Counseling needs of first responders

Donna Garber

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Counseling Needs of First Responders

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A research project submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

In

Partial Fulfillment of the Requirements

for the degree of

Educational Specialist

Department of Graduate Psychology

May 2020

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Dedication

This work is dedicated to my husband and all those who have chosen to serve as first responders to care for their communities. For all who have suffered and are suffering in silence, have felt and are feeling alone in your pain, please reach out and talk to someone. You are truly appreciated. I would also like to dedicate this work to the many first responders who have lost their lives to suicide and to their families.
Acknowledgments

I would like to express my appreciation to the following mentors, faculty, friends and family members without whose guidance, support and love this work would never have been possible. Lenni Echterling, Ph.D., thank you for setting such a wonderful example and helping me nurture my passion and belief in myself. Sharing your plethora of knowledge related to crisis and first responders has led me to where I belong. I am very grateful to Dr. Amanda Evans and Dr. Debbie Sturm for their guidance in constructing this research. My patient family, Karrie, Jon, Johnathan, Levi, Annalise and my mother, thank you for the support, love, food, hugs and understanding you have offered throughout this time of research and writing. Lastly, I want to thank the person with whom I have spent most of my life, my husband Quintin, He has committed 30 years to law enforcement and 37 years to me. I am grateful to him for all he has done to serve and protect and for trusting me with his experiences, pain, fears, and life. His continued belief in the goodness of humankind continues to inspire me and he is my greatest support.
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Abstract

This paper examines the counseling and psychological needs of first responders, as a special population with special needs. It also proposes how counselors can address these needs. Included is a review of relevant literature and concludes with strategies counselors could implement to respond effectively to direct and vicarious trauma experienced by first responders. There is also information related to pre-incident and post-incident care and addresses issues that impact this population’s response to care, ability to seek care, and the overall understanding of what mental health care really means to this group.
Introduction

When we consider there are an estimated one hundred million people in helping professions, (Izzo & Miller, 2018), as counselors we should know more about this special population. The helping professions are self-sacrificing, in many ways and therefore need special consideration.

On September 11, 2001 in New York City, the Pentagon and Stonycreek Township, Pennsylvania, the incredible sacrifices made by first responders and the role they play in our lives became extremely evident. The members of the New York City fire, police and rescue departments were seen as heroes and put in a spotlight as never before. Since that time, there have been natural disasters, other attacks of terrorism, mass shootings, civil unrest, highly publicized police brutality, use of excessive force, hate crimes, social media campaigns promoting hate, and television programs showing live action body camera footage. Events such as these have a lasting effect on the first responders who are working in the midst of it all.

First responders are more likely to have certain mental and physical issues than civilians. For example PTSD, symptoms of depression and issues with sleep were some of the mental health issues. Physical health issues included, cardiovascular diseases, hypertension, diabetes and cancer (Chopko, Papazoglou & Schwartz, 2018). With their exposure to critical incidents such as 9/11, mass shootings and the compounded daily stress of direct and vicarious trauma their mental health is constantly in danger. Stigma and shame are a tremendous barrier to what can be remarkable opportunity for prevention and postvention measures and lifesaving therapy.
Literature Review

Dr. Ellie Izzo and Vicki Miller, LMFT, reported that approximately 53% of helpers are adult survivors of some type of childhood trauma, which makes them more vulnerable to the effects of what they are calling, Second-Hand Shock Syndrome (2018). They looked at exposure to critical incidents in first responders and how Post Traumatic Stress Disorder symptomology presented. They also looked at how other symptomology presented in this group that was different than that of people with PTSD. Here they recommended the idea of Second-Hand Shock Syndrome as a ‘diagnosis’ rather than that of PTSD.

They described the syndrome as having three primary parts: second-hand traumatic stress, compassion fatigue, and vicarious trauma. They defined second-hand traumatic stress as experiencing a serious threat to a traumatized person or destruction of the traumatized person’s environment. Compassion fatigue was presented as burnout and is the result of chronic exposure to serious threats, and working with traumatized people, where listening and empathizing is required, and they are straining to repeatedly control their empathic response. Vicarious trauma is emotional trauma experienced by seeing, hearing, and witnessing the suffering of others. All of the incidents being considered as critical incidents, would be described as outside the range of usual human experience that would be extremely distressing to almost everyone.

First responders experience critical incidents at a rate that most people will never experience in their daily work. First responders may also experience additional stressors related to work such as operational and organizational issues (Chopa, Papazoglou & Schwartz, 2018). Volunteer organizations also expressed concerns related to self-competency as well as competency of others with whom they worked (Folwell & Kauer, 2018). Data collected regarding volunteer emergency medical workers indicated they were feeling a high level of stress
to perform by their community and their peers, to be prepared in any and all situations.

Volunteers in the research talked about how they used skills, defined here as Escape Coping Strategies, as one way to manage their stress. Escape coping is a strategy by which you personally deal with job stress by averting attention away from your duties. This allows a person to distance oneself from professional duties, however, not fully disconnect from friends and colleagues who continue to do the work. This is done by turning off the radio, therefore not answering calls (Folwell et al., 2018).

Additional research shows the experiences to which first responders are exposed are high in areas of badly beaten children, sexual assaults, threats to self and others, mutilated bodies or human remains, seeing someone die, and giving death notification, in midsized police departments for the purpose of research done by Brian Chopka, Patrick Palmieri, and Richard Adams (2015). The data showed that 30% of the participants reported being shot at between 1-9 times and 3% reported being shot at between 10-20 times. The results also showed that 27.99% showed symptoms of PTSD and 10.80% were experiencing avoidance behaviors. The highest rated concern related to making a mistake which may lead to death or serious injury of a colleague. As a result of this data, the researchers believe additional studies should be done to consider frequency and severity of trauma exposure in a variety of agencies and in urban and nonurban areas in agencies of all sizes (Chopko, Palmieri, & Adams, 2015).

First responders are not considered ‘victims’ or ‘survivors’ and therefore are not treated as such and cared for in the same manner as other ‘victims’ of fires, accidents, natural disasters and shootings (Garner, Baker, Haglegans, 2016). However, this population is susceptible to acute stress disorder, PTSD and depression. An additional stressor for first responders is the ‘what ifs’. They are constantly planning for what could happen. First responders are also dealing with
private trauma which they are not sharing with their friends, colleagues or even counselors. It is important for this group to be recognized as survivors due to their exposure to critical incidents so that continued research and attention can be given to them (Garner et al., 2016).

With increased media coverage, of every type, reporting mass shootings, terrorism, police brutality, and more, there is an ever-present concern about what could happen next. As mentioned in a 2012 article by Arthur Rabjohn, law enforcement is the ‘blue canaries’ for the possible chemical, biological and radiological (CBR) attacks. This offers us a sense of the concern law enforcement and other first responders may feel regarding possibilities beyond the things we might have initially considered as stressors. Rabjohn also allowed us opportunity to consider what impression the current situations may have on future generations of first responders. Chronic stress may not only be impacting the individual but also those closest to them such as family as well as those in their community who may at one time have hoped to be first responders themselves.

