations may cause him or her to second-guess job performance, despite all evidence to the contrary.

The emergency responder is taught to reject, deny and/or suppress "normal reactions" to abnormal events (Lowery & Stokes, 2005; Pulley, 2005; Toch, 2002; Wastel, 2002; Wester & Lyubelsky, 2005). The cultural belief is that the reactions are not appropriate for someone in the emergency professions (Kopel & Friedman, 1997). The distressed emergency responder may project a

facade of competence while harboring a feeling of insecurity and shame. Failure to acknowledge feelings such as sadness and anger may result in poor job performance (Anderson et al., 1995) or may simply allow the job at hand to be completed (Toch, 2002).

Traditional approaches dealing with traumatic incidents tend to either pathologize the responder or encourage the responder to ignore the event and their reactions (Regehr & Hill, 2002). However, such denial of emotions and 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), and is likely unrelated to the responder's gender. The responder may look to peers to see if they are experiencing similar emotions and effects. When peers also hide their normal psychological and physical reactions, the responder feels shame and believes he or she is alone in this experience, leading to further isolation (Garrison, 1990).

Early life experience, such as childhood trauma, may influence a career choice in emergency services. Then, a responder's same personal history, in conjunction with a treatment-averse subculture, may reduce his or her willingness to access appropriate 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). Instead of getting the professional help that is needed, the responder may seek out a peer group that relies on stimulation (e.g., work harder, faster, better) and avoidance of emotional expression, which in turn further predisposes the responder to traumatic events and the consequences of problematic coping (e.g., alcohol, affairs, and social withdrawal). Further, responders who have been involved in critical incidents may not have access to their current or early traumatic memories, thus preventing the body's natural healing process from occurring.

Memory, Meaning and Narrative

Research has demonstrated that traumatic memories may be stored in the brain differently from non-traumatic memories (van der Kolk, 1988, 1994; van der Kolk & van der Hart, 1991). Support for this phenomenon is found in neurological and trauma research. Trauma is believed to cause the autonomic nervous system and neurological functioning in the hippocampus and medial thalamus to malfunction. Though encoding of memories occurs, some believe that correct verbal encoding of long-term memories is inhibited (Everly, 1993a, 1993b; Terr, 1994; van der Kolk, 1988).

Not all memories are verbal. Body memories of trauma have been cited as examples of memories that have been repressed and stored on a somatosensory level (Erdelyi, 1990; Horowitz, 1994; Howe, Courage & Peterson, 1994; Terr, 1988, 1991; van der Kolk & van der Hart, 1991). Empirical evidence

supporting the phenomenon has been difficult to obtain; however, there are many theories that support the existence of body memories. It has been suggested that traumatic events may be encoded on a sensorimotor level without orientation to time and space (thus, they are not easily translated to language and are not easily retrieved), and that memories may be demonstrated by gestures (Horowitz, 1994; van der Kolk & van der Hart, 1991). In order for these traumatic body memories to be integrated with existing schemes, the images need to be repeatedly revisited to construct a linguistic narrative of the event (van der Kolk & van der Hart, 1991).

Foa, Steketee, and Olasov-Rothbaum(1989) (as cited in Litz & Weathers, 1994) developed a theory about how fear information is stored in the memory. They suggest that information about the event is stored in a “trauma network.” This information consists of the responder’s physical, emotional and psychological reactions to the event. Also stored in this network is the meaning a person ascribes to the event. An emergency responder, who originally felt competent in his or her performance, may now believe, “I am helpless, I have no control over what happens to me, I am vulnerable” (Litz & Weathers, 1994, p. 24). The trauma is compounded through repeated similar events that continue to chip away at the emergency responder’s belief of being a competent human being.

The meaning a responder attributes to an event is shaped by the responder’s history and commonly held ideas about the correct way to respond. For example, McFarlane’s (1989) study of firefighters in Australia found that those with premorbid psychological problems were at greater risk for problems following exposure to trauma. Beliefs about responding *correctly* are constructed within the dominant societal and responder cultures. It is the meaning ascribed to an event that determines the responder’s behaviors and reactions after the event (White & Epston, 1990; Everly, 1994).

Wedded to responders’ incident memories is a self-imposed report card in which they evaluate themselves and often impose low performance grades, regardless of objective reality. If responders are unable to focus on positive outcomes, global negative self-appraisals may develop; these must be challenged through the creation of alternative narratives before the negative stories become the dominant narratives (Brown, 2003; Bohanek, Fivush, & Walker, 2005).

Narrative theory postulates that responders develop a story about themselves and their reactions to critical incidents. Responders may see themselves as heroes or cowards, depending on the meaning they attribute to their experiences. They construct narratives to make sense of all experiences, including those that do not make sense (Freedman & Combs, 1996). They may overlook aspects of the critical incident that do not conform to their dominant problematic story.

Narrative approaches allow the externalization of symptoms (White & Epston, 1990). The ERES approach encourages the responder to decide that a symptom *belonged* to an incident and not to the responder. It engages the responder's natural and trained tendencies to take a stand against problems. The narrative restorying provides an opportunity for the responder to make new meaning and develop a sense of control over problematic symptoms (Amir, Stafford, Freshman, & Foa, 1998). The narrative externalization process helps identify the ways in which the symptoms are affecting the responder's life and what he or she might do to counter those effects. Sample questions and further explanation are included in the treatment section below.

Emergency Responder Exhaustion Syndrome (ERES)

Emergency responders who attend the West Coast Posttrauma Retreat (WCPR) consistently present with clinical symptoms that include depression, posttraumatic stress disorder, anxiety, sleep disorders and substance abuse disorders. ERES may include physical, emotional, spiritual, mental or relational symptoms of any or all of these diagnoses (Anderson et al., 1995). However, although emergency responders tend to reject the notion of a formal diagnosis (Levenson & Dwyer, 2003), regardless of its appropriateness, they can accept the concept of ERES. ERES provides a framework for clinicians to understand a variety of symptoms displayed by emergency responders. The ERES framework permits the symptoms to be placed into a culturally acceptable format, which increases the likelihood that an appropriate and effective treatment program can be constructed.

Emergency responders are often reluctant to seek and remain in treatment. 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 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%). Aversion to treatment may stem from the desire to avoid that which would remind the responder of the traumatic event, the need to be accepted within the emergency services culture and the fear of confidentiality violations (Cameron, 2004; Meyer, 2001). 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. This resistance may, in fact, be a further example of the use of avoidance and may be a simple maladaptive coping mechanism (Davis, 2002).

Teaching responders about ERES helps them understand how their career contributes to their current distress. It normalizes reactions in a culturally acceptable way. It allows a responder to recognize that the symptoms are honorable. This shift away from pathology allows a responder to address current issues without shame and seek treatment. The core ERES elements are depression, isolation, and physical and emotional exhaustion. Separating and externalizing the problem as *Depression, Isolation and Exhaustion* can help reduce the difficulties responders experience by making the symptoms manageable. ERES is a model by which responders can reevaluate their beliefs, consider the impact of family-of-origin and subculture issues, and then plan how to recover.

