Serving Those Who Serve: Understanding Emergency Service and Military Personnel and the Mental Health Counselors Who Serve Them

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Abstract

Emergency service and military personnel who work with traumatized populations can themselves experience vicarious trauma through this interaction. This can challenge the counselor who works with these populations through the processing of traumatic material and can lead to impairment. To counter counselor burnout, compassion fatigue and vicarious trauma training and supervision of these counselors must include cultural insight and clinical awareness of these populations and an understanding of the potential dangers of working with them.

Cultural Awareness

Familiarity with Emergency Service Communities

Emergency Service (ES) personnel live and work in a world that may be difficult for many of us to understand. Staffed by the professionals of Fire Services, Police Services, Emergency Medical Technicians, First Responders, emergency dispatch personnel, and everyone else that is called upon to be on-scene in the event of a potentially dangerous or traumatic situation, these professionals put themselves between harm and the civilian populations they have sworn to serve and protect (Cates & Keim, 2016; Miller, 1995).

ES personnel come from all walks of life and experience, but seem to share some common traits: they are highly dedicated to their work, self-driven to high performance standards, action-focused, socially conservative, and desire to be in control of situations and themselves. Above all else, they seem motivated to help others regardless of the circumstances and perhaps at great personal risk to themselves (Linton, 1995; Mitchell & Bray, 1990). They rescue people from fires, accidents, and dangerous situations; care for victims of trauma and injury; collect the remains of the dead and comfort the dying (Regehr, Goldberg, & Hughes, 2002). Their work can be hours of tedious duties and activities spiked by moments of panic, fear and adrenaline (Cates & Keim, 2016; Regehr, 2005). They must be constantly on guard against potential personal injury and threats to and from those they are attempting to assist for shifts lasting 8 to 24 hours. They must proceed in their work as if all bodily fluids are potential biohazards, work with administrations that are often driven more by politics than by public need, and interact with a public who is watching every move they make (Mildenhall, 2012; Regehr & Bober, 2005; Vettor & Kosinski, 2000).

ES personnel may have earned college degrees or may have acquired training specific to their work environment that could take from months to years depending on the complexity of training required. They are certified by state agencies, which require specific training and testing, and require continuing training and education to maintain their certifications (Patterson, Probst, Leith, Corwin, & Powell, 2005).

Familiarity with Military Community

Military personnel primarily work in a hierarchical structure of command that can control every aspect of military personnel's duties and activities. They operate in a culture that is globally dispersed yet members commonly identify as mission-oriented, focused on high performance standards, an emphasis on tradition, are easily bored, have a "take charge" mentality, and are dedicated to serve and defend the nation. Arguably, personality styles of ES and military personnel are similar in many ways, and specifically seem to be motivated to help others regardless of circumstances.

"Us" and "Them" - a Double-Edged Sword

ES and military communities represent closed cultures and may be resistant to seeking psychotherapy. One possible reason these cultures are closed to outsiders is the strong relationship bonds born out of intense circumstances. These intense circumstances, which may result in shared experiences of life and death conditions can create an "us" and "them" perception of reality (Tajfel, 1982). This shared identity can lead to heightened perceptions of self-worth within the group as well as a deep faith and trust that the team will be there to protect and help when the need arises. This support can be critical in situations where lack of that support can easily lead to someone's injury or death, including that of the ES or military personnel. This belief of their place in the team can allow them to make better and faster decisions with an understanding based on the teams' resources and skills.

However, much like combat operations, ES personnel must quickly and accurately discern between dangerous and non-dangerous contexts within everyday work experiences. ES personnel must use indicative factors such as behavior, body, and verbal language to determine potential threats from their environment. In ES and military work, the development of an "us"

and "them" mindset may lead to an increase in hypervigilant activity and a belief that "they" are always suspect (Miller, 1995).

