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**Early Mental
Health
Intervention for
First
Responders/
Protective
Service Workers
Including
Firefighters and
Emergency
Medical Services
(EMS)
Professionals**

Robbie Adler-Tapia

1 Adler-Tapia, R. (In press). Early Mental Health Intervention for First Responders/Protective Service Workers Including Firefighters and Emergency Medical Services (EMS) Professionals. In M. Luber (Ed.), *Implementing EMDR Early Mental Health Interventions for Man-made and Natural Disasters: Models, Scripted Protocols and Summary Sheets*. New York: Springer Publishing Company

“We wait, we hope, we pray, until you come home again.”

-Oprah Winfrey

Introduction

First responders or Protective Service Workers who respond to manmade and natural disasters experience daily career exposure to acute stress and trauma. By working in professional positions in law enforcement, fire sciences, emergency medical services, search and rescue, 911 operators and dispatchers, emergency room staff (including doctors and nurses), child welfare workers, and even psychotherapists, these individuals experience direct or secondary trauma from the work environment. The work of caring for the emotional and physical needs of others takes its toll on those in the trenches. In these inimitable circumstances, the exposure can lead to direct traumas and/or vicarious trauma for the professional in a first responder role.

This chapter will focus on clinical skills for providing emergency mental health services to first responders while adhering to the EMDR protocol in the treatment of those professionals who are exposed to trauma in the line of duty. Case conceptualization is considered through the lens of the Adaptive Information Processing Model (AIP). The reader will learn how to develop a comprehensive treatment plan with methods for advanced resourcing skills and treating professional traumas specific to first responders. Psychotherapy requires a dance between ongoing encounters with trauma in the line of duty while considering complicated forensic issues. Personal and professional trauma arises out of the mission of first responders whose role it is to protect and serve the public.

The Mission of First Responders

Since law enforcement was included in a previous chapter, this one will focus on all other “first responders” also referred to as “protective service workers.” First responder is a

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broad term that attempts to capture those who serve in many roles caring for the health and safety of the community in emergency and crisis situations. There are structural, wildland, and aerial firefighters; Emergency Medical Services (EMS) that includes paramedics, Emergency Medical Technicians (EMT), Search and Rescue professionals, as well as emergency personnel in Hospitals and other medical facilities including doctors, nurses, physician's assistants, and Ancillary Staff. First responders have also included mental health professionals who work in crisis treatment roles, child welfare workers who care for abused and neglected children, and emergency dispatchers/911 operators who take the calls and dispatch first responders. Structural firefighters commonly work in more urban areas responding to fires and safety issues in structures, transportation accidents such as occurs with automobiles and trains, and to injured persons. Wildland firefighters often fight fires in the open spaces in forests and deserts. Aerial firefighters are those who fight fires from the air by dropping water and/or fire retardant. No matter what the title or assignment, the mission of these professionals is to respond to natural and manmade disasters, and crisis situations that threaten the safety and welfare of others. First responders go to the scene exposing themselves to personal and psychological traumas in order to care for the health and safety of others.

There are no international statistics published on the numbers of first responders in the world; however, the Centers for Disease Control (CDC) reported in 2006 that,

Approximately 800,000 firefighters in the United States are volunteer firefighters and 300,000 are career firefighters. Volunteer firefighters primarily serve communities with fewer than 25,000 inhabitants, whereas most career firefighters serve communities of more than 25,000 persons. (CDC, (April 28, 2006) Weekly, Morbidity and Mortality Weekly Report, 55 (16), pp. 453.

In addition, "a 2003 survey of State EMS directors found 669,278 licensed providers in 48 States and 4 territories."

(http://www.ems.gov/pdf/EMSWorkforceReport_June2008.pdf)

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Internationally, the numbers of first responders predictably includes millions of individuals who are exposed to trauma in the line of duty. These professions expose individuals to a higher rate of personal threat both physically and psychologically while also witnessing the horrific traumas to others.

The Cost of the Career

The daily wear and tear of the job takes a toll on the individual, departments, and families. Compared to the general population, with an estimated 6.8% lifetime prevalence rate of PTSD for American adults, (as reported by the 2005 National Comorbidity Survey Report), firefighters are at increased risk for developing PTSD. The International Association of Fire Chiefs' Foundation (1991) stated that,

Stress is one of the most serious occupational hazards in the fire service, affecting health, job performance, career decision-making, morale, and family life. Emotional problems, as well as problems with alcohol and drugs, are becoming increasingly evident. High rates of attrition, divorce, occupational disease, and injury continue... [and] suicide is a real and tragic alternative for some." (<http://www.IAFCF.org>)

First Responders with high PTSD scores are also at a 3 times greater risk for developing metabolic syndromes (dyslipidemia, high blood pressure, and glucose intolerance. (First Responders Foundation; <http://www.1strf.org>). Therefore, in addition to mental health issues, first responders are at higher risk for chronic health issues and injuries including hypertension, cardiac crisis, obesity and diabetes from shift work. For first responders, the cost of the career is evident in many areas as the role includes chronic exposure to traumatic events. Some of the events are unique to the line of duty.

