

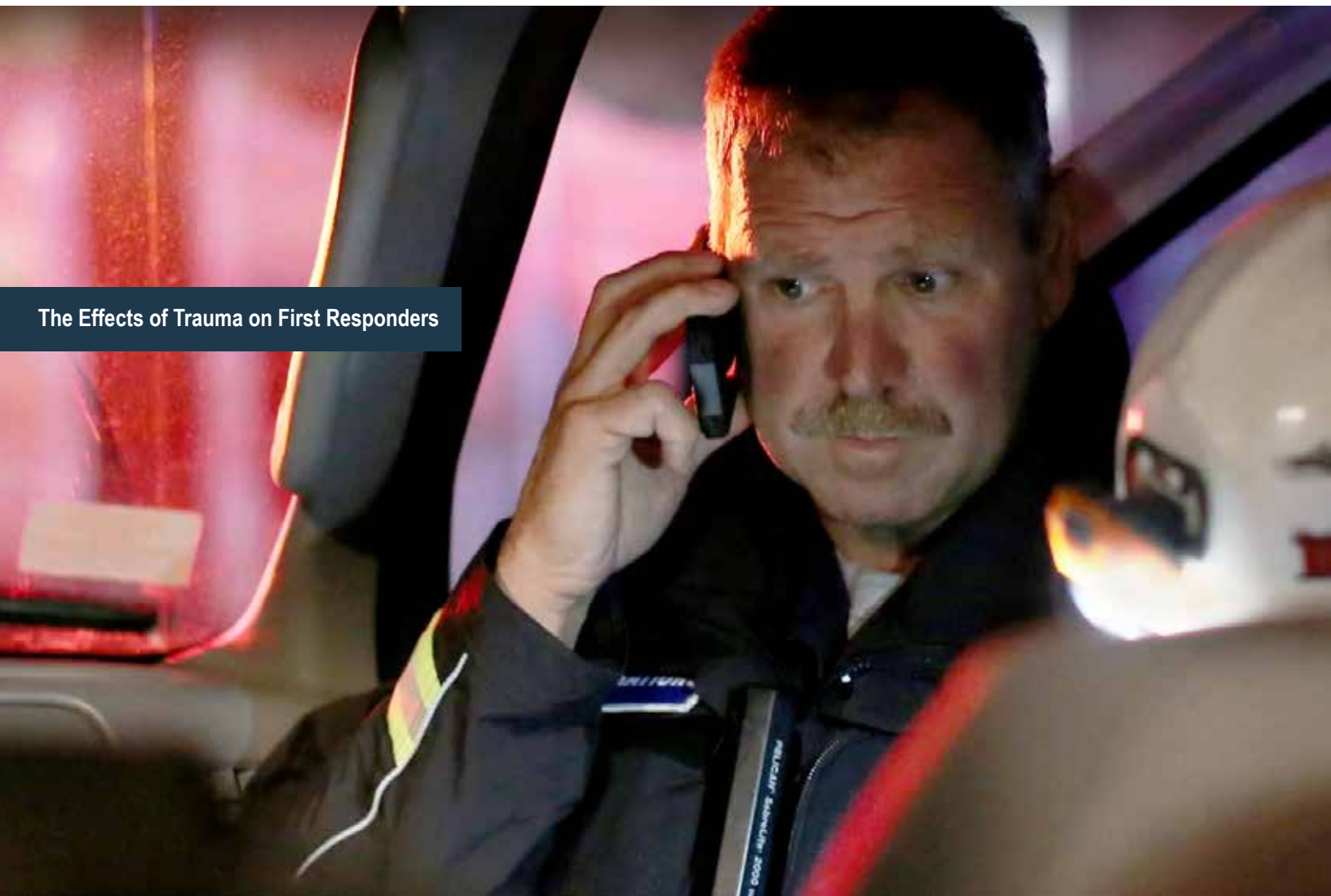
SAMHSA

Substance Abuse and Mental Health
Services Administration

A Quarterly Technical Assistance Journal on Disaster Behavioral Health
Produced by the SAMHSA Disaster Technical Assistance Center

the Dialogue

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The Effects of Trauma on First Responders

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Cover image capture from Video by Robert Scott Button (<http://robertscottbutton.com>).

The Dialogue is a quarterly technical assistance journal on disaster behavioral health which is produced by the Substance Abuse and Mental Health Services Administration (SAMHSA) Disaster Technical Assistance Center (DTAC). Through the pages of *The Dialogue*, disaster behavioral health professionals share information and resources while examining the disaster behavioral health preparedness and response issues that are important to the field. *The Dialogue* also provides a comprehensive look at the disaster training and technical assistance services SAMHSA DTAC provides to prepare states, territories, tribes, and local entities so they can deliver an effective behavioral health (mental health and substance misuse) response to disasters. To receive *The Dialogue*, please go to SAMHSA's home page (<http://www.samhsa.gov>), click the "Sign Up for SAMHSA Email Updates" button, enter your email address, and mark the checkbox for "SAMHSA's Disaster Technical Assistance newsletter, The Dialogue," which is listed in the Newsletters section.

SAMHSA DTAC provides disaster technical assistance, training, consultation, resources, information exchange, and knowledge brokering to help disaster behavioral health professionals plan for and respond effectively to mental health and substance misuse needs following a disaster.

To learn more, please call 1-800-308-3515, email DTAC@samhsa.hhs.gov, or visit the SAMHSA DTAC website at <https://www.samhsa.gov/dtac>.

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In This Issue

Throughout this year, our country has experienced many record-breaking natural and human-caused disasters. During and after these events, the affected communities rely heavily on an effective and efficient response from first responders to be able to recover. But who can first responders rely on to ensure that they can recover too?