Deployment vs. Shiftwork

Shiftwork for ES personnel can be one of the most demanding elements of the job. Work shifts for ES personnel can range from 8 to 24 hours of time, can have cyclic rotation of starting and ending times, and can put them completely out of sync with the normal 9 to 5 lifecycle of their families and communities. The cyclic nature of shiftwork can take on the elements of an entirely different life where normal living and family concerns must continue between the requirements of the job. These family and life disruptions extend into the social environment to produce a sense of alienation from everything that is considered normal in the ES personnel's life and have been shown to increase stress and job dissatisfaction due to their impact on non-work activities (Faircloth, 2011; Monk et al., 2013; Pisarski, Bohle, & Callan, 2002).

Unlike ES personnel whose shiftwork operations are relatively short, military personnel can be deployed for months and, potentially, more than a year. These cycles of deployment can have an adverse effect on the military personnel and their families and have been well documented (Carrola & Corbin-Burdick, 2015; Cozza & Lerner, 2013; Doyle & Peterson, 2005; Rand Corporation, 2016; Sheppard, Malatras, & Israel, 2010). The emotional cycle of deployment can begin long before the training and actual deployment, and can last several months, if not longer, after the deployment ends. The emotional cycle of deployment can create situations that can both positively and negatively impact military personnel and their families.

Emotional Aspects of the Nature of ES and Military Service

Many ES and military personnel may experience conflicting emotions regarding their work duties. On one hand, many often feel guilt, apprehension, and sadness about being away from their families. This may come from not being present for important events such as the birth of a child, birthdays, anniversaries, and holidays, which may generate feelings of failure or inadequacy as a parent, partner, or spouse. On the other hand, many spend months and years training to do exactly the job that combat and emergency situations demand of them and take great satisfaction and pride in performing well in difficult situations. Finally, a deployment/shift rhythm can serve as an expected routine. Often, service members will refer to their days spent on deployment as a recurring "groundhog day." This refers to the consistency of their cohort, mission, and environment. As a caveat to counselors helping ES and military personnel, every military branch, unit, job, and person experiences unique deployment experiences based on their personal and professional situations. Overly generalizing anything in this population would be a mistake and may result in the client terminating treatment.

ES and Military Personnel's Perceived Stigma against Seeking Mental Health Assistance

Many jobs and missions military personnel involve classified or sensitive information and equipment, which, if discovered or obtained by the wrong entities, could do significant damage to the nation's security. Part of qualifying for a clearance requires a person be investigated for the presence of an emotional, mental, or personality disorder which could represent a significant deficit in their psychological, social and occupational functioning

(Military Advantage, n. d.). In these authors' experiences in working with ES and military personnel, many are reluctant to disclose any information regarding mental health issues to their leadership or peers. Military personnel known, or even suspected, to have a mental health concern, especially those related to combat exposure or stress, may have the perception of their team losing confidence in their ability and unit leadership treating them differently (Warner, Appenzeller, Mullen, Warner, & Grieger, 2008). This is problematic for both ES and military personnel, as many situations require quick, responsible, and clear decisions. The result of this loss of confidence can have an isolating effect and the potential for a crisis of identity. Perceived stigma is not isolated to a military service member's own issues and may include not informing their leadership about family members' concerns. Another commonly perceived stigma for military members is that seeking treatment would harm their career, such as not receiving a promotion or a preferred duty station assignment (Warner et al., 2008). ES personnel, by contrast, are not usually engaged in matters of national security but still frequently feel that perceptions of an inability to complete their work or the opinions of weakness by their peers creates sufficient stigma for them to mask their anxieties and deny the need for any outside mental health assistance (Alexander & Klein, 2001; Miller, 1995).

Clinical Knowledge

Traumatic experiences can manifest in many ways through a person's perceptions, behavior and beliefs about the world around them. The following sections provide a generalized progression of the ways stressful events may evolve into traumatic experiences and are then expressed (Figley, 2002).