It is important to maintain adaptive coping strategies while examining those that may not be serving the responders well. One way this is accomplished is through group therapy. Groups at WCPR allow the responders to challenge negative beliefs when delivering their individual narratives and to receive other members' nonjudgmental perspectives. An advantage of utilizing groups is that they allow participants to join with others who share similar experiences and who are otherwise isolated, alienated, and emotionally restricted (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). Groups are able to "challenge members to adopt realistic goals of living fuller lives while managing risks of periodic symptom exacerbation" (Foy et al., 2000, p. 159). They also allow responders to make a connection between their critical incidents and important relationships and past experiences. Candidates for groups are emergency responders who have the ability to establish trust with peers and staff, willingness to maintain confidentiality, the ability to tolerate high levels of arousal, and are not in danger of being retraumatized by other group members' critical incidents. Contraindications for group therapy include those who are actively suicidal, homicidal, psychotic, abusing substances or who have secondary gains such as malingering, fraud, or pending litigation (Foy et al., 2000).

Discussion of ERES, whether through didactic education, one-on-one, or group therapy allows for both insight and normalization. As one responder stated, "I learned more about myself and my reactions in those two hours (ERES class) than I did during my previous year in therapy." Despite the responder's favorable relationship with his private therapist, the therapist had not presented the responder with an understanding of his symptoms that fit with his subjective reality. ERES provided a culturally acceptable explanation of his situation and for

the first time allowed him to develop an equally culturally acceptable plan to counter its effects.

Key Characteristics of ERES

The key characteristics of ERES are depression, isolation, and physical and emotional exhaustion.

Depression

Although the level of depression varies for each responder (Breslau, 2002), it is not uncommon for responders to report suicidal ideation, planning and suicide attempts. Situational events, critical incidents and life stressors are not responsible for police officer suicide; however, depression, stemming from them, does (Hackett & Violanti, 2003). It is important for a responder to understand that depression is a chemical imbalance that can create feelings of helplessness and hopelessness and when combined with poor judgment, difficulty concentrating and making decisions, poor impulse control and substance abuse, suicide may appear to be a viable option (Hackett & Violanti, 2003). Responders who are influenced by depression utilize selective perception to "prove" their insufficiency (Furr & Funder, 1998; Moffitt, K. 1994). Depression frequently blocks a responder's ability to perceive positive outcomes (e.g., "I survived") and fosters a negative belief (e.g., "I failed to save that person; therefore I am a bad person"). This cycle of depression, negative self-appraisal and a reluctance to accept positive outcomes further isolates and exhausts the responder.

Isolation

There is a strong need to conform and be a part of the team in the emergency services. Emergency responders rely on each other for emotional and physical survival, and peers motivate one another to confront and handle danger. Responders may also develop a sense of separation, isolation, secrecy and resistance to outside criticism (Brown & Campbell, 1994). At times, responders may believe that they are not worthy of the respect and trust of fellow peers. Simply leaving the job will not alleviate symptoms. In fact, separation from police duties increases vulnerability to symptoms (Paton, Violanti, & Schmuckler, 1999). Yet, they may isolate from the very people who could help them recover out of fear of being discovered as *frauds*. As an example, one responder experienced an intense negative reaction after receiving an award recognizing her investigative abilities. She explained, "No one knew how badly I felt inside (as a result of my experience investigating the case) and receiving that award just proved that I was a fraud."

Social support from colleagues may reduce the effects of critical incidents. However, when peer support does not enhance coping skills, a reverse effect can occur which may be retraumatizing (Lowery & Stokes, 2005) and cause them

to avoid certain thoughts or feelings and to further isolate themselves. Avoidance involves attempts to escape or minimize heightened emotionality (Asmundson, Stapleton, & Taylor, 2004). Emotional distancing by emergency responders makes it unlikely that they will receive the help needed. For example, student paramedics had significantly greater trauma-related symptomology when they expressed negative attitudes regarding emotional expression (Lowery & Stokes, 2005). Thus, emotional distancing is a maladaptive coping strategy.

Exhaustion

Exhaustion, as used here, means a depletion of the ability to cope. As a responder exhausts these coping abilities, symptoms such as insomnia, suspiciousness, hypervigilance, chronic fear, panic attacks, disengagement, emotional constriction, depersonalization, derealization, memory disturbance, exaggerated startle response, agoraphobia and others may appear (Briere, Weathers, & Runtz, 2005). As coping resources are depleted, failed attempts at recovery (insufficient psychotherapy, excessive overtime, etc.) reinforce a sense of personal failure, which enhances depression and isolation. As a result, adaptive coping (e.g., physical exercise, peer support, hobbies, spirituality, relaxation and family support) decreases, while maladaptive coping (e.g., engaging in high-risk activities, substance abuse and multiple sexual relationships) increases. While the responder's capacity to recover is slipping away and while support is dwindling, families and bosses become more demanding.

Stress from the job can carryover to the home, making it difficult to recover from the demands of the job at home (Peeters, Montgomery, Bakker, & Schaufeli, 2005). Increasing stress at both home and work may lead to burnout. Burnout has been defined as stress arising from the interaction between the responder and recipient (e.g., distressed citizen) (Alexander, 1999) with the failure to find meaning and growth in life (Van Dierendonck, Gaarsen, & Visser, 2005) and has exhaustion and cynicism as its core issues (Peeters et al., 2005). However, exhaustion is closely associated with core maladaptive assumptions, negative beliefs, demands and unmet expectations (Van Dierendonck et al., 2005).

A typical presentation is as follows:

Officer Smith was raised by an alcoholic, abusive father. Although shaken by his childhood experiences, Smith coped by being involved with many ego-enhancing activities outside the family. In his twenties, Smith enthusiastically entered law enforcement and was well respected as an assertive and responsible officer. During his career Smith experienced a number of events that either reinforced or challenged his belief of himself as competent and in-control. When Smith encountered a negative event he would re-devote himself to his work, often at the expense of his family, until he once again felt a sense of competence. At some point, Smith experienced an event which caused the collapse of his coping abilities and violated a number of the core assumptions

he had about himself and led to new negative beliefs (i.e., "I'm vulnerable, less than capable, and flawed"). This event not only challenged his self-concept but also connected with his core unresolved beliefs. Instead of believing that the incident was bad, Smith came to believe "I am bad." Smith attempted to cope with these new beliefs but for the first time in his life, his usual coping mechanisms were ineffective. Smith had difficulty sleeping, was anxious, and used alcohol as a way to gain temporary control of his symptoms. As Smith's depression and anxiety symptoms increased, he saw himself as a fraud and lived in fear of his "true-self" being discovered by other officers. To prevent his secret from being discovered, Smith began to emotionally isolate himself from work and his family. The resulting lack of support "verified" for Smith that he was indeed a flawed human being.

Smith's story is typical of the responders who attend WCPR. Many have experienced a stress debriefing, attended therapy and may be on psychotropic medications. Many report significant childhood trauma including emotional, physical and sexual abuse, suicide of parents or parents who are emotionally unavailable (Davis, 2002; Dietrich, 2002). Unresolved prior traumatic events may amplify symptoms associated with current critical incidents and reduce one's ability to recover (Kirschman, 1997). In one WCPR session, four out of seven responders reported being sexually abused as children and all seven reported emotionally detached parents. The literature concerning the well-documented effects of childhood abuse is covered in other publications (Albeck, 1994; Briere, 1992).

