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Vicarious Trauma and First Responders: A Case Study Utilizing Eye Movement Desensitization and Reprocessing (EMDR) as the Primary Treatment Modality

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Abstract: *Traumatic events can occur and adversely affect people during their lifetime. Natural disasters such as the earthquake in Pakistan in 2005 or the Tsunami in Asia in 2004, terrorist atrocities around the world, or personal events such as physical or sexual assault, can result in psychological difficulties for those people directly affected by these events. The diagnostic term Posttraumatic Stress Disorder (PTSD; Diagnostic and Statistical Manual of Mental Disorders, 4th edition, DSM IV, 1994) is generally used to explain the often-severe psychological sequalae (van der Kolk, 1996; Servan-Schreiber, 2004; Shapiro, 1995) that people may exhibit when directly affected by trauma. However, what of those people not directly involved in the trauma, but those who have borne witness to it, either by listening to the stories of survivors, or in the case of the helping professionals (such as police officers, nurses, doctors, psychotherapists, fire-fighters), actively working with survivors in psychological distress? This paper examines the potential psychological consequences for those in helping professions who are working with traumatized clients. This paper then focuses on a specific treatment intervention, EMDR, utilizing a case study by way of explanation.[International Journal of Emergency Mental Health, 2007, 9(4), pp. 291-298].*

Key words: *vicarious trauma, EMDR, helping professionals, police officers, cognitive schemas, stigma*

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Helping professionals (HP), exposed to others' trauma in their daily working lives, are often traumatized and overburdened by narratives and events that happened to others (Martin, 2006). According to McCann and Pearlman's (1990) Constructionist Self-Development Theory (CSDT), people will give meaning to traumatic events depending on how, as individuals, they perceive them. These interpretations of the traumatic events may result in the HP experiencing changes in the way they view themselves, others, and their world. McCann and Pearlman (1990) coined the term *vicarious trauma* to describe these disruptions in cognitive schemas. Schemas are core beliefs about the self, others, and the world, often developed from childhood experiences and maintained and reinforced throughout one's life (Young, 1990). Neuman and Gamble (1995) purport that HP experiencing vicarious trauma begin to see the world through "trauma lenses." Pearlman and Saakvitine (1995a; p.31) state, "Vicarious trauma is an occupational hazard for nurses and other health professionals who care for and support trauma survivors."

Vicarious trauma (VT) is a process through which the HP's "inner experience about the self and the world is negatively transformed as a result of empathic engagement with trauma survivors" (Pearlman and Saakvitne, 1995a; p.279). Through exposure to their client's accounts of traumatic events and the realities of people's intentional cruelty to one another and the experience of reliving terror, grief, and yearning, the helper is vulnerable through empathic engagement as both witness and participant in these traumatic renactments. These effects are cumulative and may be permanent (Pearlman and Saakvitne, 1995a). According to Dane and Chachkes (2001), VT develops over time and affects a person's professional and social identity. However not everyone who is vicariously exposed to traumatic narratives develops symptoms of VT (Lerias and Byrne, 2003). So what may contribute to its development?

Janoff-Bulmans' (1985) *Assumptive World Theory* posits the notion that individuals make assumptions about themselves and the world, the assumptions being, *"I am invulnerable," "The world is just and makes sense,"* and *"I am basically a good person."* When exposed to trauma or helping victims of trauma, these assumptions may be "shattered" (Janof-Bullman, 1985). Imagine a police officer's or paramedic's personal experience of bearing witness to the 1989 Hillsborough football tragedy where 96 Liverpool football supporters lost their lives. Then consider the helper's potentially "shattered" assumptive world; *"I am not invulnerable," "The world does not make sense, people are not supposed to die at a football match,"* and *"I don't believe I am a good person, I should have done something, I don't know how to help."* This shattering of assumptions can lead to PTSD in those actually involved and VT for those who bear witness. A further possible explanation may be the helper's own personal trauma history. If a helper has personally experienced similar traumas to those of their client, this may well conjure up painful memories of their own traumatic experiences (Cunningham, 2003; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b).

According to McCann and Pearlman's (1990) CSDT, as the helper is exposed to the graphic details of the clients' trauma, disruptions in the psychological need areas of safety, trust, esteem, power, and intimacy may occur. (These themes will be explored later in the case study.) VT can result in the HP portraying cynicism, fear, sadness, and despair (Collins, 2001; Stevens-Guille, 2003; see Table 1 for further signs of VT). It should be remembered that VT is a normal response to working with traumatized people and witnessing their stories. It is not the result of the helper's inadequacies or inherent weakness. The effects of VT are unique to each helping professional, consistent with the individual difference premise in the CSDT.