The situations first responders are generally faced with are inherently difficult and stressful. They are typically the first to arrive on the scene of events involving injuries and loss of life. They often provide emotional as well as physical support to traumatized survivors. These duties often put first responders at risk for secondary or vicarious traumatization.

Secondary or vicarious traumatization is “generally defined as experiencing similar symptoms to trauma victims as a result of indirect traumatic exposure via close contact with the survivors.”

Source: Brooks et al., 2015

First responders routinely are exposed to severe trauma. Repeated exposures, coupled with the immense stress of roles in emergency services, can lead to an increased risk for adverse behavioral health outcomes such as distress, worry, disturbed sleep or concentration, alterations in work function, difficulties with interpersonal relationships, increases in substance use, somatization, and depression (Benedek, Fullerton, & Ursano, 2007). However, it’s not all bad news. According to studies, specialized training, elevated levels of professional mastery, and assurance of personal and team capabilities act as protective factors, enhance resilience, and are associated with reduced stress (Brooks et al., 2015; Brooks, Dunn, Amlot, Greenberg, & Rubin, 2016).

This issue presents several articles reflecting the experiences of first responders. We are leading this issue off with an interview with a police officer about his battle with posttraumatic stress disorder (PTSD) as a result of a traumatic event. In subsequent articles, a



Photograph by Loren Rodgers/Shutterstock

paramedic, firefighter, and emergency room physician discuss their field experiences and how they and their colleagues cope with job-related trauma and successfully recover from disasters. One common thread in these articles is the desire on the part of first responders to help their communities. By focusing on resilience building and taking care of their behavioral health, first responders may avoid secondary or vicarious trauma and be better able to do just that.

Are you a first responder? Please share your experiences with us. We encourage you to contact us with lessons learned from your field experiences or if you would like to learn more about any of the trainings that the SAMHSA Disaster Technical Assistance Center (DTAC) has available for first responders. ■

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Robert Cousins, NRP, FP-C works as a critical care paramedic and operational medicine instructor for the federal government. He is also

active as an emergency medical services (EMS) provider and instructor in Montgomery County, Maryland. Robert was formerly a field training officer for University of Colorado Health EMS and has also worked as an emergency medical technician and paramedic in New York, New England, and Washington, DC. He has a bachelor's degree from Dartmouth College and is pursuing his master's in public health from The George Washington University. He has previously contributed to the Journal of Prehospital Emergency Care.



Laura Helfman, M.D., FACEP, WALC is a board-certified emergency physician with privileges at multiple hospitals in Tennessee and North

Carolina. She attended Barnard College, Columbia University for her B.A. and The Medical College of Pennsylvania in Philadelphia for her M.D. She is a member of the Tennessee-1 Disaster Medical Assistance Team (TN-1 DMAT), as well as a lead instructor for Wilderness Medical Associates, where she teaches wilderness first response to outdoor education professionals. She is also an avid whitewater enthusiast and professional river guide. She believes that attention to prevention, self-reliance, innovation, common sense, and teamwork are the cornerstones of effective rescue. In any trauma or mass casualty, these skills can help bring order to chaos and clarity to indecision.



Don McCullough, M.S., CMHC, EFO has spent over 35 years as a first responder, retiring at the rank of Captain in April 2016 from the City of Rochester

(New Hampshire) Fire Department. Since 2003 he has been a member of Federal Emergency Management Agency Urban Search and Rescue Massachusetts Task Force 1 (MATF-1), and he currently serves as a technical rescue specialist with the team.

He holds a master's degree in clinical mental health counseling and has worked in several clinical settings. He is also a graduate of the National Fire Academy's Executive Fire Officer Program in Emmitsburg, Maryland. Since 2005 he has been a member of the Granite State Critical Incident Stress Debriefing Team assisting police, fire, emergency medical services, and other emergency agencies that have experienced traumatic incidents, serving dual roles as both peer counselor and mental health professional. He is an approved International Critical Incident Stress Foundation Group Peer instructor and is a New Hampshire Disaster Behavioral Health Response Team regional co-leader. He is also a National Alliance on Mental Illness-trained Suicide Postvention facilitator.

He currently works as Program Coordinator for the Tri-City Co-Op in Rochester, New Hampshire. Tri-City Co-Op is a peer support agency that serves those who struggle with mental illness, substance use disorders, and homelessness. ■



Recent Technical Assistance Requests

In this section, read about recent questions SAMHSA Disaster Technical Assistance Center (DTAC) staff have answered and technical assistance requests to which they have responded. Send your questions and comments to dtac@samhsa.hhs.gov.

Request: A first responder who had taken the Creating Safe Scenes online training (<https://www.samhsa.gov/dtac/creating-safe-scenes-training>) emailed SAMHSA DTAC to inquire about additional trainings available on mental illnesses, and specifically if there were any trainings applicable to attorneys.

Response: SAMHSA DTAC provided a list of publicly available trainings that cover mental health topics, such as awareness and recognition of mental health issues and issues that may be encountered by those in the criminal justice field. The following resources were provided.

- **Psychological First Aid** (<https://learn.nctsn.org/course/index.php?categoryid=11>): This 6-hour online course is provided free of charge. Content includes an overview of mental illnesses and helps users learn how to deal with those in a mental health crisis after a disaster.
- **Mental Health Aspects of Emergencies and Disasters for Non-mental Health Professionals** (http://ynhhs.emergencyeducation.org/flyers/EM230_CourseFlyer.pdf): This course is offered online from the Yale New Haven Health Center for Emergency Preparedness and Disaster Response. The course aims to raise awareness of mental illnesses and help workers recognize the warning signs of mental health issues in others.
- **Trauma-informed Legal Advocacy Webinar** (<http://www.nationalcenterdvtraumamh.org/trainingta/trauma-informed-legal-advocacy-tila-project>): This webinar reviews how attorneys and legal counsel can support those affected by domestic violence, sexual assault, and mental health issues.