Although many responders are able to experience critical incidents without the development of an acute stress reaction, research demonstrates that the risk increases when a career in the emergency services is combined with ineffective coping strategies and an abusive/neglectful family history (Briere, 1992; Yehuda & McFarlane, 1995). It is vital to explore childhood history with a responder who is experiencing intense distress from a current event. For example, a responder who grew up in an abusive family may have internalized the belief that she deserved the abuse. As an adult responder, when she experiences a traumatic incident, the old internalized self-abusing belief enhances the current traumatic reaction, and interferes with her ability to recover. Additionally, Kirschman (1997) stated that PTSD "is produced by exposure to severe, usually life-threatening trauma, and amplified by unresolved prior trauma, the organizational response, media events, and community reaction" (p. 77). If symptoms are left untreated, there may be lasting effects (Bohl, 1995).

Treatment

A comprehensive diagnostic evaluation should precede treatment. As treatment begins, establishment of trust and a therapeutic alliance is primary. The clinician should demonstrate a concern for the responder's physical safety, conduct education about trauma, monitor symptoms, identify and address coexisting diagnoses, and provide support for any ongoing crises (Foa, Keane, & Friedman, 2000). Current research has demonstrated that police officers prefer to utilize problem-focused and direct-action strategies to deal with occupational

stress (Evans, Coman, Stanley, & Burrows, 1993; see also, Rothbaum, Meadows, Resick, & Foy, 2000). Treatment helps responders understand the ways in which they have isolated themselves, and depleted internal and external coping resources. When responders use avoidance, the therapist points it out and encourages them to stay with feelings of caring and trust, along with the feelings that were being avoided (Roemer, Harrington & Riggs, 2002).

Responders should be encouraged to develop an alternative narrative with associated counter-tactics to be utilized against the incidents' negative effects. The goal is to develop habituation of the emotional response, construction of a narrative that includes examination of the event and its consequences, and subsequent reduction of symptoms. Ultimately, treatment should help the responders connects maladaptive beliefs and responses to current symptoms with the goal of empowering them to take the necessary steps to recover.

In addition to recognized treatment factors of empathy, warmth, congruence and the therapeutic alliance (Lambert and Barley, 2001) there are specific interventions that target subculture issues that have been developed at WCPR. For example, subculture issues are discussed utilizing the overlaying template of depression, isolation and exhaustion, encouraging the responder to identify problematic beliefs and behaviors, develop alternative strategies and take steps to put those strategies into action. These specific steps are:

1. Challenging the *Myth of Uniqueness*
2. ERES Education / Externalization of the problem
3. Modified debriefing process
4. Education on psychophysiology of stress, responder personalities and other relevant topics.
5. Substance abuse treatment / education
6. Addressing earlier traumatic / unresolved issues
7. Goal setting
8. Family / work reintegration
9. Administrative / Personal Betrayal
10. Eye Movement Desensitization and Reprocessing (EMDR)

Treatment helps responders understand the ways in which they have isolated themselves, and depleted internal and external coping resources. At WCPR, it is assumed that responders have internal resources to deal with normal work-related stress, but that they may benefit from additional help in dealing with critical incidents (Regehr & Hill, 2002). For example, narrative exposure therapy involves repeated, detailed discussion of the worst traumatic event while reexperiencing the affect associated with that event.

However, it is often difficult for responders to determine the *worst* event; therefore, the responder may be asked to tell a narrative story of their life, from birth to present, focusing on their traumatic experiences. The therapist asks

about emotional, physiological, cognitive and behavioral reactions experienced during the telling of the narrative. The responder is encouraged to feel these reactions and the process continues until habituation occurs (Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004). Once these tenets are in place, the specific interventions detailed below may be employed.

Challenging the *Myth of Uniqueness*

The first intervention to treat emergency responders at WCPR is to challenge the myth of uniqueness. To process traumatic information, the clinician must help the responder move beyond emotional and cognitive defenses that interfere with treatment (Briere, 1992). In Solomon's (1988) discussion of officer involved shootings, he stated that approximately one-third of officers will have few or no symptoms, about one-third will have mild symptoms and will be able to work through them without intervention, and about one-third will have serious symptoms which will require professional intervention. At the core of the distressed responder's defense is the often unspoken belief, "I am not worthy" with its attached problem-saturated narrative.

One of the most common fears of the responders is that they are the only person experiencing the negative symptoms. Thus, the myth of uniqueness evolves. This belief paralyzes a responder's natural resiliency because it is closely associated with shame. "*Since I am the only one feeling this bad, I must be a bad person.*" Control over the traumatic event is achieved by actively restructuring cognitive schema to develop meaning. "A sense of coherence expresses the belief that life, or the situation at hand, is comprehensible, manageable, and meaningful" (Loo, 1999, p. 278). In a group setting, such as WCPR, residents interview each other in a semi-structured format to challenge this belief. Some of the questions are:

- Why are you here and why now?
- What will be the first sign that will tell you that you are getting better?
- What will other people notice?
- Who will be the first to notice and why?
- Can you tell me about a time in your life when you were able to overcome a difficult situation? What skills, traits, and abilities did you use?

Residents return from this interview and often report relief in knowing that other responders are experiencing distress very similar to their own. It is often the first step in challenging the isolation. For individualized treatment, when a group may not be available, we recommend that the clinician conduct the interview, normalize symptoms and address the *Myth of Uniqueness*.

The authors recognize that it is often difficult to have responders attend a group therapy session in the private practice setting. An option is to seek

qualified responders trained in peer support and encourage the responder to meet with the peer support responder. Departments in which peer counselors are made available have greater productivity, less absenteeism, lower levels of grievances filed, fewer disciplinary actions, and improved employee morale (Anderson et al., 1995). Initial meetings could be facilitated by the clinician within the context of a psychotherapy session. This connection with an experienced responder is a vital step in the healing and normalization process. Lehman, Ellard, and Wortman (1982) recommend that talking with someone who has had a similar experience (e.g., their study involved the death of a peer) is the most useful intervention that can be made. In cases in which the responder has lost a sense of invulnerability, they recommend that treatment be provided by a professional who is culturally sensitive. Police officers in crisis may see clinicians as mercenaries whereas peers are more likely to be viewed as competent, caring and helpful (Davis, 2002; Hackett & Violanti, 2003).

Many responder agencies have peer support teams staffed by peers who have recovered from significant trauma-related symptoms. Peer counseling is done by responders who are psychologically healthy and altruistic, and are capable of dealing with countertransference and validating others' experiences while maintaining confidentiality (Loo, 1999). These peers have the potential to act as a model of hope for the responder who is currently experiencing significant distress. For example, police officers may not be the best judge of their own reactions to stress. Peers, however, may be more objective and able to see symptoms (Toch, 2002). "Peer support programs seem to work well for suicide interventions" (Hackett & Violanti, 2003, p. 10). Peer counselors make initial interventions and make recommendations for professional treatment when warranted.

ERES Education / Externalization of the Problem

As part of the education process, the authors encourage clinicians to discuss the ERES concept and help responders separate themselves from their problems. At WCPR, during the ERES education portion, responders are asked to answer the following (or similar) questions to begin the externalization process:

- How was Depression (Isolation, Exhaustion) first introduced into your life?
- What tactics does Depression (Isolation, Exhaustion) utilize to control and stay in your life?
- What does Depression (Isolation, Exhaustion) want you to think, believe and feel about yourself (your career, family, etc.)?
- What would your life look like if Depression (Isolation, Exhaustion) were to succeed?
- What tactics have been useful in countering these negative effects?