While there are positive aspects of working with traumatized clients, such as a sense of competence in coping and maintaining an objective motivation, the concept of VT focuses upon the negative aspects of transformation within the inner self of the person working with victims of trauma (Bell, 2003). It is important to note that VT needs to be seen within the context of the work environment (Martin, 2006), as this environment can aid recovery or, conversely, stall it (Royle, 2006).

As stated previously, VT has been described as an "occupational hazard" (Pearlman and Saakvitne, 1995a; p.31) for mental health professionals. We are also becoming increasingly aware of how people suffering from a mental illness can be stigmatized and excluded by members of the public (Hayward & Bright, 1997; Hughes, 2000; Gilbert, 2000; Byrne, 2000; Crisp, 2000). Glozier and colleagues (2006) examined the attitude of nursing staff towards co-workers returning from work following a psychiatric or physical illness. They found that staff who had suffered from a psychiatric condition were much more likely to be viewed negatively than if they had suffered from a physical condition. What strategies or interventions, therefore, can be used to help the HP suffering

from VT? Attendance to the physical setting in the workplace (safe, private, comfortable), regular clinical supervision, team briefings, and balanced work and social life have been demonstrated to help sufferers of VT (Pearlman & Saakvitne, 1995a; Figley, 1995). However, for some people there is a need for personal psychotherapy in order for them to overcome their distress. This paper will examine one such treatment modality, Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 1995).

Signs of Vicarious Traumatization

- Reduced energy, exhaustion, lack of motivation, feeling that you have no time for yourself
- Disconnection from others; feeling that other people don't really understand; you don't feel close to people any more; difficulties with your partner or in other close relationships
- Emotional blunting
- Questioning career choice, feeling ineffectual
- Errors in maintaining professional boundaries, failure to set limits, a general sense of failure and resentment
- Social withdrawal
- Feelings of despair and hopelessness
- Feelings of weakness, shame guilt, *"my problems are nothing compared to theirs"*
- Loss of belief in the justice of life or in a sense of balance between good and bad, resulting in cynicism and bitterness
- Heightened sense of danger, feeling less secure, scanning for danger, including looking for violence and aggression in your environment
- Sleeping problems and nightmares
- Difficulties in concentration
- Lack of self control, increased anger, impatience, strained relationship with others
- Intrusivity and flashbacks
- Changes to your inner sense of identity and equilibrium, i.e. you find it harder to experience and integrate strong feelings, or to maintain an inner sense of connection with others or to feel grounded and anchored within yourself
- Changes to your world view or spirituality, i.e. you have lost or changed your philosophy of life, your values and beliefs about others and the external world

Herbert & Westmore (1999)

Eye Movement Desensitization and Reprocessing (EMDR)

In 1989, Francine Shapiro published her seminal paper "Efficacy of the eye movement desensitisation procedure in the treatment of traumatic memories." In 2005 the National Institute for Clinical Excellence (NICE) recommended EMDR and Cognitive Behavioural Therapy (CBT) for the treatment of posttraumatic stress disorder (PTSD). As an integrative psychotherapy, the efficacy of EMDR for PTSD is well documented in the literature, (Bleich, Kotler, Kutz, & Shaley, 2002; Chemtob, Tolin, van der Kolk, & Pitman, 2000; Clinical Outcomes Efficiency Support Team, CREST-2003; Department of Veterans Affairs & Department of Defence, 2004) with many randomised studies supporting its efficacy (Carlson, Chemtob, Rusnac, Hedlund, & Muraoka, 1998; Ironson, Freund, Stauss, & Williams, 2002; Power et al., 2002; Soberman, Greenwald, & Rule, 2002). For a critical review of the evidence see Maxfield and Hyer (2002). EMDR has also been used effectively in the treatment of other psychological problems, for example body dysmorphic disorder (Brown et al., 1997), non-psychotic morbid jealousy (Keenan & Farrell, 2000), phantom limb pain (Tinker & Wilson, 2005), and anxiety disorders (Shapiro, 2005).

What is EMDR?

The procedure in EMDR makes use of right, left, visual, kinaesthetic, and auditory stimulation while the client mentally focuses on traumatic experiences (usually memories). Traumatic memory has three components: an image, a physiological reaction to this image, and a negative evaluation of the self as a consequence of this image/recollection.