Trauma

Professional trauma is responding to and witnessing an actual or **perceived** threat to the safety/integrity of self or others that may result in intense fear or helplessness in response

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to an event. Research suggests “powerless in the face of an event” often is what causes the client to experience the event as traumatic. For first responders, responding to and witnessing a critical event or a series of distressing life events over time can lead to medical and/or physical symptoms and long-term consequences. The perception of any event varies depending on the individual, but any event with sufficient impact to produce significant emotional reactions in the present or future may need to be reprocessed. Critical incidents are commonly considered to be extremely unusual in the range of ordinary human experiences, but are daily occurrences for first responders. Such critical incidents may include: crew members death in line of duty, the death or serious injury of a child, multiple fatalities or seriously injured survivors, attempted or successful suicides, natural disasters, personal mishaps involving death or permanent injury and otherwise high emotional impact, deadly force incidents, grotesque injuries, acts of terrorism, acts of violence resulting in injury or death. Ultimately, professional trauma is anything that negatively impacts the psyche and changes the course of healthy development.

Targets of Professional Exposure

In addition to witnessing and experiencing horrific natural and manmade events as part of the career, targets of professional exposure include death notifications, personal exposure, when professional colleagues are hurt or killed in the line of duty, unique sensory flashbacks, and the residual impact of habitual stoicism, depersonalization and derealization. Targets for reprocessing for first responders can be organized with the “Parade of Faces.” See the form for “Parade of Faces” in Phase 1 of this chapter.

Professional Trauma

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In addition to the horrific experiences first responders are exposed to responding to natural and manmade disasters, there are traumas unique to the field. First responders experience “Line of Duty Traumas,” “Line of Duty Deaths” (LODD), and Post-shooting Trauma in Law Enforcement (PSTLE) (Adler-Tapia, 2012).

- *Line of Duty Traumas* are those experienced during work that include witnessing death or near death experiences of individuals in the community, other professionals, or risk to self.
- *Line of Duty Death (LODD)*, are deaths that occur when professionals die in the line of duty. When a LODD occurs, all the other professionals responding to the call are now in an even more stressful position of trying to rescue and treat a comrade.

Finally, there are traumas that occur after the professional event including:

- *Post-shooting Trauma in Law Enforcement (PSTLE)* (Adler-Tapia, 2012) are traumas that occur after the professional event. PSTLE is an acronym to explain the process that professionals must endure following a shooting. Law enforcement and first responders alike may be witnesses to a criminal investigation. The on-going stress further complicates the treatment process. There are firefighters who are also law enforcement such as those who serve

in arson investigation roles and scene management/security; therefore, the line between law enforcement and other first responders is not always clear.

Treating Trauma Exposure for First Responders

Because of the on-going exposure, departments may need a variety of mental health services before, during and after a critical incident. Ideally, training will begin during the training academy and continue throughout the professional's career.

Service needs for the department may include:

- Anniversary Meetings
- Command Consultation
- Family Crisis Intervention
- Follow-up Services
- On-Scene Support Services
- Pre-Incident Training
- Post-Incident Services

Any of these services may be part of what is requested for first responders.

Similarities and Differences with First Responders

Learning the common terms and how the individual professional conceptualizes his or her duty is a crucial part of psychotherapy as each individual is unique. However, with the global term of first responders, it is important for mental health professionals to recognize that there are similarities and differences in the roles that have to do with the duty assignment. The similarities are in the mission as defined above. The differences may be in the assignment, and enactment of the job.

Emergency Services Dispatchers or 911 operators in the U.S. dispatch other professionals to the scene of a disaster when help is needed, but rarely go to the scene. While waiting for other professionals to arrive, these “first, first responders” may need to console a child, give emergency medical directions, and organize the response of the other professionals all from auditory input. These

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individuals may later struggle with the visual creations that occurred when he/she was verbally dispatching assistance. These first responders often work in a call center or facility away from the incident.

Law Enforcement Professionals are more likely to work alone, while other first responders work in teams. Law enforcement professionals may respond to provide assistance to other professionals from the same squad, department, or area, but are often alone in the field responding to calls. Law enforcement professionals may also be in the field observing and trying to prevent crimes from occurring. Communities tend to have a negative perspective of law enforcement because these professionals are tasked with upholding laws.

Other First Responders are rarely alone. A fire crew often includes at least two professionals who depend on each other and tend to live and work together. Professional fire professionals often sleep at the fire department in order to respond faster to calls. Wildland fire professionals may spend weeks together camping in forests and less populated areas as they attempt to prevent and/or control fires that cover large areas. Whatever the assignment, these individuals can spend more time together than they do with their own families; therefore, the role of caring for “brothers and sisters” on the squads or teams of professionals becomes even more stressful and traumatic if someone is injured or killed in the line of duty. Losing “one of our own” impacts everyone more than in most professional work environments. These professionals not only put their own safety and lives on the line for the public, but also for each other. “I’ve got your six” is a term often used to describe that one professional is watching out for the back of another professional.

Ultimately it is important for therapists to ask the individual or the squad, “Tell me about your role and your assignment.” Never assume that just because a client is a first responder, that you have any idea what he or she does; however, therapists need to understand that there are some commonalities in the culture of first responders. The similarities with first responders include psychological defense mechanisms and commitment to “family.”

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Stoicism, Depersonalization and Derealization

Stoicism, depersonalization, and derealization are three common psychological defense mechanisms used by first responders to deal with the wear and tear of the career.