- What percentage of your life does the Problem control?

Modified Debriefing

Debriefings are often used to provide psychoeducation, mutual support, emotional expression and release, and for the department to demonstrate acceptance of responders' reactions (Bisson, McFarlane, & Rose, 2000; Brown & Campbell, 1994). "There appears to be little doubt that giving traumatized individuals a psychological map to understand their reactions does much to contain their distress and to allow them to institute a series of self-regulatory processes" (Bisson et al., 2000, p. 42). Although Bisson et al. (2000) caution against the use of debriefings because of the lack of empirical support and theoretical framework, they state that if debriefings are used as part of a comprehensive management program, then they may be beneficial.

Trauma work involves an in-depth revisiting of the indexed critical incident. "It is important to confront traumatic memories directly instead of trying to avoid them" (Cardena, Maldonado, van der Hart, & Spiegel, 2000, p. 259). For example, fear memories may be reconsolidated and rebuilt in the amygdala every time they are retrieved. Therapy offers the opportunity to re-transcribe these memories via reactivation of the emotions experienced at the time of the trauma. Every time a memory is retrieved, it is synthesized and rebuilt with kinder and gentler associations made with the safety established via the therapeutic relationship (Kaplan-Solms & Solms, 2002).

WCPR attendees often report multiple critical incidents and are asked to debrief the one that is currently bothering them the most (Bisson et al., 2000). This serves as a model for debriefing other critical incidents in the future. The authors have found that utilizing a modification of the International Critical Incident Stress Foundation's seven step debriefing model (Mitchell & Everly, 1997) provides a culturally acceptable framework to begin the discussions. In typical critical incident debriefings, responders are told that it is not group therapy and that the following treatment assumptions are made: 1.) The responder has an adequate premorbid level of functioning; 2.) Symptoms are normal and not signs of a serious disturbance; and, 3.) Symptoms are temporary (Bohl, 1995). Although we often make these treatment assumptions at WCPR, the modified debriefings are, in fact, group therapy. During this modified debriefing, we utilize the *Fact*, *Thought* and *Reaction* phases to engage the responder. However, the distinction among these three phases is somewhat arbitrary; for example, a responder who starts emoting during the fact phase would not be told to wait until the reaction phase. There is a need to remain flexible (Bohl, 1995).

Debriefings allow the responders an opportunity to review their experiences and to gain mastery (Talbot et al., 1992). The authors have also found that the use of certain aspects of dialectical behavior therapy (Linehan, 1993) is helpful. For example, development of coping skills such as distress tolerance, mindfulness, emotional regulation, and improved communication may allow the responders to tolerate painful reactions and reduce the use of

avoidance (Linehan, 1993). Responders are taught how to observe and discuss their critical incident, their thoughts and interpretations, their sensory and somatic responses, their emotional reactions, their desires and fantasies (including magical thinking that may produce inappropriate guilt), their heightened sense of vulnerability, and their actions following the incident (Goldfarb, 1998; Marra, 2005). Having the responder talk, stand and walk through a reenactment of the incident “frame by frame” has been beneficial, as many responders will gloss over important facts or emotionally difficult moments. This allows the clinician to obtain important information that may be needed to respond helpfully (Marra, 2005). Clinicians are encouraged to ask questions to further develop the responder’s story of the incident. Also, reframing allows for development of adaptive behaviors, such as strengthening bonds with family members, coworkers and friends (Wester & Lyubelsky, 2005). As a general rule responders prefer an active, inter-active clinical style. Sample questions are:

- At that moment (during the incident) what were you thinking (feeling, sensing)?
- How did the incident (or specific moment) affect the way you conduct your life?
- Complete this sentence: “Because of the incident (moment) I now / fear that / hope that...”
- What belief did you develop about yourself as a result of your involvement in this incident? Is this a positive belief?
- Is there anything about this incident that reminds you of something that occurred in the past?
- If the belief remains, how might it affect your life?

Havassy (1991) (as cited in Bohl, 1995) hypothesized that the ritualistic aspect of critical incident debriefings contributes to its perceived success. That is, there is comfort to be gained in social rituals, similar to the start of healing that occurs with a funeral.

Psychoeducation

Psychoeducation can be 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 et al., 2000; Carlier, 1999; Creamer & Forbes, 2004; Flack, Litz, & Keane, 1998; Hackett & Violanti, 2003). Education on the psychophysiology of trauma, emergency responder personalities, use of medication and other topics are conducted at WCPR.

Substance Abuse

Many responders utilize alcohol or demonstrate increased vulnerability to alcohol abuse as a means to manage their emotions (Beutler, Nussbaum, &

Meredith, 1988; Breslau, 2002; Briere, 1992; Tucker, Pferrerbaum, Doughty, Nixon, Jordon, & Jones, 2002). In a recent study of US combat military soldiers stationed in Afghanistan and Iraq by Hoge et al. (2004), they found that rates of PTSD, major depression and misuse of alcohol were correlated with the number of firefights that they were involved in. The authors have also observed an increasing number of responders who utilize sex (affairs, internet chat rooms, pornography) as an emotional regulator. These maladaptive coping techniques need to be identified and addressed.

Addressing Earlier Traumatic / Unresolved Issues

The authors' experience has shown that many responders who experience intense distress after an event have a history of childhood 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. Some useful questions include:

- Where and when have you felt this way (reaction or symptoms) before?
- As a result of my early experience:
 - "I believed that I..."
 - "I continue to feel like I..."
 - "I am afraid that I..."
- What do you know about yourself as an adult (beliefs, skills, traits), that would challenge earlier beliefs?
- How would your life be different if you were able to reject the old beliefs?

Goal Setting

Responders are excellent 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. Treatment goals are stated explicitly: To process memories, to learn to use adaptive skills, and to develop alternative beliefs (Roemer, et al., 2002). Goal setting includes specific steps a responder will take to improve his or her current situation. Attendees are encouraged to utilize steps that are both concrete and measurable (e.g., "I'm going to work out three days a week" vs. "I am going to improve my health"). Another goal is to empower responders to overcome and learn from their critical incidents so that they might be better prepared in the future (Violanti, 1999).

The goals address all aspects of the responder's life, including work, family, physical and mental health, and spiritual wellness (where appropriate) and include specific steps the responder will take to counter the effects of

depression, isolation and exhaustion. Ideally, the goal setting plan is put into a semi-formal contract, signed by the client and the therapist, which can then be utilized as a tool in subsequent therapy sessions or to monitor progress, compliance with treatment, and success.

Emergency responders are often 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 which enables them to continue the recovery process while helping others. As one peer counselor stated, "The first time I came back I was half client and half peer counselor; the next time I returned I felt more like a peer counselor than a client."

Family / Work Reintegration

Family discord is common among trauma survivors and requires evaluation on initial assessment (Riggs, 2000). Divorce rate estimates among emergency responders range from 35% to 75% (Wester & Lyubelsky, 2005). This is likely due to job stress that is taken home (Toch, 2002). Diane Wetendorf, a domestic violence advocate and counselor, states that "there are no statistics that tell us what percent of officers and firefighters emotionally abuse and physically batter their intimate partners. All we know is that there are many of them" (www.abuseofpower.info). However, it is known that rates of domestic violence are significantly higher in veterans with PTSD (Riggs, 2000).