The idea of fewer people coming into the field can also be a stressor, placing higher demands of the workforce. Lack of social support within the organization is a variable that explained stress in police officers. Perceived support from peers and superiors is important to safety and welfare of these professionals. Police officers are at high risk for cardiovascular disease, “if they perceive low control, high demands, or pressure to carry out tasks and poor support” (Talavera-Valasco, Luceño-Moreno, Martin-Garcia, & Garcia-Albuerne, 2018, p. 2).

Workplace burnout and compassion fatigue are other issues that people in helping careers can experience. There is so much pressure put upon them in their work, constantly increasing demands, lack of support, increase work hours and loss of relationships with people with whom
they work. As a result, their physical and emotional health break down (Talavera-Valasco et al., 2018).

When considering compassion fatigue, it is interesting to ponder how having witnessed so much pain and suffering over the course of a career that empathy has been lost. The stories and pictures sometimes seem to vanish. However, there may be one incident or victim the first responder may not be able to forget. First responders may also try to work more, in order to increase their compassion satisfaction. However, this is likely to lead to further loss of empathy and their own wellbeing (Cooper, 2015).

Research has shown there is some correlation to stress and the use of alcohol in first responders. Both law enforcement and firefighters showed increase use in alcohol as a way to “medicate.” Firefighters referred to their drinking as “Choir Practice,” where they would gather to drink, often in excess as a way of coping with the stresses of the job. Firefighters are at a high risk with data estimating that 50% of firefighters are drinking excessively. The use of alcohol also increases suicidal ideation in both groups. There is evidence that would support that chronic exposure to traumatic events, an occupational stress, puts first responders at increased risk of alcohol use and misuse (Martin, Vujanovis, Paulas, Barlett, Gallagher, & Tran, 2017).

Occupational Health and Safety reported in January 2020 on the mental health of first responders and how the job can cause more than stress. The report talked about issues of substance abuse, anxiety, PTSD and depression and how these can be comorbid. The report also addressed that 24.6% of the first responder participants felt people would care about them, however, the same study shared that 57.3% of respondents, not dealing with a mental health issue said they were sympathetic to the needs of others. This shows how first responders are underestimating the amount of people who are sympathetic to their struggle.
In April of 2018, the Ruderman Family Foundation presented a White Paper on Mental Health and Suicide in First Responders. The paper’s focus was on how constant exposure to death and destruction takes a toll on mental health and can lead to devastating outcomes. Police, firefighters and emergency medical services workers, (EMS is often put together with firefighters since fire fighters are also EMS), compared to the general public, are at a higher risk for depression, PTSD and suicide. Suicide rates nationally in 2008 were reported as 17/100,000 for law enforcement and 11/100,00 in the general public. In 2016 there was a slight decline to 12/100,000 law enforcement officers and 13/100,000 general public. However, this paper reported that 2016 was a unique, in 2017 the rate increased 30% and there were 140 law enforcement suicides, at the time of this research (Heyman, Dill, & Douglas, 2018). In 2018 President Trump signed into law the Law Enforcement Mental Health and Wellness Act. This provides funding for law enforcement to get assistance for mentoring, hotlines and mandatory mental health wellness checks. According to the authors of this paper, this is a critical step in the right direction (Heyman et al., 2018).

According to the most recent records of reported suicides in the United States were 228 deaths by suicide for 2019. This is an increase of 31.03% from 174 in 2018. Already in 2020 there have been 50 reported as of April 1, 2020. The organization Blue H.E.L.P.org, is keeping records and attempting to help many first responders, their families and organizations with information, education and support. The organization is partnered with the American Foundation for Suicide Prevention and the American Association of Suicidology. Blue H.E.L.P. stated that the information they report is only as accurate as the information they are given, as many suicides are not reported (bluehelp.org, 2020).
An example of how this is happening occurred in January 2018 when Officer Nick Budney shot himself by the river that ran behind his favorite restaurant. His family, friends, colleagues saw him as happy, hardworking, and fun. He was a 14-year veteran with the New York City Police Department working the Bronx. Nick’s mental health killed him. *Men’s Health Magazine*, highlighted Nick’s story to bring light to a subject that is often overlooked. Men and mental health, and in this case, a man who was also a first responder. Officers were interviewed and spoke of a need for better and safer equipment. They talked about the horrors they had seen in their careers. They talked about how if officers are killed the line of duty, it is talked about, but when an officer takes his/her own life, no one talks about it. Police culture places value on strength and resilience particularly when the stakes are high. The culture is “fraternal” and competitive as well as demanding and people do not want mental health issues to be held against them (Crosbie, 2018).

As suicide and other mental health issues become more prevalent, leaders in police departments are dealing with issues of stigma. When officers are taking their own lives, clearly there are issues that are not being disclosed and managed in a way to help the officer back to health. Since 2014, an average of five New York City police officers take their own lives each year. In June of 2019, the department reported that six died by suicide in the past six months. A report by Ashley Southall (2019), indicated that officers see themselves as people who, by all accounts of those observing them, are not supposed to have problems. They are to be “RoboCop.” Leadership is stating that there are often just blank faces when the issues are brought up and having officers willing to ask for help is their biggest challenge. The New York City Police Department said they were going to do “psychological autopsies” on the officers they lost to suicide to see what they could learn about what led them to the decision to take their own
lives. The report indicates that some jurisdictions report suicides as nature deaths of officers to protect police families from embarrassment or to prevent the family from losing death benefits.

The behavior of some officers indicates fear and concern related to talking about their experiences and feelings. With a mental health plan being implemented in the NYPD, some officers were making fun and making comments related to how the department was better off without those officers who had taken their own lives (Southall, 2019).

Stigma is also an issue for those in fire and EMS work. Not unlike law enforcement officers, this group of people does not want to be seen as weak nor do they want to be removed from their duties. The stigma they experience keeps them from seeking help and therefore they can continue carry the stresses that come with being a superhero. They will often brush off the stress by saying it is just what they do, or just another day on the job. If they decide to get assistance, it may be for something such as an inability to sleep and if their peers treat them differently because they are seeking assistance, this may exacerbate the issue.

With stigma being a serious barrier to mental health services, we can also look at other barriers as well. For example, there is the fear of being labeled as having a mental illness, due to the impact this may have on their identity. There is also concern related to lack of confidence in mental health providers. Cost and availability of services has also been noted as concerns related to receiving services. We have to also consider that there is self-stigma, which is that his or her own behaviors and attitudes are not socially acceptable. Self-stigma is interesting to think about since it is a product of public stigma (Karaffa, & Koch, 2016).

Christopher McKenna, in a 2017 article concerning the impact of stigma on firefighters, discussed how seeking assistance for issues related to mental health labels a firefighter as weak. McKenna examines how stigma which is internalized, can then become self-stigma. The
development of self-stigma, “has been hypothesized to lower one’s self-esteem, which in turn could inhibit one’s ambition to seek mental health care” (p. 3). Consideration must be given to the fact that the rate of suicide seems to be growing and stigma is a contributing factor (p. 4).

