

Disasters Happen: Responding to First Responders

By Susan J. O'Grady, Ph.D.

At the Contra Costa Psychological Association (CCPA) annual business meeting on January 31, 2014, representatives from the West Coast Post-Trauma (WCPR) retreat center gave a three-hour continuing-education workshop titled *The Impact of Critical Incidents & Natural Disasters on First Responders, Families and the Community*. The presenters were psychologist Mark Kamena, Ph.D., American Board of Professional Psychology (ABPP)-certified in police and public service psychology and WCPR director of research; firefighter Janice Hoaglin, advanced peer coordinator at WCPR; Tino Bamberger, retired patrol officer and WCPR volunteer; Jim Wattenberger, a battalion chief with the California Department of Forestry; and psychologist Dana Nussbaum, Ph.D., Disaster Response Lead in Marin County.

As psychologists, we sometimes treat first responders to an emergency. We may see police officers, firefighters, hospital staff, paramedics, and clergy who have suffered psychological trauma after responding to a natural disaster or critical incident. First responders may come to us to help them with post-traumatic stress disorder (PTSD), substance abuse, chronic pain, depression, and anxiety. Treatment for first responders and their families is further complicated by their access to fire arms, which increases the risk of suicide. Hoaglin, Bamber, and Wattenberger spoke openly and candidly about their trauma. Many of us in the audience were moved to hear first-hand accounts of disasters we'd only read about or seen on TV.

We know the symptoms of PTSD, which include hyper-vigilance, insomnia, flashbacks, and nightmares. Dr. Kamena and the team at WCPR prefer to use the term "post-traumatic stress injury," or PTSI. A traumatic *injury* implies that the reaction to a critical incident must not necessarily lead to a psychiatric disorder or become a chronic condition. Diagnosing a "disorder" may lead first responders to believe that their reactions are wrong and that they won't get better. By using the word "injury," we empower people to feel they have some control over how they recover from the event. [In the words of Matthew J. Friedman](#), executive director of the Department of Veterans Affairs National Center for PTSD: "The concept of injury usually implies a discrete time period. At some point, the bleeding will stop. Sometimes the wound heals quickly, sometimes not. A disorder can stretch on for decades."

An emergency can present first responders with a *critical incident*—that is, a sudden, unexpected, unusual event that includes the loss or threat of loss of life. First responders who perceive a threat or trauma can react in significant psychological and physiological ways. It's important for the treating therapist to understand the meaning clients attribute to a critical incident, which affects how it is processed. Police officers at a violent scene might be excited, afraid, or just wonder about what's for dinner that night. As Dr. Kamena put it, "The difference between an adventure and an ordeal is your perspective."

Stress, left alone, is neither harmful nor toxic. Whether the stress becomes damaging is the result of a complex interaction between the outside world and our physiological capacity to manage it. – John J. Medina, Ph.D.

Our body's reaction to stress is partly a matter of what stress we encounter, partly its duration, and partly what the responder brings to the event. Other life events can also play a role in reactions to critical incidents. At least 60% of adults in the United States have experienced at least one traumatic event in their life, such as child maltreatment, interpersonal violence, natural disaster or serious accident. Exposure to traumatic events is a risk factor for depression, substance abuse, and PTSD. When a parent or other significant adult has traumatized a child, scars are left that can reemerge in adulthood. Depression is the most common effect of trauma. However, most who have experienced a critical incident don't experience long-term consequences; in fact, only about 7% develop PTSD/PTSI, although the percentage is much higher in the military, at 20-30%.

Trauma response doesn't come out of nowhere. Most people diagnosed with PTSD have had at least two traumatic events in their life. In a study by John Briere (2012) that attempts to predict PTSD, he found that psychological neglect in childhood accounts for the largest percentage of variance, rather than the threat of physical injury. In treating clients with PTSI, it is important to explore the particular incident to which your client's reaction is tied.

The three first responders who volunteered to speak at our workshop each had been involved in a significant on-the-job event where people were killed. And each had suffered some form of psychological trauma as children, such as neglect or abuse. All had witnessed death and several had feared for their own lives. They also shared a feeling of betrayal.

Betrayal for first responders takes four forms: administrative, organizational, personal, and community. The first responders each experienced institutional betrayal following their critical incidents. One example is keeping the first responders locked in a debriefing room, away from press and victims while investigations proceeded—with no provisions made for food or water. This constitutes an institutional failure, or as we would say an empathic failure, and compounds the trauma. In the aftermath of catastrophic events, sometimes the most obvious way to support a traumatized worker is to take care of their physical needs.

Another kind of institutional betrayal was failing to protect a first responder from the press—for example, allowing private observations to be publically recorded. Such inattentiveness and lapse of judgment serve to make the primary trauma much more complex by re-opening wounds from childhood that, when coupled with intense life-threatening trauma, can lead to PTSD or PTSI.

The presentation recommended the following treatment when feeling betrayed is a problem for first responders:

1. Acknowledge it and move toward forgiveness
2. See the connection between the current critical incident and personal history
3. Help the responder understand why it is so powerful
4. Get peer validation for the first responder's experience

"What separates people who develop PTSD from people who are merely temporarily distressed is that the people with PTSD start organizing their lives around the trauma." Bessel A. Van Der Kolk

Most of us do not see first responders who are in acute crisis, so we should be aware of helpful resources to recommend such as the West Coast Post-Trauma Retreat, which offers ongoing support as well as intensive inpatient structured therapy, or Preventing First Responder Suicide. The treatment protocol for first responders at WCPR is evidence-based interpersonal and cognitive-processing therapy. Cognitive-behavioral therapy uses techniques like prolonged exposure and virtual-reality therapy. Treatment elements include cognitive restructuring, development of cohesive narrative, affect regulation, and relapse prevention. Usually after all these treatments have been introduced, EMDR is used as a final way to reduce the emotional effects of trauma. In the WCTR center, EMDR is often brief, consisting of a handful of sessions. The real work is ongoing support, through individual and group meetings. Couples and family therapy is also a major component of treatment. Peer support and 12-step programs designed to help first responders are important adjuncts to therapy.

Dr. Nussbaum wrapped up our CE session with slides from her experiences working with the Red Cross after Hurricane Katrina in New Orleans, and Hurricane Sandy in New York. She shared anecdotes about meeting the survivors of these catastrophic events. Remembering Maslow's hierarchy of needs, the bottom line: in acute disasters, we need to provide food, shelter, and listening, not psychotherapy.

Division 1 of the California Psychological Association (CPA) has a new section devoted to police and public safety. If you're interested in joining or would like to volunteer for the WPTR, please contact Dr. Kamena through the WPTR email address: wcpr2001@gmail.com. They are especially in need of trained psychologists who are experienced with EMDR.

For further reading:

Kamena, M., Kirshman, E., and Fay, Joel(2013). *Counseling cops: What clinicians need to know*. New York: Guilford Press.

Medina, J. (2011) *Brain rules: Twelve principles for surviving and thriving at work, home, and school*. Seattle: Pear Press.