Responders will have likely distanced themselves from their families as they struggle to maintain emotional composure. Officers may share more of their emotional issues with their work partner than their significant other, which has the potential of generating envy or jealousy in a spouse (White & Honig, 1995). Interactions with family members may trigger recollections and reliving of past traumatic events. These cause either rage or withdrawal that eliminates communication and triggers feelings of fear, hopelessness and anger/rage in family members, which, in turn, perpetuates the conflict (Riggs, 2000). Going home and announcing, "I'm back" can create relationship difficulties with a spouse who had assumed many additional roles (chief financial person, decision maker, etc.) within the family (Paton et al., 1999). Although an effective way of dealing with stress is to discuss critical incidents with one's spouse or significant other, a risk exists that the partner and other family members will develop vicarious traumatization (White & Honig, 1995).

Vicarious traumatization, coupled with personality changes experienced by the responder, exacerbate family dysfunction. Family members may experience physical illness, increased anxiety, lowered frustration tolerance,

depression, and symptoms associated with PTSD as a result of vicarious traumatization (White & Honig, 1995). Failure to resolve family issues may result in “permanent, and often maladaptive, adaptations” (Paton et al., 1999, p. 84). This is where the clinician can help with a renegotiation of the relationship contract. The goal is to improve family functioning, measured by reduction in conflict and increased communication (Riggs, 2000).

Additionally, responders may face stigma when they return to work after a stress leave. It may be necessary for the clinician to predict this, and to discuss issues of shame, fear, and worry. Alternatively, simply leaving the job will not alleviate symptoms. In fact, separation from police duties increases vulnerability to PTSD (Paton et al., 1999).

Administrative / Personal Betrayal

Although there are many events that can be the cause of the responders' current psychological distress, there are often times that responder's symptoms are charged by previous issues of abandonment and rejection. The earlier, unresolved issues can be activated by current events that include *Administrative/Personal Betrayal*. The authors cannot over-emphasize the damage caused by this phenomenon. Gilmartin (2002) observed that “minor dissatisfaction with the organization or agency can become all-consuming anger, hostility, and open hatred toward” management (p. 5). It is important for the clinician to not solely focus on the critical incident but to provide time for the responder to discuss issues of administrative or personal betrayal and to look for ways that current issues connect to previous ones.

Many responders believe the oft-spoken phrase “We are a police (or fire) family.” As in an idealized family, responders expect to be treated with care when they experience distress. For example, a study of New Zealand emergency responders revealed that organizational stressors predicted levels of job satisfaction more than did levels of trauma (Brough, 2004). However, at times, responders' experiences do not meet this expectation. Obsessing about administrative or personal betrayal relinquishes personal control, focusing on a situation over which the responder has no control. This can result in the responder thinking of himself or herself as a victim, which, in turn, leads to a sense of entitlement and relinquishes further control. “The victim, however, forgets loyalty and integrity and begins viewing the world as loyalty versus integrity” (Gilmartin, 2002, p. 109).

Failure to identify the earlier traumatic incident may inhibit recovery from the current event. As an example, one WCPR attendee who presented with a highly traumatic event which he successfully debriefed; however, he did not experience significant symptom reduction until he was able to connect his current symptoms to an event that occurred when he was a teenager: As he was about

to leave for college, his father told him, “Well I hope this makes a man out of you, heaven knows I’ve tried and failed.”

Examples of some questions utilized at WCPR are:

- Have you ever felt (somatic and emotional) this way before?
- Is it possible the way you are reacting today is connected to something from your past?
- What strategies did you use to cope with the previous event?
- Would these strategies work for you today?
 - If Yes
 - What keeps you from utilizing them today
 - If No
 - Why wouldn’t they work?

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 critical information. This information enables the responder to replace negative beliefs with more realistic perspectives (Figley, 1999; Shapiro, 2001). Although some researchers have found that exposure therapy may be superior or as effective as EMDR (Asmundson et al., 2004), other studies have shown both short-term as well as long-term benefits (Davidson & Parker, 2001). For example, Wilson, Becker and Tinker (1995a, b) found that initial benefits from using EMDR were sustained over a 15-month period.

Studies show that both those diagnosed with PTSD and those without the diagnosis received initial and long-term benefits from EMDR treatment. A relatively small number of EMDR sessions resulted in substantial benefits that were maintained over six months (Marcus, Marquis, & Sakai, 2004). Even stronger evidence involving benefits received from EMDR was found for people who have had single traumatic events, people who have not benefited from traditional psychotherapy, inpatient veterans, and substance abusers (Chemtob, Tolin, van der Kolk, & Pitman, 2000).

In the final stages of the WCPR program, attendees meet individually with psychotherapists. Over 90% of the time, EMDR is used as a treatment tool. The authors have had considerable success using this technique, due largely to the work that the responder completed in the debriefing and through other psychoeducational components. Responders are asked to imagine scenes in the future in which they are functioning effectively and are proud of their performance (Davis, 2002). Research is currently being conducted that will detail the treatment effects that have been observed anecdotally.

Countertransference and Parallel Process

Clinicians who work with emergency responders may encounter personal or countertransference issues. The nature of the work may evoke violent fantasies, thoughts of death, feelings of abandonment, helplessness or degradation, or other symptoms such as exhaustion, increased use of alcohol, headaches, feeling tense, difficulty concentrating, stomach aches, changes in sleep patterns, nightmares, and increased demands on family and friends (Talbot et al., 1992). It is important to not deal with these issues with the responder or at the group level; rather, the therapist may need to obtain outside resources to help resolve these issues. Clinicians work in pairs to be able to debrief and support each other (Talbot et al., 1992). However, even psychologists with years of experience have found that the stress was significant. Wester and Lyubelsky (2005) recommend that “psychologists need to develop and implement methods of overcoming professional as well as socialized barriers to the provision of psychological services” (p. 56).

Parallel process is a dynamic that may occur when clinicians supervise other therapists or act as group leaders/facilitators. Parallel process is typically defined as the replication of treatment obstacles and challenges (that occur between the therapist and the patient in clinical sessions) in supervision (between the therapist and the supervisor). For example, groups that have not achieved cohesion may leave the leader feeling isolated and increase the probability that a parallel process will occur. Staff at WCPR’s modified debriefing process include clinicians, peer counselors and a chaplain. On occasion, staff meetings may generate issues that are similar to the issues being enacted in group sessions. The authors have found it very important discuss parallel process issues with peer counselors throughout the retreat. All WCPR staff (peers, clinicians and chaplains) participate in a “debrief the debriefers” meeting after each session to help identify countertransference and discuss parallel process issues.

Discussion

ERES is a cluster of symptoms that the authors have observed in their work with emergency responders. Presenting a framework to understand their symptoms in a culturally-acceptable context is a first step toward engaging the responder in treatment. Additional resources may be needed to address the unique issues presented by emergency responders (for listings of organizations, websites, books, and videos see Gilmartin, 2002; Kates, 1999; Kirschman, 1997; Kirschman, 2004). Responders involved in critical incidents are required to make extraordinary adjustments (Bohl, 1995). However, the number and severity of symptoms that develop should not be defined in terms of the event itself, but rather by the degree to which the individual personalizes the event that makes it significant.