- *Stoicism* is a cultural expectation in that first responders are expected to *not* be impacted by the events to which they respond. This expectation manifests in a unique sense of humor, which can be interpreted as cold and/or disrespectful by others. The uniform and mask of first responders is used to cope with the career and is expected by the culture.
- *Depersonalization* is experiencing an event, but feeling like it is happening to someone else.
- *Derealization* is experiencing an event, but feeling like it isn't real.

Many first responders habitually use these defense mechanisms as the impact of chronic trauma exposure accumulates and becomes destructive both physically and psychologically. At times, the habitual use of depersonalization and derealization can result in delayed onset of PTSD. It is important for therapists to understand that these are ways in which first responders learn to cope when inundated with traumatic events and are part of the professional culture.

With some first responders there are childhood and/or family traumas that accumulate over time and impact the health of the professional. Recognizing the family impact is significant when providing psychotherapy to first responders.

The Families of First Responders

First responders have two families including the traditional family and the professional family. Both families are part of the individual's life and impact his/her response to his/her career.

The Traditional Family

This family includes spouses and significant others, parents, siblings, children, and extended family and friends. One study found empirical support for the presence of secondary trauma among the wives and significant others of firefighters. Research has

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documented the need for the identification and treatment of firefighters with PTSD and their secondarily affected significant others. (Gawrych, 2010). Additional stressors for First Responders are the health and safety of family members. Stress at work and at home often collide to cause a high rate of symptoms in first responders. Research also suggests that the health and support of the professional department and command have a significant influence on how well first responders cope with the daily trauma exposure.

The Professional Family

“My goal is to get home safe to my family and my brothers get home safe to their families, too.” With first responders, the professional family includes the squad and the department. Many first responders and especially firefighters, EMS, and search and rescue live together as part of the job for at least some time during the week. There are several types of firefighters including structural, wildland, and aerial. Most spend some time living together – structural at the station and wildland usually spend the summers together camping in areas to protect the environment and fight fires. EMS professionals usually travel in pairs or as part of a larger team of first responders. Corrections officers are locked in together in one of the most dangerous positions that exist. Because of the co-existence required of the job, these professional families not only protect the community, but each other; therefore, when there are line of duty deaths or injuries, the entire family is impacted.

Mental Health Professional Roles with First Responders

Working with the Department and Command to Provide Post-Incident Services

Working with the Department and Command staff of first responders varies for each situation and department. The Department is the employer of the first responder that interacts with other employees, other departments, and local, state, and national government entities. At times, Department and Command may seek pre-incident services

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such as pre-employment assessments, training, and education. Post-incident services may include consultation from mental health professionals and/or assistance with interventions for first responders and/or communities involved in the incident. Post-incident services are more likely to be provided in the field such as at the scene or at the department, rather than at the therapist's office.

Referrals for Mental Health Services

Along with providing information about PFA and resources included at the end of this chapter, one of the most important interventions for first responders following a natural or manmade disaster is to provide information on how to find a mental health specialist. Most first responders who realize the need for treatment are not sure how to access services. For that reason, this handout was created. See Appendix I, "How to Find a Mental Health Professional."

When responding to the needs of first responders following a natural or manmade disaster, it is helpful for the therapist to assess what services if any are available to the individual.

- Is there an Employee Assistance Program (EAP)?
- Is the EAP internal to the department or an external EAP where the individual is referred to providers in the community?
- What concerns arise from an EAP referral?
- Is there trust with the EAP providers and are the providers knowledgeable about this population and the culture of first responders?
- Is it possible for the first responder to be referred to a private practitioner? For some first responders, the concern exists that seeking mental health treatment may impact professional careers or any legal processes in which the individual is involved.
- If a first responder is a witness, will the therapist's records be protected from the legal proceedings?

Helping first responders understand what services are available and responding to any

concerns about seeking treatment is an important intervention. Once this information is available, the therapist may need to provide some education about the type of treatments that are available to first responders (see the Treatment section below)

How Do Mental Health Professionals Prepare for and Organize a Disaster Response?

Mental health professionals may be involved with preparing for and responding to traumatic incidents and disaster situations. These may include incidents limited to the department and/or larger community situations. In order to respond most effectively, it is important to assess the following needs:

To What Type Of Disaster Are You Responding?

- Are you responding to a *natural disaster* (wildland and/or forest fires, earthquakes, a tsunami, hurricane, flood, epidemic, structural collapse)?
- Or, a *man-made event* (torture, acts of terrorism, war, drug cartel wars, school shootings, gang warfare, robbery, arson, bombs, etc.)?

First responders train for many types of disasters, but the larger the event with the greater amount of individuals displaced and injured, the greater the exposure that can create response and management issues.

Who Invited The Involvement Of The Mental Health Professional?

When therapists work with first responders, one of the most important considerations is who invited the involvement: self-referral or a department referral. The dynamics about the original referral or request impact how the therapist should proceed since first responders are not always comfortable with mental health professionals and may be suspicious of the services.

Note: Earning individual and group trust is the biggest hurdle to efficacy in responding to critical incidents with first responders.

Considering the referral and the following questions are important in making clinical

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decisions when working with first responders.

Elements of a Mental Health Disaster Response

When mental health professionals are invited to provide services by the department and/or by the command staff, there are important logistical issues to consider.