Request: A state disaster behavioral health coordinator contacted SAMHSA DTAC to request a literature review on the psychological impacts of Hurricane Katrina, with emphasis on the incidence of depression and suicide following the disaster.

Response: SAMHSA DTAC provided an overview of several articles that examined mental illness incidence and prevalence after Hurricane Katrina. The articles covered a variety of different populations and demographic characteristics. Overall, the results of the literature review showed that Hurricane Katrina had lasting psychological effects on survivors. SAMHSA DTAC sent the state disaster behavioral health coordinator links to all the research from the review. Below are some selections:

- Galea, S., Brewin, C. R., Gruber, M., Jones, R. T., King, D. W., King, L. A., & Kessler, R. C. (2007). Exposure to hurricane-related stressors and mental illness after Hurricane Katrina. *Archives of General Psychiatry*, 64(12), 1427–1434.
- Mills, M. A., Edmondson, D., & Park, C. L. (2007). Trauma and stress response among Hurricane Katrina evacuees. *American Journal of Public Health*, 97(Supplement_1), S116–S123.
- Davis, T. E., Grills-Taquechel, A. E., & Ollendick, T. H. (2010). The psychological impact from Hurricane Katrina: Effects of displacement and trauma exposure on university students. *Behavior Therapy*, 41(3), 340–349.
- Hirschel, M. J., & Schulenberg, S. E. (2009). Hurricane Katrina's impact on the Mississippi Gulf Coast: General self-efficacy's relationship to PTSD prevalence and severity. *Psychological Services*, 6(4), 293.

Request: Following the civil unrest in Charlottesville, Virginia, a local organization reached out to SAMHSA DTAC to get technical assistance on leading the behavioral health response to the incident.

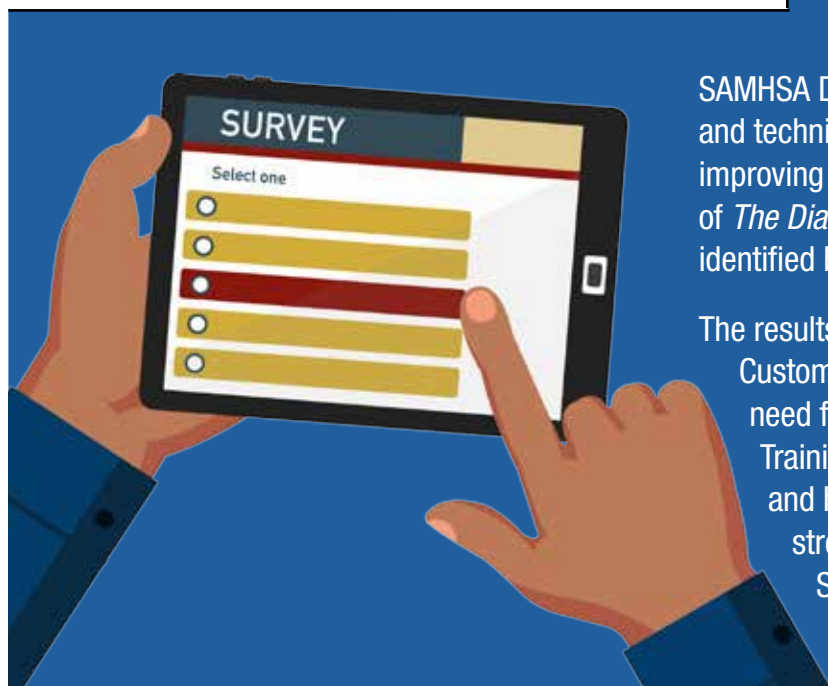
Response: SAMHSA DTAC facilitated a conference call with the organization to determine their needs and help them coordinate their response efforts. Additionally, SAMHSA DTAC provided electronic and print resources on mass violence and related topics, as well as suggestions of trainers/consultants who are familiar with Psychological First Aid and Skills for Psychological Recovery training models, to aid in the community's recovery. Below are selected resources sent.

- **Tips for Survivors: Coping With Grief After Community Violence**—This SAMHSA tip sheet presents some of the common effects of an incident of community violence, signs and symptoms of grief and anger, and useful information about how to cope with grief. Also provided are ways to support children in coping, as well as helpful resources. <https://store.samhsa.gov/product/Coping-With-Grief-After-Community-Violence/SMA14-4888>

- **Effects of Traumatic Stress After Mass Violence, Terror, or Disaster**—This National Center for PTSD webpage describes the emotional, cognitive, physical, and interpersonal reactions that disaster survivors may experience and discusses the potentially severe stress symptoms that may lead to lasting PTSD, anxiety disorders, or depression. Information on how survivors can reduce their risk of psychological difficulties and recover most effectively from disaster stress is also provided. <https://www.ptsd.va.gov/professional/trauma/disaster-terrorism/stress-mv-t-dhtml.asp>

- **Media Coverage of Traumatic Events: Research on Effects**—The National Center for PTSD presents information on the effects of intense media exposure following a disaster. The website describes the association between watching media coverage of traumatic events and stress symptoms. Guidance is also offered for providers who work with children and their parents to avoid retraumatization. <https://www.ptsd.va.gov/professional/trauma/basics/media-coverage-traumatic-events.asp> ■

TECHNICAL ASSISTANCE SNAPSHOT



SAMHSA DTAC continues to respond to training and technical assistance requests and is always improving our service to the field. This edition of *The Dialogue* is a direct response to needs identified by you—our customers and partners.