It is hoped that clinicians will find this article useful in their work and that it will enable them to recognize the signs and symptoms of work-related stress in their clients. The authors also hope that the interventions described here will help responders return to work better prepared to deal with such incidents.

Administrators need to be educated regarding the cost of traumatic stress. For example, in addition to the personal toll that is taken, there may be increased rates of accidents, absenteeism, stress-related workers compensation claims, premature retirement, and decreased rates of productivity (White & Honig, 1995). "The agency can significantly impact the law enforcement family by creating family-friendly policies and by offering psychological assistance such as critical incident debriefings that take spouses into consideration ... [As a result,] the department can have a real and measurable impact on peace officer work performance" (White & Honig, 1995, p. 204).

Conclusion

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 WCPR treatment model would be helpful. Factor analysis of each program element would provide useful information, as would development of the theoretical underpinnings of ERES. Although gains may be immediately realized in terms of symptom reduction, they may not be permanent. Analysis of long-term gains, maintenance of progress made and relapse prevention should be completed. Lastly, it will also be important to measure changes in relationships and quality of life.

REFERENCES:

- Albeck, J. H. (1994). Intergenerational Consequences of Trauma: Reframing Traps. In Treatment Theory-A Second Generation Perspective. In Sommer, J. & William, M. (Eds.), (pp 106-126) Handbook of post-traumatic therapy. Westport, CT: Greenwood Press.
- Alexander, C. (1999). Police psychological burnout and trauma. In J. Violanti and D. Paton (Eds.), Police trauma: Psychological aftermath of civilian combat (pp. 37-53), Springfield, IL: Charles C. Thomas.
- American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text revision). Washington, DC:
- Amir, N., Stafford, L., Freshman, MS., & Foa, E.B. (1998). Relationship between trauma narratives and trauma pathology. Journal of Traumatic Stress, 11 (2), 385-393.
- Anderson, W., Swenson, D., & Clay, D. (1995). Stress management for law enforcement officers. NJ: Prentice Hall.

- Asmundson, G. J. G., Stapleton, J. A., & Taylor, S. (2004). Are avoidance and numbing distinct PTSD symptom clusters? Journal of Traumatic Stress, *17* (6), 467-475.
- Benner, A. (2002). Cop Docs. Psychology Today Nov/Dec2000, Vol. 33 Issue 6, p36, 4p, 1c
- Beutler, Nussbaum, & Meredith. (1988). Changing personality patterns of police officers. Professional Psychology: Research and Practice. Vol. 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.
- Bohanek, Fivush, & Walker. (2005). Memories of positive and negative emotional events. Applied Cognitive Psychology, Vol. 19(1), 51-66.
- 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: Erlbaum.
- Breslau, N. (2002). Epidemiologic studies of trauma, posttraumatic stress disorder, and other psychiatric disorders. Canadian Journal of Psychiatry, *41* (10), 923-929.
- Briere, J. (1992). Child abuse trauma: Theory and treatment of the lasting effects. Thousand Oaks, CA. Sage Publications.
- Briere, J., Weathers, F. W., & Runtz, M. (2005). Is dissociation a multidimensional construct? Data from the multiscale dissociation inventory. Journal of Traumatic Stress, *18* (3), 221-231.
- Brough, P. (2004). Comparing the influence of traumatic and organizational stressors on the psychological health of police, fire, and ambulance officers. International Journal of Stress Management, *11* (3), 227-244.
- Brown, J. (2003). Generalization of the negativity effects to self-attributions. Psychological Reports. Vol. 93(2), 638-640.
- Brown, J. M., & Campbell, E. A. (1994). Stress and policing. Chichester, England: John Wiley & Sons.
- Cameron, J. (2004). Police officers' reactions to a traumatic event. Dissertation Abstracts International. Vol. 64(11-A), 2004. pp. 4116.
- Cardena, E., Maldonado, J., van der Hart, O., & Spiegel, D. (2000). Hypnosis. In E. F. Foa, T. M. Keane, & M. J. Friedman (Eds.) Effective treatments for PTSD (pp. 247-279, 351-353). New York: Guilford.
- Carlier, I. (1999). Finding meaning in police traumas. In J. Violanti and 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.
- Clark, M., & Friedman, D. (1992). Pulling together: building a community debriefing team. Journal of Psychosocial Nursing, *30* (7), 27-32.
- 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. (pp. 1-17)
- Creamer, M., and Forbes, D. (2004). Treatment of Posttraumatic Stress Disorder in Military and Veteran Populations. Psychotherapy: Theory, Research, Practice, Training, Vol. 41, No. 4, 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* (2), 305-316.
- Davis, N. (2002). The use of multi-sensory trauma processing to treat post-traumatic stress disorder in law enforcement officers. In C. R. Figley (Ed.) Brief Treatments for the Traumatized, (pp. 174-206). Westport, CT: Greenwood Press.
- Dietrich, A. M. (2002). Active ingredients in trauma-focused brief treatments. In C. R. Figley (Ed.) Brief Treatments for the Traumatized, (pp. 29-56). Westport, CT: Greenwood Press.
- Duggan, H. (2003). Personal Conversation. San Francisco, CA
- Eidelson, R., and Eidelson J. (2003). Dangerous ideas, five beliefs that propel groups toward conflict. American Psychologist. Volume 58 (3), 182-192. Washington, DC.
- Erdelyi, M. H. (1990). Repression, reconstruction, and defense: History and integration of the psychoanalytic and experimental frameworks. In J. E. Singer (Ed.), Repression and Dissociation (pp. 1-31). Chicago: The University of Chicago Press.
- Evans, B.J., Coman, G., Stanley, R.O. & Burrows, G.D. (1993). Police officers coping strategies: an Australian police survey. Stress Medicine, *9*, 237-246.
- Everly, G. S. Jr. (1993a). Neurophysiological considerations in the treatment of posttraumatic stress disorder. In F. M. Ochberg (Ed.), Post-traumatic therapy and victims of violence Volume 9 (4), (pp. 25-38). New York: Brunner/Mazel.
- Everly, G. S. Jr. (1993b). Psychotraumatology: A two-factor formulation of posttraumatic stress. Integrative Physiological and Behavioral Science, July- September, *28*, 270-278.
- Everly, G.S. (1994). Familial psychotraumatology: An analysis of the impact of traumatic stress upon the law enforcement family via destruction of the familial weltanschauung. In J.Y. Reese, & E. Scrivner, E. (Eds.), Law Enforcement Families (pp. 177-184). Washington, DC: US Government Printing Office.
- Everly, G.S. (1995). An integrative two-factor model of post-traumatic stress. In Everly, G.S. (Ed.), Psychotraumatology: Key papers and core concepts in post traumatic stress (pp. 27-47). New York: Plenum Press
- Everly, G.S., & Mitchell J.T. (1997). Critical incident stress management. Ellicott City, MD: Chevron Publishing Corporation.
- Federal Bureau of Investigation. (1996). Critical incident stress in law enforcement, Law Enforcement Bulletin. February. Vol 62, (pp. 10-17)
- Figley, C. R. (1999). Police compassion fatigue (PCF): Theory, research, assessment, treatment, and prevention. In J. Violanti and 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, Vol. 67 Issue 5, p10, 9p, 1 chart, 5bw
- Flack, W. F., Litz, B. T., & Keane, T. M. (1998). Cognitive-behavioral treatment of war-zone-related posttraumatic stress disorder: A flexible, hierarchical approach. In V. M. Follote, J. I. Ruzek, & F. R. Abueg (Eds.), Cognitive-behavioral therapies for trauma (pp. 77-99). New York: Guilford Press.
- Foa, E. B., Keane, T. M., & Friedman, M. J. (2000). Introduction. In E. F. Foa, T. M. Keane, & M. J. Friedman (Eds.) Effective treatments for PTSD (pp. 1-17). New York: Guilford.