- *Location* - Where will you implement the response?
- *Demobilization* – Will the first responders have time off after the critical incident before returning to work? Or, will the first responders be expected to respond to calls during the intervention? Providing mental health services for professionals who remain on duty may be quite difficult, but for some volunteer and smaller departments, there is no back up so that the first responders can be off-duty.
- *Participation* - Who needs your help and who will be part of the team of responders? What are the needs of the group to be helped?
- *Professional Response* - How many professionals are needed? Do you have enough professionals or, if not, how do you organize your disaster responders?
- *Logistics* - How long is the intervention? Who will organize food and drinks for the group? Feeding first responders is an important part of building relationships and gaining trust. Logistics may also include mental health interventions to augment department practices. Departments may contact mental health professionals, following an “After Action Review,” when concerns arise about the impact of the event on the first responders.

Post Incident Services

After Action Review (AAR)

An “After Action Review” is a common term used in military, law enforcement, and first responders. An AAR is a meeting of the professionals who responded to an event and later review the events in order to improve services and safety for professionals. An AAR often includes the following questions posed to the professionals who responded to the event. Information on the AAR can be found at the following link:

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http://www.queri.research.va.gov/ciprs/projects/after_action_review.pdf

- What was expected to happen? What was our mission?
- What actually occurred?
- What went well and why?
- What can be improved and how?
- What could have gone better?
- What might we have done differently?
- Who needs to know?

Psychological Component of the AAR

Capitalizing on a known process for first responders, therapists may consider adding a psychological component to the AAR, using a CISD/CISM model of response, or a combination of the two. The following questions can expand the AAR to address the psychological impact of the event.

- How did it impact me?
- What do I need to do to care for myself?
- How do I get closure?
- Who else is struggling?
- What if anything do I need/want to do for my brothers and sisters who also experienced this exposure?
- How does this impact our next call? Our next shift?

By teaching first responders to consider these questions, an awareness of the impact of the exposure begins to grow. With this acknowledgement, first responders then need tools to deal with the on-going and cumulative effect of trauma exposure. One common initial service that is a tradition for first responders is Critical Incident Stress Management services.

Critical Incident Stress Debriefing (CISD) AND Critical Incident Stress Management (CISM)

CISM services are an integrated, comprehensive, and multidimensional crisis

intervention system that includes CISD services. These services are intended to help individuals exposed to critical incidents. CISM services can be offered to individuals, but with first responders are most often provided to the group of professionals who responded to the incident. The focus is to provide “Psychological First Aid” as an immediate debriefing in order to minimize the harmful affects of job stress, specifically in crisis or emergency situations. CISD/CISM is most helpful when the department has prepared with pre-incident training.

CISM services include seven steps (adapted from Everly & Mitchell, 1997):

1. *Pre-crisis Preparation*: this includes pre-incident stress management training, education, and skill building.
2. *Disaster or Large-Scale*, as well as, school and community support programs that include demobilizations, informational briefings, "town meetings" and staff advisement.
3. *Defusing* is a 3-phased, structured group activity that is after or soon after- the event for assessment, triaging, and acute symptom mitigation.
4. *Critical Incident Stress Debriefing (CISD)* refers to the "Mitchell Model" (Mitchell and Everly, 1996) This is a 7-phase, structured group discussion, usually provided 1 to 10 days post crisis, and designed to mitigate acute symptoms, assess the need for follow-up, and if possible provide a sense of post-crisis psychological closure.
5. *One-On-One Crisis Intervention/Counseling or Psychological Support* throughout the full range of the crisis spectrum.
6. *Crisis Intervention and Organizational Consultation*.
7. *Follow-up and Referrals for Assessment and Treatment*, if necessary.

With this overview of CISM, the remainder of this chapter addresses post-incident services including referrals, assessment and case management, and treatment.

Self-Referral

If the individual first responder sought out therapy at the mental health professional's office, what are the expectations? This process is similar to a private referral that most therapists encounter, but unique in that there are complicated legal and professional issues involved as previously discussed.

Department Referral

If the Department contacted the mental health professional, there are many more issues to consider.

- What and how will confidentiality be managed?
- What do the individual and/or department expect?
- What is the purpose of the intervention requested?
- What and how will confidentiality be managed?
- Are on-scene services requested? If so, is there a risk to the mental health service provider?
- Does Command/Leadership expect updates about the services?
- If so, how will the therapist correspond with the Department?
- Are there privacy issues that need to be resolved?
- Will there be an Industrial Commission/Workman's Compensation Case?
- Are there criminal issues that impact this mental health process? For example, was the critical incident arson started by someone else?
 - Will this first responder have to testify about the call or any other call? First responders may not be as likely as law enforcement to be involved in criminal proceedings; however, it is imperative that mental health providers consider this possibility from the point of the initial referral and then determine what/if any impact this will have on treatment.

Psychological First Aide (PFA)

The Psychological First Aid (PFA) Field Operations Manual was written to help professionals dealing with man-made and natural disasters. This comprehensive manual provides valuable information for professionals along with training and handouts for survivors of all ages. The manual is available on-line at the following url:

http://www.ptsd.va.gov/professional/manuals/manual-pdf/pfa/PFA_2ndEditionwithappendices.pdf (downloaded 01/15/13).

In addition, there are downloadable applications that all first responders can carry on computers and smart phones to provide immediate assistance in dealing with individuals of all ages from infancy to adult. This tool is helpful to therapists and should be made available to all first responders for self-care and to assist in the line of duty. PFA also provides a way to educate first responders about the impact of exposure to man-made and natural disasters while allowing the possibility that he/she too could be impacted.