The results of the 2016–2017 SAMHSA DTAC Customer Feedback Survey demonstrated a need for more first responder information. Training disaster behavioral health workers and helping disaster responders manage stress were two of the top priorities for SAMHSA DTAC customers.

Interview With an Officer in a Large Urban Police Department

Staying Fit To Protect and To Serve: A Police Officer Talks About PTSD

In 2004, in the middle of the night, the police officer interviewed for this article was shot in the line of duty. Following the incident, he had two surgeries, and, within 2 years, he developed PTSD. His PTSD continued for several more years before it was identified. His story illustrates some common responses to trauma, emphasizes the importance of talking with peers, and highlights key lessons he has learned from his experience.

What were the signs that you were having trouble coping with what had happened?

Two years or so after the incident, I started getting sick and fell into a really lousy state. The doctors could never figure out what was wrong. From 2006 to 2010, I went to work, came home, got into bed, and never left my bed until I went back to work the next day. But I was averaging 3 or 4 hours of sleep a night. I had never sweated much before, and I would wake up in a pool of sweat. I was having migraines. I got admitted to the hospital with a 24-hour migraine, and they gave me the maximum dose of medication, and it didn't even put a dent in the pain. They sent me to a neurologist, but what I was going through was because of the trauma.

It was about 3 to 4 years of extreme misery. One thing that made a lot of sense to me was a commercial I saw for an antidepressant where they say that depression hurts. That's true—

it's not just that you're down in the dumps. You get physical pains too.

Instead of dealing with emotions and trying to get them back, it was easier to try to do something I *could* feel. I got into some bad ways of coping. If I got angry, I would drink. It also seemed that sex was a big draw for me. If I was really stressed, that was what I went to. I couldn't feel a lot of emotions. My family life suffered too—my relationship with my children dropped off.

On Halloween of last year, I tried to kill myself. That got me to a new therapist, who has been helping me a lot. It gets so bad, you sometimes feel even death has to be better than this. You don't think, "If I die it will affect these people." You're focused on how much pain you're in.

What changed so that you realized you had PTSD?

In 2009, I started talking to some officers. Two had just come back from overseas. I got in a

To
Serve
and
Protect



conversation trying to find a decent doctor, and they said it sounded like I had PTSD. I did some research and took a couple of online tests and realized they were probably right.

Did you seek out professional behavioral health support?

Yes, twice—the first time in 2009. That first therapist helped a little, but I was the first person with PTSD she had worked with. I was out of work for a while, and then I went back, a little too soon, and things got bad again because I didn't have really good coping skills.

Later, I ended up finding a therapist who specializes in trauma in first responders. He used Eye Movement Desensitization and Reprocessing

The mentality in first responders is you suck it up and you go on, and sometimes you just can't.

(EMDR) with me. It doesn't work for everyone, but it was amazing for me. I also got my poor coping skills identified, and things are a lot better now. A few things have happened since then that I don't know if I would have been able to handle before I saw him. I have better coping skills, and I never drink when I'm mad or upset. If I have a bad day I move around and don't stay in my room.

Are there things you still need to do differently from day to day from someone who hasn't had trauma?

I still don't like fireworks. My wife loves the Fourth of July, but it's tough for me to go downtown and watch fireworks—not because of the sound, but because of the smell. The smell of burnt gunpowder is a trigger for me.

How did you figure out about the smell as a trigger, or about any other triggers you have?

My first therapist wouldn't give me approval to go back to work until I had fired my gun, so I went to a gun range. Our department range is open air, but I went to an indoor gun range with a friend of mine. I smelled the gunpowder, and suddenly it was 3 in the morning again, and the target was the suspect in the incident where I got shot. It

was an awful experience, and the only flashback I've had. Part of the way in, I told my buddy I was done, and he made me continue on. I had to fight through it. I was thankful that he was there and recognized it and helped me fight through it.

Do you think there are any organizational or cultural changes that are needed to help first responders who are dealing with trauma?

If officers are involved in situations with shots fired and they don't get injured, they usually have to go back to work pretty fast. Most places give you 3 days off, tests are done, evaluation, and then back to work. The mentality in first responders is you suck it up and you go on, and sometimes you just can't.

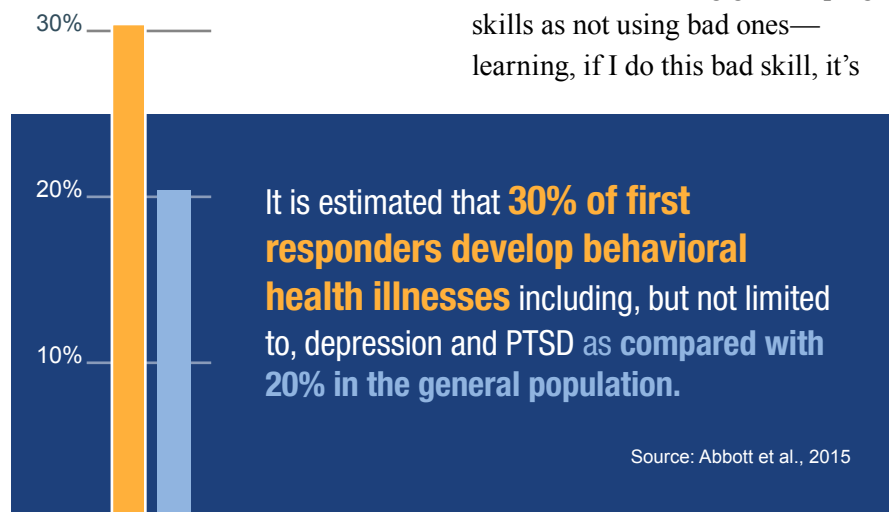
Also, first responders should approach their peers when they

think they're having problems. It's not easy to approach someone you think is having issues, but sometimes that's what you have to do. It doesn't matter what rank you're at. You can always pull someone aside and talk to them.