Critical Incidents

Critical incidents are defined as events that have the potential to cause an individual or group of individuals to feel overwhelmed by, and unable to cope effectively with, the experience (Mildenhall, 2012; Mitchell & Bray, 1990). While most people can imagine the traumatic severity of a natural disaster or mass casualty event, it is frequently a personal and more human-sized event that triggers the sharpest emotional responses for ES personnel (Calhoun & Tedeschi, 1998; Regehr, Goldberg, Glancy, & Knott, 2002). The risks for ES and military personnel are magnified as their potential for being traumatized by events run parallel, and sometimes concurrently, with their exposure to be exposure to traumatic material through the experiences of others and work-related secondary exposure.

Compassion and Empathy

Compassion is feeling deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause. While this may be a motivating force to help others, practitioners must understand their limitations in helping to alleviate the pain suffered by the client (Regehr et al., 2002; Valent, 2002).

Empathy, by contrast, is the ability to view the world through the experiences of another as if they were that person. This empathic response can be the connection that enables ES and military personnel to better care for their patients, but can also place them in danger as it makes

them open to absorption of traumatic material and the subsequent impulse to perhaps respond to life-saving and ongoing traumatic events (Regehr et al., 2002; Valent, 2002).

Secondary Traumatic Stress

This concept refers to the impact on people who witness or experience a traumatic event, but are not the immediate victims of that event. This is a recurring situation for ES and military personnel (Figley, 1995b; Kirby, Shakespeare-Finch, & Palk, 2011). A natural consequence of knowing or witnessing a traumatizing event can be the internalization and expression of stress symptoms. This reaction to trauma can be considered inevitable for ES personnel (Figley, 1995b) and military personnel that have experienced combat and may occur regardless of race, gender, age, or level or training (Edelwich & Brodsky, 1980).

Burnout

A state of exhaustion (physical, emotional and cognitive) caused by a depletion of one's ability to cope with one's everyday environment (Figley, 1995a). It is characterized by exhaustion and reduces a person's world view so that it is impossible for that person to believe they can be capable (Stamm, 2002). Symptoms can include some psychophysiological arousal, sleep disturbance, headaches, irritability, and aggression, physical and mental exhaustion and a decrease in work performance (Maslach, Schaufeli, & Leiter, 2001; Ray, Wong, White, & Heaslip, 2013).

Compassion Fatigue (CF)/Vicarious Traumatization (VT)

Compassion fatigue (CF) is a combination of secondary traumatization and burnout precipitated by events that bring professionals in direct contact with traumatized persons (Figley, 1995b). CF is defined as "a state of tension and preoccupation with traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders and persistent arousal associated with the patient" (Figley, 2002, p. 1435). Symptoms of compassion fatigue can mimic to a lesser degree those of traumatized people and signifies more progressed psychological disruptions.

The effects of vicarious traumatization (VT) are cumulative, permanent, and evident in both professional and personal domains. They include significant disruptions in the way a person makes meaning of the world and their place within it, and can alter one's beliefs, concerns and needs for oneself and others, including one's interpersonal relationships (Figley, 1995a; Sprang, Whitt-Woosley, & Clark, 2007; Stamm, 2002). Symptoms commonly expressed include anxiety, depression, judgmental expressions with lowered tolerances, reduced social interactions, isolation, and altered beliefs about oneself and others.

The mindset of military and ES operations are highly polarized; shades of gray are often not considered or tolerated. CF/VT falls into this gray category and is therefore too ambiguous for this action oriented population. Arguably, many military and ES leaders do not understand how it is possible to become traumatized by an event in which they were not directly or physically involved. Even when diagnosed or presented with evidence of CF/VT the common reaction is denial. Denial insulates, at least temporarily, from the possibility of being considered "weak" or unfit for duty however treatable or temporary the condition.