Pluralistic ignorance is the phenomenon that an individual in a group privately rejects a belief, feeling or behavior, yet believes that the other members of the group privately accept it. This includes things such as drinking. However, an individual’s behaviors are often motivated by a desire of belonging (Karaffa, et al., 2016).

The real human side of what can impact stigma can be seen when we look at examples of first responders who are relieved of duty after an incident from which they have suffered a mental health injury. When they share regret for speaking out and feel the outcome, they experienced is a direct result of seeking services. Chrystal Hayes, in a 2017 article in USA Today, reports on the impact of post traumatic stress disorder on a first responder post critical incident and prior to ten years of service. It allows an inside view of what it is like to seek services and then feel doing the right thing is being used as a tool of manipulation. This report gives an interesting view on the prominence of stigma in the first responder culture and barriers to care.

In addition, there are barriers of fear that services will not be confidential and seeking services would have a negative impact on their career. There was data to support that people did not know where to get help and even had difficulty getting time off to go to their appointments. It was stated that judgement by coworkers and leadership was also a concern, which leads us back to stigma, both public and self. One in three respondents reported experiences of stigma, (33.1%), one in eleven (9.3%), experienced barriers to care. There were positive relationships
found between stigma and probable alcohol use disorder as well PTSD and depression (Haugen, McCrillis, Smid, & Nijdam, 2017).

First responders do care about mental health, as was determined by University of Phoenix in an online survey conducted in 2018. Of the respondents, 98% agree that mental health was as important as physical health. It was also found that 83% believed that people seeking counseling would get better. However, 47% felt their job would be negatively impacted if they were to seek professional help. With this group, they felt the reasons would be receiving different treatment than coworkers (53%), supervisors, (52%), and concerns related to being seen as weak by their colleagues, (46%). The survey also showed that more than half, (65%), have either sought counseling or have considered counseling. The survey also showed that 85% of respondents reported they would be more encouraged to seek services if someone in a leadership role talked about their experiences (PR Newswire, University of Phoenix, 2018).

One study assessed a prevention program among urban police officers for work-related stress. The assessment looked at the efficacy of a prevention program to improve psychobiological response to work-related stress. The program showed improvement in sleep, reduction in stomach issues and less exhaustion. It would indicate there are positive outcomes from preventative practices. The use of group sessions, guided imagery and relaxation techniques and coping skills, along with technical/strategical skills, are implemented in the sessions. These sessions encourage cue-controlled relaxation and give the officer more control over the situation and an ability to imagine the possibilities (Arnetz, Arble, Buckman, Lynch, & Lubin, 2012).

There is also interesting information that indicating some critical warning signs in police officers. As well as identifying officers that maybe at higher risks. In this report by Tristan
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Martin, from Syracuse University and Richard Martin, from Mercer University, they discuss the myths which surround law enforcement suicide as well.

The use of screeners may also give us some insight into how to better serve first responders with the exposure to vicarious trauma they face regularly. Increased activity in the amygdala and decreased cortical inhibition, leads to an alteration in the fear response system. PTSD is characterized by four symptom clusters following exposure to trauma. These are intrusive thoughts, avoidance of triggers, numbing of negative emotions and hypervigilance. Research has shown that the use of the PTSD Screener for civilians, used for firefighters after 9/11, proved helpful in gathering information. Those who screened higher for PTSD were also ones who were more likely to seek counseling and more likely to require mental health medical leave. If this screening was done as part of the annual physical, for first responders, it may prove to be of benefit to all involved (Robertson, 2019).

Dr. Brian Chopko, Dr. Konstantinos Papazoglou and Dr. Robert Schwartz published an article, in October 2018, on psychiatryonline.org, titled *Mindfulness-Based Psychotherapy Approaches for First Responders: From Research to Clinical Practice*. This work was to show a way to assist in managing special circumstances under which they work and the stresses that lead to their special needs. The mindfulness approaches discussed by Chopko, et. al. includes Acceptance and Commitment Therapy (ACT), which is mindfulness-based healing using cognitive and behavioral based strategies to help the individual to perceive and act differently.

There is also Mindfulness-Based Cognitive Therapy (MBCT), which integrates mindful meditation and cognitive behavioral therapy techniques. MBCT has been shown to reduce depression symptoms. There are more generalized mindfulness-based strategies such as breathing techniques known as Large, Deep Exhale and Diaphragmatic Breathing, which
stimulate the peripheral nervous system (PNS). Progressive Relaxation and Mindfulness Imagery are also used as ways to assist first responders.

First Responder Resilience: Caring for First Responders, a book written by Dr. Tania Glenn, recommends having first responders receive support from peers first. She discusses how we are asking a first responder go against “their first inclination, bottle up, stuff, or ignore their trauma and give us the chance to walk them through it instead” (Glenn, 2017, p. 41). Dr. Glenn also believes it is important to help first responders understand how the brain works in times of trauma. Know your audience, Glenn recommended, when your audience sees you as lacking credibility because you are ‘touchy feely,’ teach them about how things work and talk a language that is more meaningful to them.

Knowing our audience and understanding them as a special population are vital to providing quality care. Mental healthcare for first responders requires counselors to adhere to strict ethical principles with respect to human dignity and the rights of first responders and their mental health. “Rather than endorsing the myth or positive stereotype of super heroes who do not have needs for care,” we as mental healthcare providers need to “respect that first responders are equally vulnerable to the psychological effects of trauma and have individual and cultural differences” (Lanza, Roysircar, & Rodgers, 2018, p. 194). Considering prevention, postvention and treatment for first responders, Lanza, et al. (2018), reflect on social support, control, stress mediators, resilience and psychoeducation as ways to assist first responders with their mental health needs. These researchers also mention that subgroups, (firefighters, law enforcement, volunteers, clergy, etc.) will also have their unique needs.

Unique needs include the impact of chronic exposure to critical incidents, which include ‘suicide by cop.’ This occurs when people want to die, however they do not want to take their
own life and will threaten a law enforcement officer forcing the use of lethal action. This is a traumatic situation, and unique to law enforcement. Dr. Richard Lumb discussed how first responders, “endure as a silent witness”, (p. 9). They are physiologically and psychologically on and have to be ready to make a split-second decision, as would be the case with a ‘suicide by cop’. Lumb described how the changes begin in the academy where it is decided if you are ‘fit’ enough and the culture and beliefs shift. The academy is teaching skills and changing beliefs and setting rules.

First responders are also working with ways to cope as they navigate through their journey from the academy and into the work and their experiences of chronic exposure to trauma and critical incidences. An empirical model of first responders coping strategies, based on nationally represented survey sample of 6240 first responders was done by Earmonn Arble and Bengt Arnetz (2017). They discuss an approach/avoidance bifurcation coping model. They found that in both cases there were support system and physical health. They also looked at substance use and post-traumatic growth as it applied to both methods of coping.