Do you have any self-care practices that work well for you or your colleagues? What keeps you grounded in this work, and where do you look to keep a positive outlook on life?

I talk to people more. One thing that really helps me is the work I do as a field training officer. When new officers graduate the academy they ride with me, and I show them how to use what they learned there and put it into practice on the streets. I talk about my incident a lot to my rookies. I've got a PowerPoint I use, and teaching about it makes me talk about it, and talking about it makes it better.

My faith has grown a little bit, and I tend to pray more. But for me, it's not so much using good coping skills as not using bad ones—learning, if I do this bad skill, it's



going to lead to this bad outcome. It's easier to do the poor coping skill than face the reality of the good coping skill.

Do you think there are key takeaway messages from your experience?

Had somebody seen my symptoms as PTSD sooner, before those two officers did, and had I actually gotten help and talked about my experiences sooner, it could have saved me 3 years of struggle without knowing what was wrong. It's important to tell police and other first responders what can happen after an experience like a line-of-duty

If someone had explained to me after the shooting the signs and symptoms that could come up—not being able to sleep, and problems in your work and family life—and let me know that I needed to talk about it and work it out, I think that would have helped me.

shooting. If someone had explained to me after the shooting the signs and symptoms that could come up—not being able to sleep, and problems in your work and family life—and let me know that I needed to talk about it and work it out, I think that would have helped me.

Also, it's really important to talk with others, and if you can find one,

a peer group or support group of first responders who have similar issues is invaluable. It blew me away when I found out the number of officers that had been involved in shootings. I was feeling as though no one could feel as bad as I was feeling. But when I talked to others, they would let me know that yes, I was feeling really screwed up, but it was normal for the situation I'd been in.

Where I live, there are groups for people who developed PTSD after experiences in the military, and how they get PTSD is different from how first responders do. Police, fire, and emergency medical services are in the same settings, and we relate more.

I can say this—if I can help anybody to not go through what I went through, I'm more than willing to do what I need to do to make that happen. I don't mind talking to anyone who's been in a similar situation because I can relate. ■

Self-care tips for first responders:

Be aware of the stress you will be dealing with. For example, certain incidents may have specific effects on people with prior exposure to traumatic experiences.

Recognize good work during the disaster, empower staff, and assign responsibility to staff to have a protective effect.

Attempt to limit stress and keep in mind personal safety while looking after affected people.

Be aware of personal vulnerability and recognize signs of burnout and compassion fatigue.

Develop plans prior to the disaster and set limits, plan on taking breaks, sleeping adequately, and eating nutritious meals and exercising during the relief work.

Source: Quevillon et al., 2016

The following page is an **informational pullout poster** that you can print and post. It provides signs and symptoms of PTSD as well as resources for first responders to turn to for help.

Having Trouble Forgetting That Call?

Feeling overly stressed or tense?

Know the signs and symptoms of posttraumatic stress disorder (PTSD):

Distressing memories of traumatic events

Nightmares

Irritability, angry outbursts, or aggressive behavior

Feeling “on guard”

Difficulty concentrating or sleeping

Feelings of overwhelming guilt or shame

Being easily startled or frightened

Self-destructive behavior

It is estimated that 1 in 10 first responders will develop PTSD.

You aren't alone.

Find out where you can get help.

National Suicide Prevention Lifeline: 1-800-273-8255

Safe Call Now: 206-459-3020

Share the Load: Fire/EMS Helpline 1-888-731-FIRE (1-888-731-3473)

SAMHSA Behavioral Health Treatment Services Locator: 1-800-662-HELP (1-800-662-4357)

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Perception Is Reality for Disaster Survivors

By **Don McCullough, M.S., CMHC, EFO**

Responding After Hurricane Sandy

On October 29, 2012, Hurricane Sandy slammed into central and northern New Jersey, as well as New York City and the southern Long Island shoreline, bringing with it a devastating storm surge.

As a rescue specialist with the Massachusetts Task Force 1 (MATF-1), 1 of 28 Federal Emergency Management Agency (FEMA) Urban Search & Rescue teams in place across the United States, I deployed with the team to New York City—specifically, the Rockaway section of Queens. The team arrived in the afternoon and was immediately tasked with search and rescue operations through the neighborhoods of the Rockaways, moving south toward the shoreline.

By nightfall, rescue squads reached the beaches of the Rockaways. It was a surreal landscape. By 10 p.m. safety concerns led command staff to terminate operations. I remember standing on the hard-packed beach sand and feeling a rock under my foot. I moved my boot and looked down. It wasn't a rock I was standing on. It was the hex nut affixed to the top of the cap to a fire hydrant. The storm surge had moved the entire beach inland 200 yards. The following day we resumed operations on Staten Island.



FEMA's Urban Search and Rescue MATF-1 Team responding to Superstorm Sandy. Image capture from Video by Robert Scott Button (<http://robertscottbutton.com>).