With information and education, therapists who work with first responders need to consider how to intervene and what services are necessary when first responders seek out the expertise of a therapist.

Assessment and Case Management

Assessment and case management following a critical incident may require the management of personal health. This may include safety planning, assessment for danger to self (DTS) and/or danger to others (DTO), assessment of individual first responders, referrals for medication assessment and management, assisting individuals in locating appropriate mental health services, and treatment.

Mental health professionals need to consider the legal and ethical complications of multiple roles in training and education, assessment, and treatment. Training and consultation roles may be necessary in order for the mental health professional to act in accordance with professional standards of care. Mental health professionals can respond to the department and/or to the individual; however, it is important to be aware of

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boundaries, confidentiality, and dual relationships. When in doubt, the mental health professional should seek consultation with his/her professional organization and or other colleagues.

Safety Planning

Mental health professionals may be contacted to assess the safety of the first responders. As part of the process, therapists many need to address the following questions.

- How does the therapist intervene if the first responder is still on the job?
- What documentation, if any, will the department request?
- Is there a risk to the public, the individual, and/or other first responders? This risk needs to be assessed in light of the possibility that the first responder is an armed professional.
- Are mental health services a requirement for return to duty?
- What assessment will the mental health provider be asked to provide to the department, if any? In some cases, the mental health services are part of a “Fitness for Duty” process where the department command is trying to determine if the first responder is capable of carrying out his or her duties as a professional.

If the mental health professionals are not part of the Fitness for Duty team, they need to ask about the fitness for duty process in order to make case management and clinical decisions when working with first responders.

- Is a safety plan necessary?
- If so, who needs to know?
- How do you protect a career?
- Is a DTO assessment necessary?
- Is a DTS assessment necessary? How will this occur?

Assessment of danger to self can include the Modified SAD PERSONAS Scale Pearls:

Revised ‘SAD PERSONS’ helps assess suicide risk (*Campbell*) downloaded 03/02/13.

<http://medicine.missouri.edu/psychiatry/uploads/Psychiatric-Interview.pdf>

SAD PERSONAS Scale

- *Sex*
- *Age*
- *Depression*
- *Previous attempt*
- *Ethanol*
- *Rational thinking loss*
- *Social supports lacking*
- *Organized plan*
- *No spouse*
- *Availability of lethal means*
- *Sickness*

After assessing the risk of danger to self or others, the therapist must make an appraisal of how to manage the risk. This may include immediate intervention, contact with department and staff, referral to a higher level of care, and medication management.

Assessment of Individual First

Responders

Assessment is a multi-faceted process including a clinical interview and standardized measures. The assessment should consider both exposure to traumatic events and life stressors along with the evaluation of subsequent symptoms.

Resources for locating assessment tools are included at this end of this chapter.

Referrals for Medication Assessment and Management

In addition to emergency psychological services and on-going mental health treatment, some first responders may need to be referred for medication management and or addictions treatment. Determining the process for this to occur and how the individual first responder's care will be monitored needs to be determined at the onset. Some first responders need assistance in identifying and accessing care. There are different treatment modalities for which first responders can be referred for individual psychotherapy.

Treatment

Treatment Modalities may include debriefings for groups such as CISD/CISM, and/or individual psychotherapy including Cognitive-Behavioral Therapy (CBT), Cognitive Processing Therapy (CPT), Prolonged Exposure (PE) Therapy, and EMDR. For the purposes of the remainder of this chapter, the treatment of first responders will be conceptualized through the phases of the EMDR Protocol (Shapiro, 2001).

This chapter does not replace training in the Standard EMDR Protocol (Shapiro, 2001)

19 Adler-Tapia, R. (In press). Early Mental Health Intervention for First Responders/Protective Service Workers Including Firefighters and Emergency Medical Services (EMS) Professionals. In M. Luber (Ed.), *Implementing EMDR Early Mental Health Interventions for Man-made and Natural Disasters: Models, Scripted Protocols and Summary Sheets*. New York: Springer Publishing Company

and the EMDR Basic Training. The remainder of this chapter will provide a review of the EMDR phases, and scripted protocols with suggestions for modifications when working with First Responders.

EMDR with First Responders/Protective Service Workers

Notes

Treatment Planning and Interventions: Case Conceptualization with EMDR

There are certain issues to consider that effect EMDR Case Conceptualization and Treatment Planning when working with first responders that may alter the “flow” or how to proceed with psychotherapy. One of the most significant factors is the overlay of legal issues. Legal/Forensic issues may include criminal and/or civil litigation.

Criminal Investigations may occur when first responders are responding to an event that is a crime such as arson, homicide, or other criminal events. When proceeding with EMDR, the therapist needs to discuss these issues with the client and determine if there are any issues that may impact the flow of treatment. Furthermore, will the therapist's notes be subpoenaed or will the therapist need to testify? It is prudent to proceed with every client as if there may be forensic involvement.

Civil Court Issues may occur if there will be a civil lawsuit filed against the department and/or against the parties in a case. This could occur in a car accident in which one vehicle driver sues another driver. The first responder may be a witness in a civil case; therefore, the client's records may be requested in the case. The first responder also might have a workman's compensation case against the department if physical and/or psychological injuries are suffered on duty. In this case, the therapist again needs to consider how the treatment process may be forensically complicated.

With any type of litigation, it is important for the therapist to have complete and comprehensive records in compliance with ethical and legal standards. It is helpful to seek consultation from professional organizations and legal professionals in accordance with the mental health professionals' license and training.