- Ford, J. (1999). Disorders of extreme stress following war-zone military trauma: Associated features of posttraumatic stress disorder or comorbid but distinct syndromes? Journal of Counseling and Clinical Psychology, Vol. 67 No 1,3-12
- Foy, D. W., Glynn, S. M., Schnurr, P. P., Jankowski, M. K., Wattenberg, M. S., Weiss, D. S., Marmar, C. R., & Gusman, F. D. (2000). Group therapy. In E. F. Foa, T. M. Keane, & M. J. Friedman (Eds.) Effective treatments for PTSD (pp. 155-175, 336-338). New York: Guilford.
- Freedman, J., & Combs, G. (1996). Narrative Therapy. The social construction of reality. New York, N.Y.: W.W. Norton Company.
- Furr, R., & Funder, D. (1998). A multimodal analysis of personal negativity. Journal of Personality and Social Psychology, Vol. 74, No. 6, 1580-1591
- Garrison, W.E. (1990). In modeling inoculation training for traumatic incident exposure. In J.T. Reese, J.M. Horn, & C. Dunning (Eds.), Critical incidents in policing, (pp. 107-117). Washington, DC: US Government Printing Office.
- Gilmartin, K. (2002). Emotional survival for law enforcement. Tucson, AZ: E-S Press.
- Goldfarb, D. A. (1998). In search of the silly thought: An addition to the debriefing process. The Police Chief, (October, 1998). www.Heavybadge.com/silly.htm, accessed 11/05
- Hackett, D., & Violanti, J. (2003). Police suicide: Tactics for prevention. Springfield, IL: Charles C, Thomas.
- Harris, C.J. (1995). Sensory based therapy for crisis counselors. In C. Figley, (Ed.), Compassion fatigue: Coping with secondary traumatic stress, (pp. 101-114). New York: Brunner Mazel.
- Higgins, G. O. (1994). Resilient adults: Overcoming a cruel past. San Francisco: Jossey-Bass.
- Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. New England Journal of Medicine, 351 (1), pp. 13-22.
- Horowitz, M. J. (1994, July). Does repression exist? Yes. Harvard Mental Health Letter, Vol 11(1) (pp. 4-6).
- Howe, M. L., Courage, M. L., & Peterson, C. (1994). How can I remember when "I" wasn't there: Long-term retention of traumatic experiences and emergence of the cognitive self. Consciousness and Cognition, 3 (3/4), 327-355.
- Janoff-Bulman, R. (1985). The aftermath of victimization; Rebuilding shattered assumptions. In C.R. Figley, (Ed.). Trauma and Its Wake: The Study and Treatment of Post Traumatic Stress Disorder, (pp. 15-35). New York: Brunner/Mazel.
- Jones, J. W. (1995). Counseling issues and police diversity, In M. I. Kurke & E. M. Schrivener (Eds.), Police psychology into the 21st century (pp. 207-254). Hillsdale, NJ: Erlbaum.
- Kaplan-Solms, K., & Solms, M. (2002). Clinical studies in neuro-psychoanalysis. New York: Other Press.
- Kates, A. R. (1999). Cop shock: Surviving posttraumatic stress (PTSD). Tucson, AZ: Hulbrook Street Press.

- Kirschman, E. (1997). I love a cop: What police families need to know. New York: Guilford Press.
- Kirschman, E. (2004). I love a fire fighter: What fire families need to know. New York: Guilford Press.
- Kopel, H., & Friedman, M. (1997). Posttraumatic symptoms in South African police exposed to violence. Journal of Traumatic Stress, Vol. 10 Issue 2, p307, 11p.
- Lambert, D., & Barley, M. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. Psychotherapy. Volume 38, Number 4. (pp. 357-361).
- Lehman, D., Ellard, J., & Wortman, C. (1982). Social support for the bereaved: Recipients' and providers' perspectives on what is helpful. Journal of Consulting and Clinical Psychology, 54(4), 438-446.
- Levant, R. F. (1998). Desperately seeking language: Understanding, assessing, and treating normative male alexithymia. In W. S. Pollack & R. F. Levant (Eds.), New psychotherapy for men (pp. 35-56). New York: Wiley.
- Levenson, L., & Dwyer, A. (2003). Peer support in law enforcement: Past, present, and future International Journal of Emergency Mental Health, Vol. 5(3), 147-152
- Linehan, M. M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.
- Litz, B.T. & Weathers, F.W. (1994). The diagnosis and assessment of post-traumatic stress disorder in adults. In M.B. Williams, (Ed.) Handbook of Post Traumatic Therapy, (pp. 19-37). Westport, Conn.: Greenwood Press.
- Loo, R. (1999). Police Suicide: The ultimate stress reaction. In J. Violanti and D. Paton (Eds.), Police trauma: Psychological aftermath of civilian combat (pp. 37-53). Springfield, IL: Charles C. Thomas.
- Lowery, K., & Stokes, M. A. (2005). Role of peer support and emotional expression on posttraumatic stress disorder in student paramedics. Journal of Traumatic Stress, 18 (2), 171-179
- Marcus, S., Marquis, P., & Sakai, C. (2004). Three- and 6-month follow-up of EMDR treatment of PTSD in an HMO setting. International Journal of Stress Management, 11 (3), 195-208.
- Marra, T. (2005). Dialectical behavior therapy in private practice. Oakland, CA: New Harbinger.
- McCunn, L. & Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. Journal of Traumatic Stress, 3 (1), 131-149.
- McFarlane, A. C. (1988). The phenomenology of posttraumatic stress disorders following a natural disaster. Journal of Nervous and Mental Disease, 176, 22-29.
- McFarlane, A. C. (1989). The aetiology of post-traumatic morbidity: Predisposing, precipitating and perpetuating factors. British Journal of Psychiatry, 154, 221-228.
- Meyer, T. (2001). An investigation of attitudes and beliefs about mental health services and service utilization within a law enforcement population. Dissertation Abstract International. Spaulding University Vol. 61(7-B), Feb 2001. pp. 3852.
- Mitchell, J.T. (1990). Law enforcement applications of critical incident stress teams. In J.T. Reese, J.M. Horn, & C. Dunning (Eds.), Critical incidents in policing, (pp. 201-212). Washington DC: US Government Printing Office.
- Mitchell, J., & Bray, G. (1990). Emergency services stress: Guidelines for preserving the

health and careers of emergency services personnel. Englewood Cliffs, N.J.: Prentice Hall.

Mitchell, J., & Everly, G. (1997). Critical incident stress debriefing: An operational manual for CISD, defusing and other group crisis intervention services. Ellicott City, Maryland: Chevron Publishing.

Moffitt, K. (1994). Depression and memory narrative type. Journal of Abnormal Psychology, Vol. 103 (3), pp. 581-583.