I have described some scenes the search and rescue squads were operating in to set the stage to describe the psychological state of the storm victims. Imagine a scene of destruction, with normality turned on its head and an eerie quiet in the air, with no electricity and very few moving vehicles, which were mostly emergency vehicles. People stood in their yards, hands over their mouths and staring. Others wandered around in the streets, stopping to look at something damaged or destroyed that just 2 days before had looked completely normal. All these people were in that initial reaction state

of numb shock and disbelief that we all experience in the immediate aftermath of widespread disaster.

First responders to such events, whether emergency personnel or disaster behavioral health responders, can expect many of the victims to be in a state of psychological upheaval. They will demonstrate a wide range of behavioral responses you must be prepared for. MATF-1 conducts an annual training that covers an overview of disaster behavioral health for victims and rescue personnel. This training enables



FEMA's Urban Search and Rescue MATF-1 Team responding to Superstorm Sandy. Image capture from Video by Robert Scott Button (<http://robertscottbutton.com>).

team members to anticipate a range of behavioral responses by victims and provide basic Psychological First Aid for them.

The MATF-1 training also covers self-care practices while in the field, such as hydration, nutrition, rest, and “hot wash” talks (squad-level discussions after a work period to discuss events and activities, as well as physical and mental well-being). Self-care is taken seriously by the team. If a deployed team member is unable to do his or her job for any reason, it diminishes team effectiveness to carry out its mission.

For example, we conducted search and rescue operations in one particular area of Staten Island devastated by the storm surge that traveled through a neighborhood inland for a quarter mile, swallowing

every home. Every structure was heavily damaged or destroyed, and several had been washed out to sea. There were several deaths in this neighborhood, and there were reports of missing people. Many of the damaged homes had already been condemned by city officials, which left victims standing in their yards, unable to enter to retrieve belongings. Others wandered aimlessly in the streets. Still others sat on their front steps crying. Encountering this type of scenario is a defining and motivating moment for all first responders. It is the moment the gravity of the event becomes starkly evident and the moment when training, experience, and teamwork take over. Victims are engaged to assess needs; provide available comfort measures; and give any pertinent, factual

information, such as the location of the nearest Red Cross field station, that may be of help.

Handling Survivor Reactions

In an adjacent neighborhood, just a 10-minute walk away, it was a totally different scene. This particular neighborhood suffered relatively little damage other than a few downed trees and loss of power. A distraught older woman approached us in front of her home. Seeing our FEMA uniforms, she said that some of her patio furniture had been damaged and asked for assistance in the form of a check to replace the patio furniture. We spent some time with her, just listening. We then politely explained we were a search and rescue team and she would need to apply for funds through another FEMA department.



FEMA's Urban Search and Rescue MATF-1 Team. Image provided by Don McCullough.

After a little while she was able to collect herself, and we continued on our way.

Her reactions mirrored those from the destroyed neighborhood we had just left. Later, some team members expressed difficulty having any empathy for her. They were frustrated by her behavior after witnessing the level of tragedy experienced in the previous neighborhood.

During our “hot wash” discussions we are encouraged to talk about frustrations or difficulties with a “better out than in” philosophy to “get things off our chests.” Principles of disaster psychology from our annual training are then discussed. As disaster responders, we must remember to set aside judgmental thoughts that have no productive value while we are at work. In fact, this kind of thinking

is debilitating at a time when our resilience is being taxed to the maximum.

Encouraging Responder Resilience

Professionals in the behavioral health community need to recognize the unique culture of the first responder community and work toward competency in assisting them. The first responder is not going to ask you for help. The behavioral health professional has to go to them and overcome a strong resistance and stigma attached to seeking psychological help. Strength and the ability to endure physical and mental extremes are highly valued, and anything less is viewed as weakness. Behavioral health professionals with particular training in the peer counseling model of providing stress awareness and resiliency-building practices

would be of great value to the first responder community.

MATF-1 has been proactive in this area and has included a member for 10 years who is a behavioral health professional. Over that time, through use of the peer counseling model, an attitudinal shift has occurred. The resistance to seeking help with mental and emotional stress is greatly diminished, and resilience among the members has been enhanced.

As previously mentioned, there are 28 FEMA Urban Search & Rescue teams positioned across the country. Opportunities exist for behavioral health professionals to become attached to these teams in a variety of ways and even become members. This creates a unique opportunity to become familiar with a unique world inhabited by remarkable men and women. ■

Psychological Trauma in First Responders Following Disaster Response

By Robert Cousins, NRP, FP-C

The First Responder Role

The first responder community—police, fire, and emergency medical services personnel—encounters the full spectrum of human emotion. There are periods of banality and moments of terror. We get heartwarming glimpses into the best humanity has to offer, and we run calls so horrifying they are never discussed, lest others have our nightmares too. This comes part and parcel with the work. No one has “seen it all,” but sooner or later most first responders start wondering if they’re getting close.

The burden of these psychological stressors, including the disproportionately high incidence of suicide attempts among first responders, has been well documented. In many cases this trauma is long overlooked due to many providers’ not realizing the effects of their exposure until years after the fact.

The Effects of Disaster Response

Disaster response is different. During a disaster, existing infrastructure and procedures are

overwhelmed, and normal rules cease to apply. And while disaster response training has improved, no amount of tabletop exercises can prepare you for the real thing. First responders are used to operating on the edge, so to speak, but during disasters they are forced far beyond even their own flexible comfort zones. And that’s just in the first 15 minutes.

Part of what makes disaster response so psychologically challenging for first responders is the compressed, intensified nature of operations.