Contemplating ways to cope and emotionally survive is the focus of Dr. Kevin Gilmartin’s book, *Emotional Survival for Law Enforcement: A Guide for Officers and Their Families* (2018). He considered ways officers can work with and overcome the internal assaults they experience as a result of the job and their personal lives. Gilmartin examined the life of the officer from idealism to cynicism and changes in belief and culture to chronic exposure to critical incident and organizational issues. He covered a gamut of emotional issues such as entitlement, blame, feeling like the victim, and control to mention a few. There is also opportunity to discover how the journey of emotional survival impacts relationships and how relationship are imperative to the healing process and ultimately being a survivor.
Thinking about first responders can bring an emotional response for many people. Dansun Photo Art put together a tribute to first responders in 2017. The tribute showed scenarios in which first responders are on the job, however we are seeing what they are feeling, rather than just what they are doing. It made first responders relatable. They do not seem hard, untouchable and impenetrable. The tribute shows them as they are; people who feel pain, sadness, anger, frustration, loss, despair, and all the emotions that others feel. The tribute was meant to allow the public to see them as human, as one of us. For most, it will bring on an emotional response, however it may not be the same one as it would have prior to seeing the tribute.

**First Responders**

According to Merriam-Webster Dictionary, 2020, a first responder is defined as, “a person (such as a police officer or an EMT) who is among those responsible for going immediately to the scene of an accident or emergency to provide assistance.” First responders would then include police officers, fire fighters, paramedics, emergency medical technicians, emergency dispatchers, rescue disaster volunteers, and all branches of the military. These are the people called upon in situations of danger, disaster, death, and destruction. They are running toward the danger when everyone else is running away. “However, ‘victims’ of trauma seem to be considered more carefully in the mental health literature,” (Garner et al., 2016, p. 168).

First responders are a specially trained population of people for whom protecting others, securing a dangerous or unstable situation, protecting property as well as themselves, is priority. However, this group has a willingness to put others first. They risk their own safety, even their lives, while trying to protect someone else’s. They are at higher risk for direct trauma and vicarious trauma than the average person. They can be victims themselves of shootings, assaults, accidents, and verbal abuse, just to mention a few.
There can also be pressures such as bureaucracy, the media’s depiction of their role, behavior and overall performance as well as social media impact on public perception. All of this can lead to issues such as difficulty connecting to their community, reduced workforce, longer working hours, inadequate equipment, reduced or inadequate training and more. They experience compassion fatigue, loss of interest in the job, and are, “particularly susceptible to acute stress disorder, PTSD, and depression,” (Garner et al., 2016, p. 168). Individual susceptibility can also be influenced by marital status, substance abuse, social support, work environment, and feelings of self-worth (Garner et al., 2016).

Counselors need to be aware what this special population faces day after day and how it is impacting them. It is not a one-time event, but rather a cumulative effect which is causing these people to turn to drastic measures as a way to stop their pain. The initial response may be, “They know what they signed up for,” however, the toll it takes as well as the deterrents keeping them from the help needed to manage this constant exposure, need to be addressed in a more direct way.

Counselors should have a better understanding of direct and vicarious trauma and the ways it can be experienced by a first responder. There are many ways the trauma can be processed, and a person’s personal history and current situation will influence how they experience trauma. We need to be open to understanding how they see themselves in the world and how they feel they are perceived in culture at large. It is also our responsibility to consider what it might be like for the first responder to seek assistance. Is there concern or fear and questions such as, “What will happen to me, my job, my life?” As counselors, the need to explore the possible outcomes first responders may experience as a result of continued exposure
to trauma. We must also assist in cultivating ways to intervene with preventative and restorative care.

First responders are a vulnerable population and have not been viewed the same as “victims” of the incidents with which they work. The needs and possibilities which can be offered to these “self-sacrificing” helpers should be explored by counselors and other mental healthcare professionals. Finding ways to empower them as they navigate the very difficult work they have chosen to do is vital to their safety and well-being. It is also important to understand this group as people beyond what they do for a living. Try to get to know them as human beings and be human ourselves first (Glenn, 2017).

Direct and Vicarious Trauma

As counselors, we can recall many events clients have experienced that were traumatic: sexual assault, abuse, neglect, abandonment, torture, loss, burns, car crashes, and the list goes on. First responders may have personally experienced one or more of these traumas, which may be what brought them to the field in the first place. However, they are then exposed to traumatic events again and again day after day. They see it, hear it, smell it, feel it, and even taste it. These are experiences they do not forget, and they have to go back tomorrow, anticipating what the day may bring, hoping for the best, preparing for the worst.

First responders begin a shift aware of the possibilities: traffic stops, motor vehicle accidents, structure fires, people with illness, and with these incidents, witness and encounter irate people, pain, suffering, and fear. The impact these incidents will have we know is troubling. For example, my husband was called to a domestic disturbance where the husband had beaten the wife and was threatening to kill her. When my husband arrived, not only did he find a home in total disarray with an injured, terrified woman, and a man out of control, but two little, dirty,
crying, children trembling together in a corner of the room terrified out of their minds. When he
told me, he was angry and upset, and he said, “I just wanted to beat the guy, but I couldn’t. I
have to treat him with dignity, and it makes me want to throw-up!”

First responders witness mangled bodies, survivors of sexual assault, neglected and
abused children, victims of suicide, abused and tortured animals, and hostage situations. They
are threatened, shot at, they make death notifications, and they have their loved ones threatened.
All these things and more are stressful and are chronic in the first responder life.

The way critical incidents are perceived, experienced and processed may be different for
different people based on their own personal history and current life status. Relationships,
physical and mental health, culture, worldview and other factors also play a role in the
perception of an experience and the way different people will process that experience. We had
two small children at home at the time my husband worked the domestic violence case involving
the two small children and there is no doubt that only added to my husband’s frustration.

My husband, a now 30-year veteran law enforcement officer, offers an example of the
emotional impact on first responders that comes from years of exposure. While on duty, he drove
his police cruiser to the middle school where our son attended, feeling an almost uncontrollable
urgency to see our then, 14-year-old son. When our son came into the office, my husband took
him in his arms and just held him, unable to speak for fear losing emotional control. Earlier that
morning, he had worked a fatal car accident involving a young boy. He told me when the
emergency medical technicians pulled back the sheet, from the boy’s face, he was looking into
the face of our son. He felt something so terrifying and painful in that moment. He experienced
overwhelming sadness, fear and even physical symptoms of nausea. Even though he had seen
many accidents and fatalities over the years, this time, something was different. This is just one
example of the traumatic experiences faced by the brave people whom we all rely on to care for us in our darkest moments, the impact of which, we do not realize.

The trauma experienced by a first responder is not the immediate trauma of the incident to which they have been called. However, it is the constant and repeated exposure to human suffering and the scale to which they are exposed most of society never sees, is what makes their situation different (Rabjohn, 2012). “When you see a mother stab her baby though the ear canal with a pair of scissors, and under the jaw with a butcher knife, and you walk into that scene and there’s blood all over and you have small children, you’re never going to forget that shit for the rest of your life. Ever,” he said. “And that’s like, just a Tuesday. Some of the stuff you see out here — it’s just unbelievable horrors” (Crosbie, 2018, para. 20). Continued exposure to traumatic experiences such as this can lead to issues for first responders.