If a first responder is referred by his/her department, the therapist must consider

20 Adler-Tapia, R. (In press). Early Mental Health Intervention for First Responders/Protective Service Workers Including Firefighters and Emergency Medical Services (EMS) Professionals. In M. Luber (Ed.), *Implementing EMDR Early Mental Health Interventions for Man-made and Natural Disasters: Models, Scripted Protocols and Summary Sheets*. New York: Springer Publishing Company

that there could be employment issues that also need to be clarified before proceeding with treatment. For example, did the first responder's command staff refer him/her for treatment? If so, what will be expected from the therapist? Will the treatment be comprehensive or focused specifically on work related issues? Is treatment a condition of fitness for duty and/or return to duty?

Comprehensive versus Work-focused Treatment

The therapist must determine if is this comprehensive treatment of event-focused treatment? Event focused treatment occurs when trauma reprocessing is restricted to the specific event or critical incident that brought the first responder into care. When this occurs the therapist may need to use EMD rather than EMDR. With event-focused reprocessing phases of EMDR, there are specific steps included in the treatment.

Phase 1: History Taking, Case Conceptualization, and Treatment Planning Phase

This phase of treatment involves gathering a history of the client's symptoms, developing rapport, conceptualizing the client's needs, and creating a treatment plan. With first responders, a recent incident may have precipitated the treatment referral.

Targets of Opportunity

What brought the individual into the office? The target of opportunity may be the one that is most easily accessed and presented by the client as the precipitating factor for the treatment visit. Those targets may be from a recent professional event, a personal event, or a combination. It is important that mental health professionals honor the information that the client presents as the precipitating event while also educating the client about the possible associated events. This clinical decision will not only impact the treatment process, but also the therapist-client relationship, and the client's willingness to participate in treatment. At times, the precipitating event may be the result of professional exposure.

Targets of Professional Exposure

Targets of professional exposure include death notifications, personal exposure, when professional colleagues are hurt or killed in the line of duty, unique sensory flashbacks, and the residual impact of habitual stoicism, depersonalization and derealization.

Organizing targets for reprocessing for first responders can be organized with the “Parade of Faces.” See the form for “Parade of Faces,” in the Preparation Phase of this chapter and Appendix II.

Diagnostic Challenges

Therapists working with first responders need to consider the diagnostic issues with which the first responder presents for treatment. Some are obvious and some are more subdued.

- How does the diagnostic process impact the individual’s job and career?
- With the specific diagnosis, is the first responder willing and/or able to return to the line of duty?
- If there is a concern regarding the first responder’s wellbeing, what safety planning is necessary?

Phase 2: Preparation Phase

Resources/Tools for First Responders to Manage the Line of Duty

Exposure

There are many resources available to first responders both from the department and from the community. Internet resources are listed below. First responders need to be taught and encouraged to participate in emotional self-care. Emotional Self Care for first responders includes having the right EQUIPMENT.

- **EQUIPMENT** is an acronym for first responders to remind them to maintain their health while in the line of duty.
- Engage your resources and acquire new ones.
- **Quality of Life** is important each day!
- Utilize medical and mental health services

22 Adler-Tapia, R. (In press). Early Mental Health Intervention for First Responders/Protective Service Workers Including Firefighters and Emergency Medical Services (EMS) Professionals. In M. Luber (Ed.), *Implementing EMDR Early Mental Health Interventions for Man-made and Natural Disasters: Models, Scripted Protocols and Summary Sheets*. New York: Springer Publishing Company

- Improve your longevity by participating in daily self-care – diet, exercise, and hearth health
- Prepare for survival by practicing and learning new skills
- Mentor others by modeling healthy professional behavior both on duty and off.
- Educate yourself about the long-term impact of trauma exposure and keep acquiring new resources for coping
- Never forget that you are as important as those you protect, serve, and rescue!
- Take care of each other - at work and at home.

Containers

Training as a first responder is essential but not complete without learning how to contain the intense psychological and physiological experiences from the line of duty. Rather than stoicism, dissociation, depersonalization, and derealization, first responders can be taught various types of containers to cope with the work related exposure. It is important to remind the first responder that a container is not intended to be closed indefinitely, but, instead, to hold the individual's response that would interfere with the work in the present, until the job is done. Sometimes professionals may respond to sequential events and need many containers during a shift. It can be a healthy process to contain traumatic events until a more appropriate time and then address the trauma; however, many first responders never get around to emptying the container. This is the point where first responders need to learn unique skills for being able to respond to calls day after day – year after year.

Phase 3: Assessment Phase

The goal of the assessment phase is to access and activate the memory network for trauma reprocessing. One clinical decision point when using this protocol is whether to do EMD (Shapiro, 1989) or EMDR (Shapiro, 2001). EMD is dedicated to “restricted reprocessing” (Outcalt, 2012, verbal communication) focused on reprocessing one target at a time rather than using the full EMDR (Shapiro, 2001) protocol in which all potential associative links are addressed. After a critical incident with first responders, the

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therapist may decide to proceed with EMD. EMD then restricts the reprocessing to the incident while containing other associative links. This phase is focused on the specific event while containing all other associations.

Phase 7: Closure

At this juncture, the therapist will have structured the therapy sessions in order to implement the procedural steps of the Assessment Phase and move to the Desensitization Phase in one session. The goal is to allow time to have completed the procedural steps and begin bilateral stimulation to reprocess the critical incident in one session.