National Institute of Justice. (1999). At a glance: Recent research findings. National Institute of Justice Journal, 27.241 (pp. 26-28).

Neuner, F., Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T. (2004). A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. Journal of Consulting and Clinical Psychology, 72 (4), pp. 579-587.

Parnell, L. (1997). Transforming trauma: EMDR. New York: W. W. Norton & Co.

Paton, D., Violanti, J., & Schmuckler, E. (1999). Chronic exposure to risk and trauma: Addiction and separation issues in police officers. In J. Violanti and D. Paton (Eds.), Police trauma: Psychological aftermath of civilian combat (pp. 37-53). Springfield, IL: Charles C. Thomas.

Peeters, M., Montgomery, A., Bakker, A., & Schaufeli, W. (2005). Balancing work and home: How job and home demands are related to burnout. International Journal of Stress Management, 12(1), 43-61.

Progrebin, M. R., & Poole, E. D. (1991). Police and tragic events: The management of emotions. Journal of Criminal Justice, 19, 395-403.

Pulley, S. (2005). Critical incident stress management. <http://www.emedicine.com/emerg/topic826.htm>.

Regehr, C., & Hill, J. A. (2002). Crisis debriefings for emergency service workers. In C. R. Figley (Ed.) Brief Treatments for the Traumatized, (pp. 292-305). Westport, CT: Greenwood Press.

Riggs, D. S. (2000). Marital and family therapy. In E. F. Foa, T. M. Keane, & M. J. Friedman (Eds.) Effective treatments for PTSD, (pp. 280-301, 354-355). New York: Guilford.

Roemer, L., Harrington, N. T., & Riggs, D. (2002). Behavioral/cognitive approaches to post-traumatic stress: Theory-driven, empirically based therapy. In C. R. Figley (Ed.) Brief Treatments for the Traumatized (pp. 59-80). Westport, CT: Greenwood Press.

Rothbaum, B. O., Meadows, E. A., Resick, R., & Foy, D. W. (2000). Cognitive-behavioral therapy. In E. F. Foa, T. M. Keane, & M. J. Friedman (Eds.) Effective treatments for PTSD, (pp. 60-83, 320-325). New York: Guilford.

Rudoffosi, Daniel. (2003). Personal communication. San Francisco, CA

Ryan, A.H. & Brewster, M.E. (1994). PTSD and related symptoms in traumatized police officers and their spouse/mates. In J.T. Reese, & E. Scrivner, (Eds.). Law Enforcement Families, (pp. 217-226). Washington DC: FBI.

Scrivner, E. M., & Kurke, M. I. (1995). Police psychology at the dawn of the 21st century. In M. I. Kurke, & E. M. Scrivner (Eds.), Police psychology into the 21st century (pp. 3-30). Hillsdale, NJ: Erlbaum.

Shapiro, F. (2001). Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures, 2nd ed. New York: Guilford Press.

- Shusman, E.J., Inwald, R.E., & Knatz, H.F. (1987). A cross-validation study of police recruit performance as predicted by the IPI and MMPI. Journal of Police Science and Administration, 15, (2), 162-169.
- Silva, M.N. (1990). The delivery of mental health services to law enforcement officers. In J.T. Reese, J.M. Horn, & C. Dunning. (Eds.), Critical incidents in policing, (pp. 335-341). Washington, DC: US Government Printing Office.
- Solomon, R. (1988). Post-shooting trauma. The Police Chief, October, 40-44.
- Stephens, C., Long, N., & Miller, I. (1997). The impact of trauma and social support on posttraumatic stress disorder: A study of New Zealand police officers. Journal of Criminal Justice, 25(4), 303-314.
- Talbot, A., Manton, M., & Dunn, P. J. (1992). Debriefing the debriefers: An intervention strategy to assist psychologists after a crisis. Journal of Traumatic Stress, 5 (1), 45-62.
- Terr, L. (1988). What happens to early memories of trauma? A study of twenty children under age five at the time of documented trauma events. American Academy of Child and Adolescent Psychiatry, 27(1), 96-104.
- Terr, L. (1991). Childhood traumas: An outline and overview. American Journal of Psychiatry, 148 (1), 10-20.
- Terr, L. (1994). Unchained memories: True stories of traumatic memories, lost and found. New York: Basic Books.
- Toch, H. (2002). Stress in policing. Washington, DC: American Psychological Association.
- Tucker, P., Pferrerbaum, B., Doughty, D. E., Nixon, S. J., Jordon, F. B., & Jones, D. E. (2002). Body handlers after terrorism in Oklahoma City: Predictors of posttraumatic stress and other symptoms. American Journal of Orthopsychiatry, October 2002, 469-475. Vol.72(4)
- U. S. Department of Defense. (2005). TriWest educates providers about post-traumatic stress disorder. Tricare Provider News, 4. Issue L (pp. 1-2).
- van der Kolk, B. A. (1987). Psychological trauma. Washington, DC: American Psychiatric Press.
- van der Kolk, B. A. (1988). The biological response to psychic trauma. In F. M. Ochberg (Ed.), Post-traumatic therapy and victims of violence (pp. 25-38). New York: Brunner/Mazel.
- van der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. Harvard Review: Psychiatry, 1 (5), 253-265.
- van der Kolk, B. A., & van der Hart, O. (1991). The intrusive past: The flexibility of memory and the engraving of trauma. American Imago, 48 (4), 425-454.
- Van Dierendonck, D., Gaarssen, B., & Visser, A. (2005). Burnout prevention through personal growth. International Journal of Stress Management, 12(1), 62-77.
- Violanti, J. (1999). Death on duty: Police survivor trauma. In J. Violanti and D. Paton (Eds.), Police trauma: Psychological aftermath of civilian combat (pp. 37-53). Springfield, IL: Charles C. Thomas.
- Wastel, C. (2002). Exposure to trauma: The long-term effects of suppressing emotional reactions. Journal of Nervous and Mental Disease. Vol. 190(12), 839-845.
- Wester, S., & Lyubelsky, J. (2005). Supporting the thin blue line: Gender-sensitive therapy with male police officers. Professional psychology: Research and Practice, 36, (1), 51-58.

Wetendorf, D. (2005). Developing policy on officer involved domestic violence. www.abuseofpower.info. Retrieved Nov 2005.

White, M., & Epston, D. (1990). Narrative means to therapeutic ends. New York: Norton.

White, E. K., & Honig, A. L. (1995). Law enforcement families. In M. I. Kurke, & E. M. Scrivner (Eds.), Police psychology into the 21st century (pp. 189-206). Hillsdale, NJ: Erlbaum.

Wilson, S. A., Becker, L. A., & Tinker, R. H. (1995a). Eye movement desensitization and reprocessing (EMDR) treatment for psychologically traumatized individuals. Journal of Consulting and Clinical Psychology, *63*(6), 928-937.

Wilson, S. A., Becker, L. A., & Tinker, R. H. (1995b). Fifteen-month follow-up of eye movement desensitization and reprocessing (EMDR) treatment for posttraumatic stress disorder and psychological trauma. Journal of Consulting and Clinical Psychology, *65*(6), 1047-1056.

Yehuda, R., & McFarlane, A.C. (1995). Conflict between current knowledge about posttraumatic stress disorder and its original conceptual basis. American Journal of Psychiatry, *152*, 1705-1713.