**Impact of Cumulative Traumatic Exposure**

Cumulative traumatic exposure has been shown to have a negative impact on first responders resulting in mental health issues such as PTSD, suicide and substance abuse. Taking a closer look at each area can give more insight to what this population is experiencing as critical incidents and how they are perceiving these experiences.

As a result of the repeated exposure to critical incidents which is the cause of direct and vicarious trauma, first responders are experiencing serious mental health issues. NBC distributed a survey, in the California Bay Area, and of the 4,022 emergency medical service providers who responded, 86% said they had experienced a critical incident. As a result of that stress, more than one-third (37%) said they had contemplated suicide and 6.6% said they had made an actual attempt. In the survey, which included California firefighters, 70% revealed they had trouble
sleeping, 64% were easily angered or withdrawn, and 31% developed a substance abuse issue (Martin, & Martin, 2017).

**Post-Traumatic Stress Disorder**

Post-Traumatic Stress Disorder (PTSD) is, “the end result of exposure to a stress trauma so extreme it is beyond human coping capacity” (Glenn, 2017, p. 28). Two different individuals can witness the same incident and have totally different responses. It is really all about, “what your brain interprets as trauma” (Glenn, 2017, p. 28). As you take in information through your senses of sight, hearing, touch, smell and taste, the information enters through the frontal lobe of the brain and is processed into your memory, depending upon the relevance. Trauma is stored in your frontal lobe, which acts like a firewall for trauma and this allows you not to become too overwhelmed. Your brain will, overtime, attempt to push the traumatic information out, however, if it is too traumatic, it will need assistance to do so. As the frontal lobe attempts to ‘download’ the traumatic memory, the individual will then relive the experience over and over and feel distress which will trigger the fight or flight response. With this response being triggered time and time again, cortisol is produced, and it will cross the blood-brain barrier and then enters the limbic system. The cortisol causes the hippocampus to shrink, which manages trauma and loss, to shrink. It is at this point the amygdala becomes damaged and it is the gatekeeper to the fight or flight response. When it is damaged, an individual no longer has a sense of safety. Stimuli such as a loud noise can trigger fear. Logic is no longer prevalent. The person is in a loop of survival. This is what PTSD looks like (Glenn, 2017).

Recent research has shown that chronic exposure to stressful and traumatic events, which include a significant increase in mass shootings since 2000, can have negative effects on the first responders called to work with these situations (Lanza, Roysircar, & Rodgers, 2018). There is a
worldwide increase in the incidence of PTSD, however in the first responder or rescue worker population, those numbers are as high as 10%, which is considerably higher than the public at large. This same population, when suffering with PTSD, is at greater risk for depression, alcoholism, and suicidal thoughts (Robertson, 2019, p. 1041).

Considering these statistics and understanding what is happening with the brain in PTSD, the question is how these traumatic incidents might be impacting their work. In the United States each month, 3.6 days of work per 1000 workers are lost due to PTSD. It is also interesting to consider that after the 9/11 attacks on the United States of America, first responders with PTSD were three times more likely to lose their jobs and those with three or more chronic comorbid diagnoses with their PTSD were 11 times more likely to experience the loss of their job (Robertson, 2019, p. 1041).

With firefighters it is reported that 18%-22% are dealing with PTSD and behavioral health injury. In the state of California, they are recognizing that there are many people who are feeling isolated and do not know where to turn for assistance. They are trained to be “battle-hardened” and to manage what they see and do (California Professional Firefighters, 2017).

When we are seeing such high numbers of mental health injuries, we have to think about ways to make counseling services more available, less fear inducing, and we need to make ourselves aware of the needs of the first responder population.

**Alcohol Abuse**

First responders often turn to alcohol use and abuse as a way to medicate and numb the pain and feelings they experience as a result of chronic exposure to trauma. The data showed that in police officers, alcohol use is positively associated with increased suicidal ideation. Firefighters are also at high risk an estimated 50% of firefighters are reporting excessive
drinking, which is defined as three or more drinks on one occasion. Increased use increased the risk of harmful consequences and is associates with ideation (Martin, Vujanovis, Paulus, Barlett, Gallagher, & Tran, 2017). The use of alcohol as a “medication” to assist with the issues related to vicarious trauma, PTSD, and depression may be exacerbated and therefore lead to a greater dependence on the substance.

**Suicide**

The day in the life of a first responder can be one that starts simply with a speeding ticket stop or a fender bender, or a transport to the hospital for a minor injury. It could later be something more serious such as a house fire, heart attack, or assault. Even later in the day there could be a three-vehicle accident with entrapment, multiple fatalities, and the arrest of a perpetrator who has sexually assaulted a child and is sitting in the police vehicle smirking as the injured child is being loaded into the ambulance. These first responders are then supposed to go home to family and just turn all this off. This is when the internalization of these feelings begins and the “tough it out” comes in and suicide can become a real issue.

Research has shown there are signs to look for such as talk of death or suicide, verbal cues such as wishing they were dead, time to end it all, or you won’t have to worry about me anymore. Self-isolation was indicated as another sign as was improved mood after being depressed, neglected appearance and hygiene talking about being out of control and being annoyed at something that will ruin his or her career but not really acting as if they care. Other things to be aware of would be if the officer gives up his or her weapon to a colleague for safe keeping, or if they display the weapon recklessly or take unnecessary risks on the job. If they become hostile, argumentative, insubordinate defeated or hopeless. If the officer develops issues with drugs and/or alcohol this too can be a warning sign (Martin & Martin, 2017).
There are also some indications that the average age of law enforcement officers who die by suicide are age 40-44, have been on the job at least 16 years and 91% of them are male. They are at highest risk when on the job 15 to 19 years and 63% were single. Military veterans were 11% of the death by suicide in law enforcement officers. In this group the weapon of choice was a gun and personal issues were also dominant in 83% of these cases. The leading states for law enforcement suicides were California and New York (Martin & Martin, 2017).

Suicide is a serious issue within the first responder population as a whole. Research by the Ruderman Foundation in 2018 showed that 46.8% of firefighters reported having had suicidal thoughts (Heyman et al., 2018). Police officers reported having pervasive suicidal thoughts at a rate of 7.8%. The rate among the general public was 4.3% according to 2017 statistics from the National Institute of Mental Health.

There are also reports that indicate the emergency medical service personnel may have higher rates of suicidal ideation, but there are still questions related to much of the data collected in these groups due to the manner in which the information is collected. In a study noted in the SAMSHA, Disaster Technical Assistance Center Supplemental Research Bulletin, First Responders: Behavioral Health Concerns, Emergency Response and Trauma report, (2018), 37% of fire and emergency medical service personnel with 25% male and 23.1% male law enforcement officers experienced suicidal ideation. Emergency communication workers must also be considered here. When we think about this particular sub-group, consider this group can only imagine what is happening based on what they hear via emergency communication radios and phones. They are unable to see what is happening for themselves and may often hypothesize something worse than what is actually occurring.