Post-Traumatic Growth (PTG)

Exposure to trauma has historically been thought to only produce negative outcomes that range from distressing to overwhelming in their impact. In addition to the negative outcomes, but also triggered by the trauma, is the potential of post-traumatic growth (Calhoun & Tedeschi, 1998;Triplett, Tedeschi, Cann, Calhoun, & Reeve, 2012; Yalom, 1980). PTG is considered to be more than surviving or recovering from the traumatic event or events and may be a movement by the individual towards growth beyond their previous level of functioning (Tedeschi, 1995). Individual may experience growth in many ways including dramatic changes in the truths they hold about the world and people, about their own personal narrative, and may develop a greater connection through interpersonal relationships or spiritual beliefs. In any case it is important to remember that growth is best viewed as a multidimensional concept, and that an individual that has experienced a traumatic event may perceive constructive changes in some elements of their worldviews and perceptions and have none, or perhaps negative changes, in others (Calhoun & Tedeschi, 1998; Tedeschi & Calhoun, 2004).

Clinical Considerations

Overcoming Stigma Attached to Mental Health

Based on the clinical experiences of the authors with ES and military personnel, it is important to build and maintain rapport with these communities as part of the helping process due to the tight-knit professional structures within these communities. For instance, a clinician may lose rapport during the first few sessions if the client must interrupt the process of explaining an issue to inform the clinician of verbiage specific to their field. This may be due to a power shift in the relationship, which this population is trained to be aware of. These populations expect the clinician to be a subject matter expert in their respective field just as they are experts in military or ES fields. Furthermore, a significant part of their occupations is looking for threats and power dynamics. When a clinician needs to be "trained" by the client, they lose some authority.

In addition, if a clinician through body or verbal language, is rejecting of situations explained by the client such as war, death, or violence they may lose trust. Knowing how to speak the basic language of ES and military personnel and not being afraid to go through the process of reexamining the often unimaginable dark places with them is a necessary skill for all counselors working with these populations. Asking meaningful questions regarding a client's military or emergency service helps build much needed rapport in the counseling relationship. Most members enjoy talking about their service, and specifically for military members, enjoy discussing their Military Occupational Specialty (MOS) and their favorite/least favorite duty station.

Assessing for Sleep/Shift Work as a Stressor

Due to the nature of their work many ES and military personnel perform shiftwork which may place additional psychological and physiological stress on the individual (Monk et al., 2013; Murphy, Beaton, Cain, & Pike, 1994; Pigeon, Britton, Ilgen, Chapman, & Conner, 2012; Pisarski

et al., 2002). Violanti et al. (2008) suggested police officers performing shift work had increased but different rates of suicide ideation based on the time of day the shift occurred in relation to the sex of the officer. For example, female officers on day shifts had higher rates of suicide ideation than female officers working other shifts. Furthermore, male officers had higher rates of suicide ideation when they worked midnight shifts (Violanti et al., 2008). Studies involving military personnel found a positive relationship between sleep disturbances and suicidality (Pigeon et al., 2012).

Sleep hygiene evaluation may help identify problem areas in sleep quality and duration. Sleep hygiene psychoeducation techniques may include only using the bed for sex and sleeping, adhering to sleep times, keeping a sleep diary, and avoiding caffeine (Mairs & Mullan, 2015). For more severe concerns, Cognitive Behavioral Therapy for Insomnia (CBTI) may alleviate some depressive symptoms and sleep disturbances (Manber et al., 2011). Although it is not known which specific element of CBTI is most efficacious for helping veterans one of the components of CBTI that is easily implemented is sleep hygiene psychoeducation (Phelps, Varker, Metcalf, & Dell, 2017).

Code-Switching: Matching Roles and Communication Styles

The professional self-identity of ES and military personnel can be a powerful force forged through shared adversity and experiences. It can provide an emotional buffer and promote emotional resilience against the rigors of the service and required duties. Unfortunately, it can also cause disruptions in family and community life if ES and military personnel stay in their work roles when communicating with their significant others (Faircloth, 2011; Pincus, House, Christenson, & Adler, 2001; Regehr, 2005; Shakespeare-Finch, Smith, & Obst, 2002; Stafford & Grady, 2003).