Photograph by Michael Jung/Shutterstock

Very few **first responders** will take initiative to seek out behavioral health care on a normal day. Throw in an ongoing disaster, and **that number drops to zero.**

All disasters, whether natural or human-caused, are chaotic. Events unfold quickly, and information is alternately difficult to come by or arriving in an overwhelming torrent. What's more, communications are compromised, resources are limited, logistics are impeded, and patient volume is high. And in the case of human-caused disasters, such as active shooter incidents or bomb detonations, patients are often much more seriously injured than during weather-related disasters.

This operating environment is extremely challenging. It can also be energizing at first, but the adrenaline always wears off, and there is still work to do. For this reason, it is critical that first responder care be incorporated into any disaster plan. Food, water, shelter, and rest must all be incorporated into the disaster pre-planning and must also

be executed along with the rest of the disaster mitigation and recovery efforts.

The Role of Behavioral Health

Behavioral health, in the form of first responder care, must play a role here. Disasters, particularly human-caused ones, expose responders to situations they have not previously experienced or even imagined. The scale, scope, and duration of disasters exceed anything first responders encounter in the regular scope of their duties. And if their regular duties invariably bring exposure to psychological stressors, hyper-intense disaster events will exponentially increase the mental burden on responders.

Many behavioral health providers who have disaster response training already work alongside first responders and have been

exposed to the first response culture. During a disaster, however, demand will exceed supply. Additional behavioral health resources may need to be deployed, some of whom may be entering the public safety environment for the first time. It is critical, however, that whoever is called upon understands the culture. Whatever operational briefing the behavioral health staff receive must include an introduction to working with first responders. Otherwise their efforts will be at best fruitless, if not actively counterproductive.

Barriers to Care Among First Responders

First responders often take on a "whatever it takes" mentality, which is a positive trait; in this line of work, giving up is not an option. But this can be taken too far. All too often, behavioral health needs are seen as a sign of weakness, and those who admit such needs are stigmatized. Very few first responders will take initiative to seek out behavioral health care on a normal day. Throw in an ongoing disaster, and that number drops to zero.

Depending on the nature of the disaster, it may not be practical

Higher levels of **resilience** and lower levels of burnout were associated with first responders who had **disaster behavioral health training**.



Source: Atkins & Burnett, 2016

to provide behavioral health support to responders during disaster operations. For example, a weeks-long hurricane recovery effort is fairly well suited to onsite behavioral health care. An active shooter response, on the other hand, will be over in a matter of hours, and it may not be practical to divert responders during active operations. And as mentioned above, responders may be unwilling to access resources onsite for fear of appearing weak before their peers.

Effectively reaching first responders begins by understanding that for them, the unusual is all in a day's work. First responders tend to have well-developed coping mechanisms, and they will process what they see differently than the rest of the public. It would be wise in the planning stage to dedicate certain behavioral health resources to the responders and task separate resources to assist victims. This would save the behavioral health providers from constantly changing gears as they switch back and forth between populations.

First responders absolutely benefit from having onsite behavioral health resources available to them, and this practice should be maintained or instituted where needed. But it is essential that every single responder to a disaster be followed up with privately after the event is concluded, be checked in on periodically, and have ongoing access to behavioral health care. ■

Steps for leaders to **minimize stress** before, during, and after **deployment:**



Plan in advance of disaster mobilization, and develop clear, written protocols and strategic plans.



Include all the team members in the development of the protocol, and ensure they are all adequately trained.



Gather as much information as possible about the disaster to reduce the dangers from the disaster exposure.



Develop a clearly defined leadership cadre, establish sub-teams, and determine factors that would prevent some of the team members from participating.



Model the structure of the team on the Incident Command System.



Develop clear lines of communication.



Assess the welfare of their team, resolve any conflicts between team members, and rotate assignments.



Provide team group sessions upon return to their home base, as well as staff support services.



Thank the team following conclusion of the assignment.

Source: Mitchell, 2011

How Do First Responders Experience and Cope With Trauma?

By Laura Helfman, M.D., FACEP, WALS

“You see things; and you say ‘Why?’ But I dream things that never were; and I say ‘Why not?’”—George Bernard Shaw

First responders are motivated by a strong desire to alleviate suffering and save lives during times of crisis. Whether due to natural phenomena or human action, trauma leading to injury or death requires prompt and steady hands and minds. Often when a disaster occurs, there is little time to prepare and limited information about the nature of the mission. First responders hit the ground running in many cases in harsh environments with limited resources and backup, despite the risk of personal peril. What matters most is that someone somewhere needs assistance, and to a first responder that means it is time to “answer the call.”

A traumatic event is defined as a situation that causes perceived or actual threat of death or serious injury to self or others, which evokes feelings of fear or horror. In my experience as an emergency physician and as a first responder, I have seen survivors having multiple physiologic and psychological responses during a traumatic event that are both expected and normal. A healthy recognition of these responses is essential for the responder and mission success.



PTSD prevalence per occupational group:

Ambulance personnel 4.6%

Firefighters 7.3%

Police officers exposed to major disasters 4.7%

Other rescue teams 13.5%

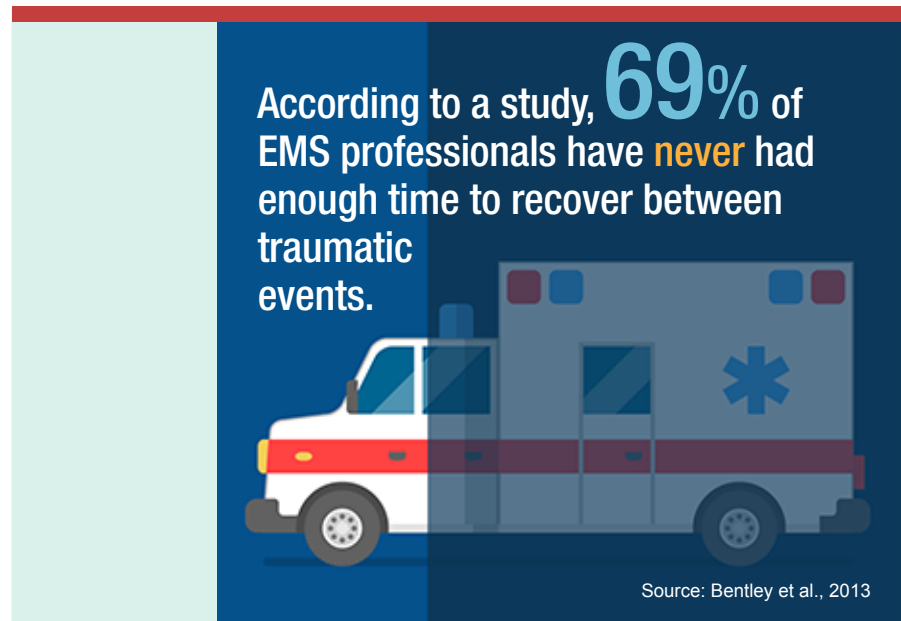
Source: Berger, 2012

In times of crisis, fight-or-flight (adrenergic) responses may cause elevated heart rate and blood pressure. This can lead to hypervigilance or a feeling of being on overdrive. If the mission is extended in the case of large-scale disasters, there may be problems with sleeping, changes in appetite, irritability, and impatience. Often, there is profound fatigue caused by long shifts with limited down time and limited space for sleep and relaxation. The longer the mission, the greater the risk of shifting from normal to maladaptive responses.

Inherent in any response to trauma is a degree of anxiety regarding one's own personal safety and the safety of the team as well as those who are in need. It is also common to feel overwhelmed and frustrated. These feelings can be magnified when resources and personnel seem insufficient or are slow to arrive.

Additionally, there are often bureaucratic obstacles that either get in the way of providing care or mandate adherence to outdated protocols. Depending on the setting, there may be confusion as to the chain of command when many different agencies are involved. This can lead to a sense of loss of control.

Maintaining objectivity, which is necessary and required, can be difficult. Many rescuers are particularly affected when they are involved with the care of someone that reminds them of their own child or family member, especially



when there is significant injury or a fatality. Over a lifetime of service, many first responders can recount times when it was difficult to separate the personal and the professional.

To cope with the effects of trauma, many emergency personnel will rely on defense mechanisms that aim to minimize psychological trauma. Stoicism, depersonalization, and derealization are the three most common ways that responders will separate themselves from what they are experiencing. Over time these coping skills are detrimental and can lead to delayed PTSD.

One of the best ways to avoid burnout and PTSD is for first responders to bond with their fellow rescuers as a team, or “family.” This extended family then becomes a source of strength both during and after an event. Team loyalty takes on a life of its own. With loyalty comes accountability and responsibility,

which in turn lead to a stronger ability to respond.

In my experience, there is a spark that ignites and unites those who choose to respond to disasters. Though the danger is often great, the cries of the wounded and needy take precedence over personal comforts and security. This willingness to serve is one of the greatest gifts that any of us can give to our neighbors, our country, and humanity.

“All you need are these: certainty of judgement in the present moment; action for the common good in the present moment; and an attitude of gratitude in the present moment for anything that comes your way.”—Marcus Aurelius

I would like to thank the members of TN-1 DMAT (the Tennessee-1 Disaster Medical Assistance Team) for giving me the friendship and guidance to become who I am and the opportunity to serve. ■

RECOMMENDED RESOURCES

Creating Safe Scenes Training Course

This SAMHSA DTAC training course aims to help first responders better comprehend mental illness and substance use (behavioral health) disorders so they can serve individuals in behavioral health crisis more effectively and safely. Through a series of first-hand video accounts, informational slides, and quizzes, first responders will learn methods for taking care of others in behavioral health crisis. They will gain a better understanding of why a behavioral health crisis may occur, the best way to make a connection with an individual in crisis, and more.

Read more and find a link to the training at <http://bit.ly/2zlfDuV>.

Shield of Resilience Training Course

This SAMHSA DTAC training course is designed for law enforcement officers. It is a useful tool to help recognize signs and symptoms of various mental health issues. In addition to videos and quizzes, the training also provides resources to help law enforcement officers understand how to build resiliency and when and where to seek help if necessary.

Read more and find a link to the training at <http://bit.ly/2yifUM4>.

Tips for Disaster Responders: Identifying Substance Misuse in the Responder Community

This tip sheet identifies factors that may create a higher risk of substance misuse in disaster responders. It lists signs of possible substance misuse to look out for in yourself and in others that may display themselves physically, emotionally, and socially. Along with when to seek help, the tip sheet also provides a list of helpful resources that are available for your benefit.

Read and download the tip sheet at <http://bit.ly/2zH9NVZ>.

Access the tip sheet in Spanish at <http://bit.ly/2yjZZwJ>.

Disaster Rescue and Response Workers

The U.S. Department of Veterans Affairs discusses the risk of psychological issues rescue workers have after directly experiencing or witnessing disasters. They offer tips on how to manage stress after the disaster and upon returning home.

Access these tips at <http://bit.ly/2m8dMVF>.

Coping With a Disaster or Traumatic Event

The Centers for Disease Control and Prevention provides emergency responders with tips on recognizing signs of burnout and secondary traumatic stress, which can both arise after a stressful and traumatic event. It shares techniques on working with other emergency responders to manage stress and methods for doing so on your own. The page also shares several additional resources.

Access this page at <http://bit.ly/2AwJ1N4>.



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