**Boundaries to Assistance and Challenges for Counselors**
Working with first responders will bring with it challenges that are not typically present with other clients. The first responder culture fosters the belief system that people within the group are tough, superheroes, who are “just doing their jobs,” and are not supposed to let things get to them. As a result, they tend not to talk about their emotions or share about things they experience which cause them to feel anxiety, depression, or even suicidal. They are concerned about what people will think, say or do if they disclose how they feel. They are experiencing stigma, as well as other boundaries which keep them from seeking the help, they need in order to do their jobs optimally and in some cases, save their lives.

**Mental Health Stigma**

Mental health stigma is described as an adverse and invalid attitude about a person which is similar to a prejudice or negative stereotype, and leads to negative actions or discrimination (Hagens, et al., 2017, p. 219). We can look at stigma in three different forms, public stigma, self-stigma, and label avoidance. Each of these have specific negative ideation attached to them.

Public stigma is the degree to which a person is aware of the stereotypes held by the public, of people who seek mental health services. Basically, the public does not feel a first responder should seek services because they are “tough” it is “their job” they get “used to it,” “it’s what they do.” The public’s opinion of how a first responder should or should not respond to a situation is the stereotype set in place that forms the public stigma which then does not ‘allow’ this population to seek services.

Self-stigma is the application of these stereotypes to oneself, which leads to internalizing feelings of loss of power and control as well as value. Here we are looking at the first responder seeing themselves as the public has defined them. They see themselves having to be the “Hero” the “tough” the “unshaken” the “this is my job” people. The ones who need no assistance and are
supposed to just “shake it off”. Once the first responder adopts this belief and internalizes it, we have self-stigma where they believe that seeking services is not something they want or need, but it is something that goes against who they are.

Label avoidance is when people do not acknowledge symptoms and therefore will not participate in mental health care services. This behavior allows them to avoid the stigma and what they believe are negative consequences of being labeled. The label of ‘weak’ or the shame of being weak, which is not something associated with this special population (Hagens, et al., 2017). Earlier research indicated it was self-stigma which had a greater impact than public stigma on first responders and thus needs to be considered when planning interventions (Karaffa, et al., 2016, p. 771).

An example of how stigma is reinforced within the culture of first responder can be seen in a situation involving 45-year-old Eatonville Police Department officer Omar Delgado. Officer Delgado worked the Pulse nightclub mass shooting on June 12, 2016. During that incident 49 people were killed and many others were injured. Officer Delgado was one of the first on the scene and is being called a hero for the people he helped saved as he went into the building said to be littered with bodies and assisted the injured out. Officer Delgado is suffering with Post Traumatic Stress Disorder and is being terminated from his job just months before he would be fully vested. His yearly income is $38,500 and because he is being terminated before being fully vested, he will receive only 42% of his yearly income. If he were to be fully vested, he would receive 64% and benefits for life. The explanation for his termination is that they need someone to fill the position he can no longer perform. Officer Delgado has been on desk duty since the critical incident (Hayes, 2017).
Stigma keeps first responders from seeking the help they need for the mental health issues caused by their chronic exposure to critical incidents as well as personal issues. First responders believe that their peers are less willing to seek mental health services than they are actually were. This is a misconception that is impacting this group by possibly causing the group to be less truthful and leading them to change their behaviors. In order to reduce pluralistic ignorance, it is important to challenge misconceptions, encourage conversations which will present actual attitudes and group norms (Karaffa, et al. 2016, p. 773).

It should also be noted that the use of alcohol seems to have a connection to stigma. There are also indicators that people with positive screenings for depression and PTSD endorse barriers to care and stigma more often that those who screeners were negative. There was evidence that showed if people had previous mental health care experience, they were more likely to use services and have a more positive attitude and stigma tolerance. However, the greatest encouragement is found in peer support programs (Haugen et.al. 2017, p. 223).

Other Barriers

Stigma is a primary boundary to care for first responders, however other issues can be barriers to care as well. First responders have identified a number of areas with which they are concerned. Research showed that first responders indicated that the most common barrier was scheduling appointments and not being aware of where to go to get the help. People expressed concern as to the confidentiality of the services provided. They were also noting having difficulty getting time off from work and even being discouraged by leadership to receive mental health services. There was continued reports that some first responders we feared the negative impact that seeking mental health services would have on their career (Haugen et.al., 2017, p. 223).
Strategies for Counselors

When working with a first responder client the most important thing to consider is they are human first and so are we (Glenn, 2017). We must also keep in mind that sometimes they are not ready to talk about the details and they are often not emotional, it is the physical information that can open doors and it is the basic needs that need to be met. Just be there, help them to normalize their feelings, break down the stereotype.

It is important to educate ourselves about this special population and try to understand, not only what they do but also who they are as a group and also individuals as they seek assistance. We must try to understand ways to assist to bring down walls of stigma in order to educate and help each other in their time of need. This special population, as well as their leadership and the community, need assistance to breakdown unrealistic stereotypes and redefine what “first responder” really means and help all to see “human first.” Maslow’s hierarchy gives a clear picture of what we all need, this includes the first responder in times of crisis and the day to day chronic exposure to critical incidents and vicarious trauma.

Consider the basic needs of a first responder in time of crisis, which for many is all the time, given their constant exposure to critical incidents, the basic needs are food, water, warmth and rest. In a situation where they are working long hours, sometimes outdoors, in extreme conditions, there is a possibility these needs are not being met as was the case in New York City on September 11, 2001. People were working long hours and food and water were not at the top of anyone’s list. People needed to be reminded, food and water needed to be brought to them, they often collapsed in exhaustion. Also, part of basic needs for Maslow is security and safety. This one is big for first responders due to the nature of many critical incidents such as fires, mass
shootings, robberies, and domestic disputes, for example, these situations can be very volatile. They do all they can to secure these situations, but there are no guarantees.

The psychological needs in the hierarchy include intimate relationships and friends. This for first responders can difficult. Families can feel left out because the connection that first responders have with their crew, partner, squad, etc. is typically pretty close. They rely on each other, often to stay alive. They share things together that they share with no one else in the world. See things, hear things, experience things which are not shared with their family. It is hard for families to understand and it can be hard even for the first responder to understand. The life of a first responder can be hard on an intimate relationship as well as on friendships a person had prior to entering the first responder life (Lumb, 2014).

We all want to feel a sense of accomplishment and that is part of the life of a first responder as well. Going into the line of work you want to save people, help people, make a difference in the world. However, media coverage of misconduct, people dying due to slow response, wrong address given, and more, can lead a first responder to feel failure, question themselves and fear how they are seen in the community. The ultimate goal would be to fulfill your full potential and be all you can be, but with the chronic critical incidents and vicarious trauma it is difficult for first responders to focus on their accomplishments.