To improve communications ES and military personnel can use verbal and physical techniques to intentionally code-switch when they are interacting with their significant others, which may reduce conflict. For the purpose of this discussion, code switching refers to the transition between use of job specific linguistics and the varied linguistics used in a home environment (Barker et al., 2008; De Fina, 2007; Donohue, 2004; Giles, Willemyns, Gallois, & Anderson, 2006; Halim & Maros, 2014; Molinsky, 2007; Singo, 2014; Vogt, 1954). ES and military personnel regularly engage in code switching (CS) although they may not be aware of the terminology for it. For example, police officers are trained in ways of speaking within the police culture, such as using interrogation or other various communication techniques, and it has been suggested that officers should be able to code-switch on the job (Barker et al., 2008). These skills can be expanded, imported, and intentionally tailored to the culture of ES and military personnel relative to their home environments.

Counselors can use CS to approach intentional changes in the ES and military identity of their clients in many ways. If possible, establish a place in the work location where ES and military personnel can change out of work clothes/gear before going home. Alternatively, a place in the home can be established where they can change out of work clothes/gear and into home clothes before interacting with any family member. During the time they are changing clothes/gear, they can intentionally direct their thoughts about leaving the job with the clothes/gear and focus on being home in the role they are about to occupy, e.g. spouse or parent. Regardless of where the change (of clothing/gear and role) occurs, the ES and military personnel can state when entering the family residence, "I am home now." This statement is two-fold in

that it reminds them that it is time to be in their home role and it informs family members that they are ready to engage with them in their home role.

At least initially, until the code-switching becomes more natural, ES and military personnel may have to work at modifying their internal self-talk by disputing thoughts that come out of their work role. For example, "I am not on the job, this is my child not a perpetrator" or "I do not need to be hypervigilant right now, my family is not a threat" or "I will not use my work authority in the home."

When the ES and military personnel have transitioned from work to home, they can address their family specifically by name, which may assist in anchoring them in their home role. ES and military personnel can also refrain from asking "why" questions i.e., "Why did you do that?" and instead ask questions such as: "How is it that this happened?" or "What caused this to happen?" Avoiding why questions may reduce eliciting shame, guilt or the feeling one is on trial from significant others. ES and military personnel can also intentionally resist using work vernacular at home. Of course, this may take practice. For example, refrain from using terms like "copy that" or "I am tracking." Finally, ES and military personnel can monitor the pitch and tone of their voice along with their body language so that it is more conducive to communicating with loved ones and less a statement of authority.

PTSD/Traumatic Growth

It is important for the clinician to remember that what they may consider efficient coping mechanisms may not be the same elements that are necessary for the client's psychological growth. For traumatic growth to occur the client must have experienced some form of traumatic experience and accompanying distress. This distress cannot be dismissed in the service of making the client feel better and must be addressed to allow the client to reframe and process their traumatic experiences (Calhoun & Tedeschi, 1998; Tedeschi & Calhoun, 2004).

In the course of clinical services with clients who experienced traumatic events, the clinician should not be focusing on the potential of posttraumatic growth following a traumatic event. As the client begins to regain some measure of emotional stability and redefine their perceptions following the event the clinician should then be aware of the ways in which they can help the client identify areas of potential growth (Calhoun & Tedeschi, 1998).

Conclusion

We cannot afford to ignore the toll that working with traumatized populations can take on emergency service and military personnel. In work duties that place all of these professionals in the path of seemingly certain traumatization we, as clinical professionals, must be aware of the processes of secondary traumatic stress, burnout, compassion fatigue, and vicarious traumatization and how they may manifest in work, community and family interactions. To best serve our communities and those who put their lives on the line to protect and assist others in need, we must address the situations that promote the processes of trauma and work to build understanding and resilience in these populations who are already at high risk for secondary traumatization and compassion fatigue.

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