If this is the first time the therapist has proceeded with the Desensitization Phase with this client, ~~go to Step number 10 below.~~ ?

If the therapist started reprocessing a memory in a previous session, if the session was complete or incomplete, the therapist proceeds with reprocessing the previously identified critical incident.

EMDR and First Responders/Protective Service Workers

Script

Phase 1: History Taking

Say, *“How did it impact you?”*

Say, *“What do you need to do to care for yourself?”*

Say, *“How do you get closure?”*

Say, *“Who else is struggling?”*

Say, “What if anything do I need/want to do for my brothers and sisters who also experienced this exposure?”

Say, “How does this impact our next call? Our next shift?”

I am not sure what this refers to. Should this be fleshed out or in the notes? It seems some of this you already covered.

- Intake
- Assessment
- Documentation
- Flow of EMDR
- Treatment planning while on duty
- Treatment planning while on light duty
- Decisions to return to work as targets for EMDR
- Identifying targets for reprocessing

Target Identification of Parade of Faces for First Responders:

Parade of Faces Script (See Appendix II)

Using the Parade of Faces as the metaphor for creating a targeting sequence plan, A Parade of Faces is a metaphor for all the calls that linger and haunt first responders contributing to the onset of physical and mental health issues. The calls that linger include often:

- First and worst calls
- Child related calls and fatalities
- Suicides

- Calls where the professional felt personally threatened or was injured
- Calls with intense odors and or human remains
- Associations with professional's personal life

Using the Parade of Faces form the therapist can begin collecting targets for trauma reprocessing with EMDR. This first call can actually have occurred long before the client became a first responder. Often the individual witnessed something in childhood. For example, police officers might have witnessed someone being beaten such as domestic violence or a bully. EMS personal have reported witnessing horrific injuries when they felt helpless.

Say, *“When you think about the calls that haunt you, what calls are the most difficult? ___*

Say, *“What is the first call that haunts you?”*

Say, *“Image the calls like a parade that you watch from the first to the most recent call. Those may include calls about suicides, children, severe bodily injuries, and/or body odors such as blood, brain matter, decomposition, burning flesh. When you think about that parade of faces of the calls that haunt you, what’s your negative belief about yourself now? Those might be things like, ‘I should have done something?’ ‘I’m powerless?’ ‘I can’t forget or get over it.’”*

After documenting the negative cognition,

Say “*Now tell me about the first call that made you proud about becoming a first responder?*”

Say, “*Now I want you to think about your positive belief about yourself when you think of your career. What would that be?*”

Say, “*I want you to imagine the parade of the calls that haunt you on a television channel and you have the remote. On what channel would you put all of the calls that haunt you?*”

The therapist now documents the channel for the critical events, and then identifies a channel for the positive events.

Note: The therapist needs to use the terms the first responder identifies about being successful in the field.

Say, “*What channel would you use for all the calls where you felt successful and helpful?*”

Phase 2: Preparation Phase

The goals of the Preparation Phase of EMDR include identifying the resources the client has and teaching additional resourcing skills. The second goal of this phase is teaching the mechanics of EMDR.

Resources

Find out what resources the client has.

Say, *“What are the types of resources that you count on?”*

After the client responds, then ask, about the needed resources.

Say, *“What resources do you need? Ask yourself the following questions:*

Say, *“Do I need to assess my diet and improve my eating?”*

Say, *“Do I need to improve sleep hygiene?”*

Say, *“Do I need to care for my physical health?”*

Say, *“Do I need to learn stress management skills?”*

Say, *“Do I need to explore my spiritual needs?”*

Say, *“Do I need to use the skills I already have?”*

Say, *“Do I need to learn interpersonal skills in order to have healthier personal and professional relationships?”*

Say, “*What residual effects do I carry from my childhood that interferes with my current life?*”

Say, “*What residual effects do I carry around from my personal life that I need to deal with?*”

Say, “*What residual effects do I carry around from my professional life that I need to process?*”

Resilience and Hardiness

Training in resilience and hardiness improves the first responder’s ability to cope with the career and the “wear and tear” of doing the job.

Say, “*How am I assessing the current impact of these issues in my life?*”

If the first responder assesses that there is an impact on his life, find out how he processes current stressors and traumas.

Say, “*What skills and/or tools do I use?*”

Say, “*What skills and/or tools do I need?*”

Professional Grief and Loss Resources

29 Adler-Tapia, R. (In press). Early Mental Health Intervention for First Responders/Protective Service Workers Including Firefighters and Emergency Medical Services (EMS) Professionals. In M. Luber (Ed.), *Implementing EMDR Early Mental Health Interventions for Man-made and Natural Disasters: Models, Scripted Protocols and Summary Sheets*. New York: Springer Publishing Company

Because first responders enter in the middle of the story, they often don't see the beginning or end.

Say, *"How do I get closure?"*

Say, *"What are my religious and spiritual needs?"*

Say, *"Is it appropriate/helpful for me to attend funeral services or practice closure other types of closure?"*

Containers

Teaching first responders how to use various types of containers will help them cope with work related exposure.