As counselors, we can better acquaint ourselves with the first responders by working closer with them to understand who they are and what they do. We can do things such as ride along experiences. This would give us opportunities to understand what their lives are really like. It would not necessarily mean we would be in the middle of a critical incident ourselves, however, it would allow us time with a first responder to hear their stories and see the world a bit
more through their eyes. This type of experience can be arranged through a local police, fire, or EMS agency.

As described earlier, Glenn (2017), is a great resource. This book offers a no-nonsense approach to educating first responders to what is happening to their bodies when they are exposed to chronic trauma and critical incidents. This approach, according to Glenn, seems to be the best tactic with this particular population. In her experience, this special population responds well to the physiological explanation of what is occurring in the brain rather than the emotional explanation. She advises that when first responders can see something happening in the body, they are more acquiescent.

Spending time learning about the first responder culture by reading articles, listening to podcasts and talking to local first responders, would be an important way to introduce ourselves to this special group. As counselors, we need to get to know what is happening inside and outside the firehouse, squad room, rescue squad building, and communications center. We need to see what these people are like as ‘people.’

Teaching beep breathing techniques which encourage the individual to focus on the body’s movement as they breath have been found beneficial. Other practices such as mindfulness imagery and progressive relaxation have also shown beneficial. These techniques have helped reduce symptoms of depression (Chopko, 2018).

Counselor Education

As counselors, it is important that we understand our own feelings related to first responders. Educating ourselves about their selection process, training and education process and their special needs, is vital for counselors to serve as good therapist for this special populations. The unique needs of this group would indicate the need for counselors to seek training in areas of
direct and vicarious trauma as well as chronic trauma and second-hand shock, PTSD and suicide prevention.

First responders have a culture all their own. This is a group of people who have been trained to go where others do not want to go. They are willing to be self-sacrificing and they go into their respective academies as civilians but come out connected to one another, willing to die for one another and in many cases, leave behind the life they once knew. This includes leaving behind old friends, old habits, and old ways of living their lives. They have now become different people with new beliefs and new ways of doing things. They have new responsibilities, and this takes priority; it is a new identity (Lumb, 2014).

Counselors need to educate themselves related to symptomology of PTSD, depression, anxiety and substance use. They also need to be aware of techniques for grounding, and it has been recommended by Tania Glenn (2017), the use of EMDR works well for first responders who are dealing with PTSD. Relaxation techniques are also important.

Group counseling for first responders should be considered but in order to implement this properly, you must consider a few points. Dr. Glenn (2017) indicated that the use of a circle format for group counseling with first responders does not work well. She stated that if you are using the room where these people typically congregate for roll call or other meetings, maybe even their meals, you are making it into a space where they are going to feel uncomfortable. Place the chairs in rows where they are not having to face each other. You will also want to have snacks and coffee, water or something there for them. Make the group as physically comfortable as possible. It is vital that the time allows for as many people as possible to attend, especially if this is post crisis. Also know your audience. Do not have people who were first on the scene with
people who heard about it two days later. This can cause more trauma. If at all possible, have a peer support leader with you in the group (Glenn 2017).

**First Responder Education**

In order to assist first responders in their journey through their career and help them survive emotionally, counselors need to assist with educating leadership on the importance of mental health. We can encourage leaders to improve training and work to improve job satisfaction, which some research indicates improves first responders’ resilience in times of crisis. Focusing on positive emotions in the pre-crisis, during crisis and post-crisis times, will also improve resilience and satisfaction with life and overall sense of well-being (SAMHSA, 2018).

It is also important to recognize that not only do different people experience and process things differently, but we need to work with people and the recognize that how they responded to an event is also important to their care. For example, a first responder who was first on the scene of a horrific accident involving multiple fatalities, including children, is going to experience this incident in a different way than the first responder directing traffic. That first responder will also experience the incident in a different way than will the person in communications, and the person who was off duty and hears about it later from a colleague will experience in another way. The many different aspects related to proximity physically and emotionally to the incident will contribute to impact on the first responder (Glenn 2017).

Leadership and management working with First responders should be educated to take a positive approach to the use of mental health services with their teams. The ‘why’ is not important, however the fact that each member _IS_ seeking mental health services (Spencer-Thomas, 2015) should be what is important. This can encourage people to use the services
without feeling singled out or judged. This approach could make members feel confident in their
decision. Members of this unique group are encouraged to stay fit, use the gym, stay healthy and
this could be another area of their lives that leadership/management, could encourage them to
maintain by keeping it positive and having an ‘everyone is doing it’ attitude.

Working with leadership to organize peer mentoring and support groups is the ideal type
of support for first responders initially. Counselors can assist with the training of peer groups as
a way to reduce the fear and improve communication and accessibility of services and to
establish credibility. These experiences offer opportunities to normalize their feelings and
emotions, thus reducing stigma and improving the possibility they will continue to receive
services.

**Screening**

Counselors can use screeners in individual and in group settings for depression, anxiety,
alcohol and suicide. It is with these screeners that we can identify the needs of our clients or have
a baseline from which we work. We can use the BASC depression and anxiety screeners to give
us valuable information in these two areas. The Columbia Suicide screener can give us
information regarding suicide to help start the conversation regarding this topic and help the
client, as well as the counselor, see from where the client may be coming on this topic. There are
many resources from which we can pull screeners for use in individual sessions and groups.

Mental health screening was part of the intake process for my husband when he became
part of his initial assignment in law enforcement. It was again when he changed agencies after 27
years. This is an indication that some level of mental health evaluation is done at some level in at
least those two agencies, and likely more to some degree. Given the rate of suicides in the first
responder population, it seems to make sense that we should be screening more often. First
responders have annual physical examinations to ensure they are physically healthy enough to do their jobs. Mental health check-ups are not typically part of that check-up other than possibly a general question or two. It is curious to think about if this should be part of the annual check-up.

Since there is research to show that cumulative stress reduces productivity and leads to missed days from work, that alone should encourage employers to look into ways to improve the overall well-being of their employees. Physicians and other medical professions in a primary care setting have access to a Primary-Care PTSD screener (Robertson, 2019), that can be helpful to them with this special population and give important information that could assist in directing people to the mental health resources they need.

Community Education

Community education must begin by first helping people understand that first responders are human first. People have chosen to serve their community in this way, however, they themselves are citizens and members of the same community. They feel pain, fear, sadness, loneliness, depression, anger, and loss. They do not wear superhero capes; they are not immune to the tragedy they witness, and they are not without fault. They make mistakes, and they fear them. They have to make decisions in a split second, they do not have hours, days or replay to decide what is or would have been the exact right thing to do. They are doing the best they can to do what others have chosen not to do.

Counselors need to help educate the community by helping to normalize the emotions of first responders in the community to its people. It is okay for a first responder to be sad, afraid, upset, overwhelmed. It is also up to the mental health community to help educate others about the impact of vicarious trauma and chronic exposure to critical incidents. People do not know what they do not know so it is part of the mental health community’s responsibility to teach
others about these important topics in order to close the gap between our first responders and the communities where they serve.