The procedure works with all three of these aspects by encouraging the client to think about the traumatic event while at the same time recognizing the physiological reaction in the here and now. The client is instructed to be aware of the negative evaluation of the self and then to receive bilateral stimulation from the clinician. The goal is to reduce the negative emotional response to the traumatic image and to reduce the level of physiological disturbance, along with a modification of the client's negative view of the self to a more realistic, appropriate, and adaptive view. The authors emphasise that although we refer to the "procedure" of EMDR, it is a psychotherapeutic process and therefore issues such as client safety, therapeutic alliance, comprehen-

sive assessment and case conceptualization, confidentiality, boundary issues, and a full explanation of the model with valid consent are paramount.

Principles of EMDR (Shapiro, 2001)

- This model regards most pathology as derived from earlier life experiences that set in motion a continued pattern of affect, behavior, cognition, and consequent identity structures.
- Pathology is viewed as configured by the impact of earlier life experiences that are held in the memory in state-specific form (therefore remaining as unprocessed memories).
- Present day stimuli elicit the negative affect and beliefs embodied in these memories and influence the person to continue to act in a way consistent with these earlier events.
- EMDR facilitates more positive and empowering present affect and cognitions to generalize the associated memories throughout the neuro-physiological network and leads spontaneously to more appropriate behaviors, thoughts, and feelings.

This paper now focuses on the case of a helping professional suffering from vicarious trauma. It will describe his psychological assessment and case conceptualization, before exploring the use of EMDR as a potential treatment intervention.

Vicarious Trauma: A case study utilizing EMDR

Bruce (*name changed to preserve client anonymity)* was a serving police officer with family liaison responsibilities. He was suffering from cumulative trauma through his helping role and feeling increasingly helpless and isolated. He reported being overburdened by events that had happened to others, including murders, serious accidents, and suicides. The clinical diagnosis from the referring Occupational Health Unit was depression. Bruce had received general counseling and then a short course of Cognitive Behavioural Therapy. He did not feel any benefits from this and was referred for EMDR therapy some three years after his last significant incident. During this time, he had been on administrative duties and sickness leave.

On assessment with a trauma clinician, Bruce reported the following symptoms synonymous with VT:

- Disconnection from others, social withdrawal and suspiciousness
- Feeling ineffectual and lacking confidence
- Feelings of despair, horror, and being overwhelmed
- Feelings of weakness, shame, and guilt, continually examining his involvement in cases and questioning his actions
- Sleeping problems and nightmares
- Aversion of further exposure to trauma narratives and "bad news" (via friends and media), yet simultaneously obsessive thoughts about negative events and death
- Difficulties in concentration, memory recall, and inability to focus on work
- Increased anger, impatience, strained relationship with others, "looking for a fight"
- Intrusive images of situations he had been involved in
- Physical symptoms of a painful stomach and rash on his face

Bruce had previously served in the armed forces. He compared the difficult times he had encountered in the armed forces with those in the police service. He described his attitude as relaxed and philosophical then. He felt that the army had been supportive and empowered him, whereas the police service had a "them and us" management style. He felt cynical about the motives of those in police service management and sadness at how he had changed from being a highly confident and motivated individual. There was a complete lack of trust in his managers to support him in his role and a shattered belief in his own competence and self-esteem.

VT had led to disruption in Bruce's cognitive schemas regarding his professional identity. His self-evaluation included phrases such as *"I am useless," "I am worthless," "I can't stand this,"* and *"I am vulnerable."* This exacerbated his feelings of despair and anger.

Bruce had been prescribed an anti-depressant, Citalepram 20mg, by his GP. He was a non-smoker and had a

low to moderate alcohol intake. His previously good self-care (running and cycling) had completely stopped some time ago. As stated earlier, VT is a normal response, not an inherent weakness. However, Bruce's environment had appeared to hinder his recovery. Bruce had concerns that he was viewed negatively by his managers and had found it very difficult to admit to a problem – a common issue within the police service (Royle, 2003). He felt stigmatized, isolated, and was worried that nobody, his clinician included, would believe his condition was genuine. Accessing support had been a lengthy process and he had waited three years before being provided with appropriate therapy. Problems regarding rehabilitation and being on administrative duties exacerbated this shame and feelings of inadequacy.

Bruce was referred for EMDR therapy (Shapiro, 1995) because this has been shown (NICE, 2005) to be an effective course of treatment for his intrusive images and also because the previous counseling had not been seen as helpful by Bruce. His clinician agreed with this but felt more importantly that EMDR would be the most effective way of dealing with the "shattered schemas" (Janoff-Bulman, 1985).

EMDR treatment plan and typical session

The treatment plan began with a consideration of client safety and building a therapeutic alliance (Shapiro 1995). A comprehensive assessment was made of Bruce's current situation and past history. Issues of confidentiality and boundaries were agreed upon and a full explanation of the model was given. Bruce gave his informed consent to EMDR. Relaxation methods and general stress management strategies were explored and evidence gained that he was committed to using these.

