See conference presentation: Nov. 20, 3:00-4:00 p.m. "Incorporating Trauma Informed Services into Emergency Management"

Trauma Informed Emergency Management: Past, Present, Future

By Raquelle Solon, Business Solutions Engineer, FEI Behavioral Health, Milwaukee, Wisconsin

Knowing where we've been helps to shape the future of where we want to go regarding traumatic stress management.

Traumatic or critical incidents are situations that would cause any of us to experience intense emotional, mental and/or physical reactions. Our ordinary ability to cope is literally overwhelmed.

These experiences often are triggered by a fear of serious injury, threat of violence or death, or witnessing of the same. The same can be said for repeated exposure to lower-level stressors, such as job insecurity or excessive workloads, without resolution or support.

Incorporating trauma-informed approaches for emergency management and first responder teams is critical to maintaining their well-being, health and resilience.

Honor the Past

"Idiotism" from the late 1700s and "hysterical" in the 1800s were the unflattering, and by today's standards insulting, terms used to describe the symptoms of traumatic stress experienced by individuals firsthand and/or from witnessing events.

In February 1915, the term "shell shocked" would appear in the medical journal *The Lancet*. It would be around this same period that French psychiatrist Regis, during his review of mental disorder cases, found that 80% of World War I combatants presented with no physical wound, "but in all cases fright, emotional shock, and seeing maimed comrades had been a major factor."

Post Traumatic Stress Disorder (PTSD) wasn't officially a diagnosis with specific symptoms and added to the American Psychiatric Association's (APA) *DSM-III* until 1980, though the *DSM-I* published in 1952 referenced "gross stress reaction." PTSD is the basis for understanding traumatic stress in the field of first responders.

Acute Stress Disorder (ASD) was introduced in APA *DSM-IV* in 1994 and can present whenever there is a traumatic stress event, from a car accident to random acts of violence. This disorder is different than PTSD as it affects the individual from three days to four weeks. After the four-week mark, the symptoms are no longer considered acute, and the individual is assessed for transition into PTSD.

The pinnacle event that led to wider recognition of traumatic stress in first responders was Sept. 11, 2001. 9/11 was the catalyst for engagement of first responders to seek help with counselors, employee assistance programs (EAPs), and other practitioners. This event is where we first started learning about helpful interventions from cognitive behavioral therapy (CBT), which focuses on improving emotional regulation; developing coping strategies and problem-solving; Eye Movement Desensitization and Reprocessing (EMDR) therapy, which can relieve psychological stress; and massage and breathing techniques utilized to alleviate stress.

Treasure the Present

The events of 9/11 highlighted the need to have interventions with emergency management/first responder teams as the focus. First responders don't do well with traditional interventions. Instead, there's a need to first reach a safe place to debrief and/or defuse with their peers, allowing them to put words to thoughts, feelings and reactions, which help to integrate memories of critical events in a healthy way.

Another outcome of 9/11 was solidifying what was already known about ASD and PTSD in the workplace: that organizations need to add policies, procedures and training with a focus that normalizes the psychological effects on people in emergency management. Just by the nature of doing their job – responding to emergencies – there can be injury due to traumatic stress.

Today we have the brain science to understand traumatic stress and the impact it can have on an individual neurologically, biologically, psychologically and socially. 9/11 is an example of acute trauma, a traumatically stressful event over which those affected have little or no control.

In addition, we now have information about the effects of other types of trauma, such as the Adverse Childhood Experience (ACE) study and the life-long effects an individual may have; historical trauma and the potential of epigenetic effects; and secondary trauma, where events aren't experienced firsthand but through hearing stories or witnessing events. This scientific evidence explaining cause and effect

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helps to alleviate some of the stigma associated with seeking assistance.

Treasuring today means recognizing the value of non-clinical stress reduction interventions. One of those is peer support. A peer support team is a core group of employees who are trained to provide support, information and referral for co-workers in need of assistance related to a critical incident, day-to-day work stress or personal/life stress. It can be informal or very formal, but whatever the structure, peer support is a non-judgmental, safe and supportive relationship between people who have a lived experience in common and can provide emotional and social support. This can bridge the gap for EAP clinicians and help the organization build a healthy employee base.

Another intervention tool utilized today with emergency personnel is defusing or psychological triage. This is more immediate in nature than peer support, typically occurring within hours of the event. Its aim is providing rapid stress relief and stabilization immediately following the critical incident. It is provided by a trauma-trained responder through either individual or group attendance of personnel involved in the critical event.

Sadly, today first responders are 20% more likely than the general public to commit suicide, with rates for police being higher than those of EMT and firefighters. Suicide is the most severe, but not the only, problem. Approximately 29% of firefighters abuse alcohol, up to 40% of EMT's engage is high-risk drug and alcohol use, and 25% of police have an alcohol or drug use issue.

Loneliness, isolation, stigma, fear, shame – any and all of these can contribute to the overwhelming feelings resulting from both acute and prolonged exposure to traumatic events, which can lead to unhealthy coping behaviors or, at its worst, to suicide. While we are on the path of awareness and recovery, we still have work to do.

Shape the Future

Everyone can be affected by ASD. However, those with a higher ACE score will have more vulnerabilities and triggers than someone with no ACE score. Brain science supports this and can help us remove the stigma associated with addressing mental health concerns. Viewing the brain for what it is, a working organ in the body, also can help remove the stigma associated with seeking treatment. Treatment for major depression has a 65% success rate whereas heart disease only has a 41%-52% success rate – but no one is stigmatized for visiting a cardiologist.

Focusing the future on mental health support through the interventions mentioned earlier, paired with wellness and resilience, can strengthen both employees and the organization. Embedding counselors in the workplace as an internal EAP resource focused on the wellness of those in critical incident response roles and who can partner in establishing peer support programming, along with strategic partnerships of external EAP providers, will be crucial to reducing the attempted and successful suicides of emergency personnel.

Promote healthy relationships in the workplace. There is power in connection. When someone hears their peer who they view as a "big strong tough guy" share the stresses he or she experiences, a connection that someone else feels the same way forms that is integral to the healing process. Strong connections also can stave off loneliness and isolation. Futuristically, organizations can go as far as teaching the family members, friends, and significant others of emergency teams about traumatic stress so they are able to engage with more support, compassion, empathy and understanding.

Emergency managers and responders live with both acute and secondary traumatic stress by nature of their professions. As younger generations start filling these roles, it's important to start with self-awareness. Know your ACE score. Have a safe place in your life where you can go and recharge, allowing your adrenaline and cortisol to release. Be open to wellness and resilience programs. Have an established group of people you consider safe who you can defuse and debrief with, along with teaching your social circle about possible effects on your well-being.

Conclusion

In closing, we've come a long way from derogatory and non-trauma informed views such as "idiotism" or "hysterical." We're doing great work today with peer support, debriefing, defusings, psychological first aid, etc. But there's still work yet to be done. When the stigma is completely gone, we'll have removed the "pull yourself up by your boot straps" mentality from our way of thinking, recognizing the complete person physically, emotionally, psychologically and spiritually. Complete person wellness and individual resilience will be paramount, because we'll have realized that healthy employees means stronger organizational resilience with better outcomes. ▲