Conclusion

To understand and recognize the extraordinary needs and serve the people in the special population known as first responders are great honors and responsibilities. There is a unique culture and exceptional amount of pressure, both self and communally inflicted on these incredibly dedicated public servants. This population must be treated within the mental health community, in ways which is more specific to their needs, as well as to their ways of relating to the world and their understanding of their role in that world. It is the responsibility of counselors and other mental health practitioners to educate themselves to the possible outcomes of chronic exposure to critical incidents and vicarious trauma. Counselors must become culturally competent as it relates to the first responder culture as well as the cultures within it. We must also understand the impact stigma, health, personal history, worldview and community have on mental health and overall wellbeing of first responders. Counselors also need to be honest with themselves and think about their personal views this special group. What biases are held, what expectations are there, what influences the counselor’s view of this population, in order to better serve these clients.

Reducing death by suicide and mental health issues, improving overall wellness, and increasing of job performance, as well as quality of life, is the ultimate goal in this group. In order to realize these improvements, we must reduce barriers to care by making peer resources more readily available, offering more flexibility in services, speaking in physiological terms, and normalizing clients’ responses to chronic exposure to critical incidents and vicarious trauma.
Stigma and the culture of the first responder seem to be the biggest barriers to care. The fear of job loss and not being tough are outcomes for seeking care that need to be replaced with an attitude of normalizing mental health care for first responders as we do physical care. Counselors, communities, families, and friends must make themselves available to our first responders, allowing them to be ‘human first.’ We need to give them space to feel and express emotions without judgement or fear, because the truth is it may save their life.
Reference


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Heyman, M., Dill, J., & Douglas, R. (2018). Police officers and firefighters are more likely to die by suicide than in line of duty, Ruderman Family Foundation [White Paper].

http://rudermanfoundation.org/


PR Newswire, (2018). University of Phoenix finds 93 percent of first responders say mental health is as important as physical health: mental health survey.


https://illiad.lib.jmu.edu/illiad/illiad.dll?Action=10&Form=75&Value=696419


https://youtu.be/fBJbo7mnnBs

Resources

Columbia-Suicide Severity Rating Scale

https://www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf

Life Events Checklist (LEC)


Patient Health Questionnaire (PHQ-9)


The Alcohol Use Disorders Identification Test (AUDIT)

### COLUMBIA-SUICIDE SEVERITY RATING SCALE

**Screen Version**

<table>
<thead>
<tr>
<th>SUICIDE IDEATION DEFINITIONS AND PROMPTS</th>
<th>Past month</th>
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<tbody>
<tr>
<td><strong>Ask questions that are bolded and underlined.</strong></td>
<td><strong>YES</strong></td>
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**Ask Questions 1 and 2**

1) **Wish to be Dead:**
Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.

\[ \text{Have you wished you were dead or wished you could go to sleep and not wake up?} \]

2) **Suicidal Thoughts:**
General non-specific thoughts of wanting to end one’s life/commit suicide, “I’ve thought about killing myself” without general thoughts of ways to kill oneself/associated methods, intent, or plan.

\[ \text{Have you actually had any thoughts of killing yourself?} \]

If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.

3) **Suicidal Thoughts with Method (without Specific Plan or Intent to Act):**
Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. “I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.”

\[ \text{Have you been thinking about how you might kill yourself?} \]

4) **Suicidal Intent (without Specific Plan):**
Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to “I have the thoughts but I definitely will not do anything about them.”

\[ \text{Have you had these thoughts and had some intention of acting on them?} \]

5) **Suicide Intent with Specific Plan:**
Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.

\[ \text{Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?} \]

6) **Suicide Behavior Question:**

\[ \text{Have you ever done anything, started to do anything, or prepared to do anything to end your life?} \]
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.

If YES, ask: **How long ago did you do any of these?**
- Over a year ago?
- Between three months and a year ago?
- Within the last three months?
# COLUMBIA-SUICIDE SEVERITY RATING SCALE

*Screen Version*

## SUICIDE IDEATION DEFINITIONS AND PROMPTS

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<thead>
<tr>
<th>Question</th>
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<th>No</th>
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<td>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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New York State Psychiatric Institute, 1651 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu
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### PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**NAME:** __________________________  **DATE:** __________________________

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "✓" to indicate your answer)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(Higher scores indicate greater depression. A score of 10 or more is suggestive of a diagnosis of depression. Your healthcare provider can make this diagnosis."

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not at all
- Somewhat difficult
- Very difficult
- Extremely difficult

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A2663B 10-04-2005
PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✔️ in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder
- if there are at least 5 ✔️ in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder
- if there are 2-4 ✔️ in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✔️ by column. For every ✔️: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Box to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✔️ Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Depression Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>Minimal depression</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild depression</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate depression</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe depression</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe depression</td>
</tr>
</tbody>
</table>

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LIFE EVENTS CHECKLIST (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally, (b) you witnessed it happen to someone else, (c) you learned about it happening to someone close to you, (d) you’re not sure if it fits, or (e) it doesn’t apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

<table>
<thead>
<tr>
<th>Event</th>
<th>Happened to me</th>
<th>Witnessed it</th>
<th>Learned about it</th>
<th>Not Sure</th>
<th>Doesn’t apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Natural disaster (for example, flood, hurricane, tornado, earthquake)</td>
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<td>2. Fire or explosion</td>
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<td>3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)</td>
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<td>4. Serious accident at work, home, or during recreational activity</td>
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<td>5. Exposure to toxic substance (for example, dangerous chemicals, radiation)</td>
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<td>6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)</td>
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<td>7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)</td>
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<td>8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)</td>
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<td>9. Other unwanted or uncomfortable sexual experience</td>
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<td>10. Combat or exposure to a war-zone (in the military or as a civilian)</td>
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<td>11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)</td>
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<td>12. Life-threatening illness or injury</td>
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<td>13. Severe human suffering</td>
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<td>14. Sudden, violent death (for example, homicide, suicide)</td>
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<tr>
<td>15. Sudden, unexpected death of someone close to you</td>
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<td>16. Serious injury, harm, or death you caused to someone else</td>
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<td>17. Any other very stressful event or experience</td>
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</table>
The Alcohol Use Disorders Identification Test (AUDIT), developed in 1982 by the World Health Organization, is a simple way to screen and identify people at risk of alcohol problems.

1. How often do you have a drink containing alcohol?

(0) Never (Skip to Questions 9-10)
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily
6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never  
(1) Less than monthly  
(2) Monthly  
(3) Weekly  
(4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?

(0) Never  
(1) Less than monthly  
(2) Monthly  
(3) Weekly  
(4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never  
(1) Less than monthly  
(2) Monthly  
(3) Weekly  
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

(0) No  
(2) Yes, but not in the last year  
(4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?

(0) No  
(2) Yes, but not in the last year  
(4) Yes, during the last year

Add up the points associated with answers. A total score of 8 or more indicates harmful drinking behavior.