To reiterate, the procedure in EMDR makes use of bilateral stimulation while the client mentally focuses on the traumatic experiences. Visual stimuli, in the form of right-left eye movements (EM) were utilized with Bruce. The most traumatic memory targeted related to Bruce working with a family that had suffered a sudden and violent bereavement. This memory had resulted in intrusive imagery and thoughts that were still distressing him some three years later. The image he had was one of him leaving the house of the family and feeling tearful. The physiological reactions were those typical of anxiety. Bruce's negative evaluation of himself as a consequence of this recollection was *"I am vulnerable."*

Bruce was encouraged to think about this image, while at the same time being aware of his current physiological reaction and the negative cognition of vulnerability. Bilateral visual stimulation (moving his eyes from side to side by following the movement of the clinician's hand) was then induced. Bruce noticed changes in his thoughts and emotions during subsequent series of eye movements. He remarked on confusion as to why he was "feeling wobbly" and a fear of breaking down at an operational debriefing. He remembered comparing himself with other officers who were less closely involved in the case and feeling vulnerable in comparison. During the processing, a shift occurred in Bruce's self-evaluation. Between EM sets, he began to report the following positive changes: *"We're all affected by different things at different times ... it's never going to be the same incident,"* and *" rather than being vulnerable, I can be strong because I know the risks and can assert myself in the future."*

Bruce was encouraged just to think about this. The EM continued until he reported feeling calm and repeated the same positive cognitions. The clinician then returned to the original target image and asked him to notice his thoughts and feelings and whether these were different. Bruce reported no change to the image but a feeling of anger and a sense that it wasn't his fault. The clinician administered further EM and Bruce noticed his anger increasing and peaking before falling away. At this point, his thoughts were: *"I learned a lot from all this. I can take control of my own welfare."*

Further EM led to a firmer emphasis on this more positive self evaluation, *"When I'm properly better, I think I'd like to talk to probationers and tell them what can happen"* and finally, *"I'm not vulnerable."*

At this stage, Bruce reported feeling calm and confident in his ability to protect himself. His clinician asked him to hold this thought with the original image and administered further EM. When asked how true this new self-evaluation felt, Bruce believed it to be 100% true. He was asked to concentrate on his body to see if he noticed any discomfort, but he reported no residual discomfort. The session was closed with a safety assessment and a reminder that information processing could continue. Bruce was keeping a log of his thoughts, feelings, memories, and dreams between sessions, which would be useful in reviewing any changes in his mental state prior to the next session.

Outcome of Therapy

In three subsequent sessions using bilateral visual stimulation, Bruce similarly tackled the main incidents that had occurred in his duties as well as negative cognitions concering power, safety, and self-worth. He was changed by his experience of VT and felt that it had actually made him stronger now that he had dealt with those issues. His anger and lack of confidence were processed. Bruce ended therapy with a belief in his ability to do a good job and better protect his professional boundaries. He had resumed his self-care, particularly in relation to exercise, and had, with his doctor's consent, discontinued the prescribed anti-depressants.

At the end of therapy, Bruce felt he needed to continue to build his confidence over time as he gradually returned to operational duties, but he was no longer overwhelmed and despairing about his role. Including assessment, he was seen for a total of eight sessions. Bruce's progress was reviewed by his therapist 15 months later. He remained free from medication and was able to undertake operational police duties. He reported feeling and acting more assertively in respect to his professional boundaries and was optimistic about his future.

Conclusion

Vicarious trauma (VT) may well be an "occupational hazard" (Pearlman and Saakvitne, 1995a; p.31) for the empathic helping professional (HP). This can lead the victim to experience wide-ranging psychological distress, including intrusive, aversive memories, lack of self-control, feelings of inadequacy and hopelessness, and social withdrawal (Herbert & Westmore, 1999). VT may also result in isolation in the working environment due the stigmatizing attitude of the victim's work colleagues and management (Glozier, Hough, Henderson, & Holland-Elliot, 2006). There are strategies that have been employed to lesson the likelihood of VT occurring, such as attending to the physical work setting (safe, private, comfortable), regular clinical supervision and team briefings, and a balanced work and social life (Figley, 1995). If, however, bearing witness to another person's tragedy does traumatize a helping professional, personal therapy can be an option. This paper has shown how one individual benefited from receiving EMDR, enabling him to return to work feeling more positive about his future. More research is required when considering the most effective treatment options for HPs; however, recognition that vicarious trauma is a factor in the working life of HPs may at least encourage victims to seek psychological help earlier.

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