Note: Containers are not intended to be closed indefinitely

Containers Script

Say, *"Sometimes we have thoughts, or feelings, or body sensation that get in the way at work or at home. Do you ever have thoughts or feeling like that? I want you to know that if we need to we can put those thoughts or feelings in a container like a box or something really strong that they can't get out. What do you think you would need to hold those thoughts or feelings?"*

Next say, *"I want you to be able to put all of those thoughts or feelings, or what we worked on today in that container. Sometimes we need different containers for different*

thoughts or feelings. Sometimes, it helps to draw pictures of the _____ (container) and make sure it's strong enough to hold everything that you need it to hold.

Let's imagine that everything you worked on today is put in the container and we lock it away/seal it away until we meet next time when we can take it out to work on it again.

When we get together we will work to empty your container so there's always room for new stuff if you need it. If you start thinking about things that bother you that are too hard to handle or it seems to come out before our next session, you can just imagine putting it into the container and sealing it in there until we meet again.”

Phase 3: Assessment Phase

The assessment phase can be remembered using the acronym “TICES:” target, image, cognition, emotion, and sensation.

T The *target* is the critical incident. This can be selected from the “Parade of Faces.” When responding to a recent critical incident with first responders, the target is the event.

Say, “*We discussed the parade of faces that haunt you. For today we agreed that we are going to focus on this critical event _____ (Therapist repeats the target).*”

I The *image* is the worst part of that specific critical incident. If the critical incident is more recent, there may be multiple images that arise. Of the images, the therapist can make a chronological list of the images and start with the first one specific to that critical incident.

Say, “*When you bring up that event we agreed to work on today, what image comes up for you as the worst part of the event?*”

If the critical incident is recent, the therapist can say, “*When you bring up that event, what image is the first image that comes up for you as the worst part of the event?*”

C The *cognitions* are those associated with the critical incident. The negative and positive cognitions need to be consistent and then the therapist needs to assess the Validity of Cognition (VoC).

Negative Cognition (NC):

The therapist may use the negative cognition previously elicited while completing the “Parade of Faces” protocol.

Say, “*When you think about that event, what is the negative belief you have about yourself now?*”

Positive Cognition (PC):

Say, “*When you think about event, what would you rather believe instead?*”

Or you can say, “*What’s the good thought that you want to tell yourself instead?*”

Eliciting the Validity of Cognition (VoC):

Say, “*When you think about those words, _____ (PC), how true do those words feel to you now on a scale of 1 completely false to a 7 meaning completely true?*”

E - Eliciting Emotions:

Say, “*When you bring up that critical incident, what emotions come up for you now?*”

Once the emotion(s) are identified, the therapist needs to assess the Subjective Units of Disturbance (SUDS) on a 10 point scale with 0 no disturbance and 10 the most disturbance the first responder is experiencing in relation to the critical incident.

To elicit the SUDS:

32 Adler-Tapia, R. (In press). Early Mental Health Intervention for First Responders/Protective Service Workers Including Firefighters and Emergency Medical Services (EMS) Professionals. In M. Luber (Ed.), *Implementing EMDR Early Mental Health Interventions for Man-made and Natural Disasters: Models, Scripted Protocols and Summary Sheets*. New York: Springer Publishing Company

Say, “When you think about that incident and those emotions, how disturbing does it feel to you now on a scale of zero meaning no disturbance and 10 the worst you have ever experienced?”

S The *sensations* are the physical sensations the client is experiencing in relation to the critical incident and the corresponding emotions. In order to elicit the body sensations associated with the target the therapist

Says, “When you bring up that incident and those emotions, where do you feel that in your body now?”

After eliciting the procedural steps of the Assessment phase, the therapist continues with the desensitization phase of EMDR.

Phase 4: Desensitization Phase

During the desensitization phase, the therapist is regularly helping the client to contain other associations and focus on the specific critical incident that is the focus of this episode of care. Other associated incidents do need to be documented for possible future care.

To begin desensitization:

Say “I’d like you to bring up that event _____ (label and describe using client’s word), and the words _____ (repeat the negative cognition in client’s words), the _____ feeling, and notice where you are feeling it in your body and _____”
(therapist uses whatever BLS previously identified.)

Begin the BLS. (You established the BLS method and speed during the introduction to EMDR). The type of BLS may need to be changed often in order to assist the individual in sustaining attention.

If the client appears to be too upset to continue reprocessing, it is helpful to reassure the client by saying the following:

Say, *"It's normal for you to feel more as we start to work on this. Remember we said it's like _____(metaphor) so just notice it. It's old stuff."* (This is not always necessary.)

After a set of BLS, instruct the individual by saying the following:

Say, *"Take a deep breath."* (It is often helpful if the therapist takes an exaggerated breath to model for the client, as the therapist asks the client for brief feedback on the process.)

And then say, *"What did you get **now**?"* Or, *"Tell me what you got?"*

Or if the client needs coaching, say, the following: *"What are you *thinking, feeling, how does your body feel, or what pictures are you seeing in your head*?"*

After the client recounts his/her experience, the therapist says the following:

Say, *"Continuing with that incident we're working on, just notice what comes up, and go with that,"*

Do another set of BLS. (Do not repeat the client's words/statements.)

As an optional phrasing you can say, *"Just notice that."*

The therapist does not need to understand what is happening, only the client does because what matters is how the individual has maladaptively stored the information.

Again ask the following: say, *"What do you get now?"*

If new negative material presents itself, continue down that channel with further sets of BLS.

34 Adler-Tapia, R. (In press). Early Mental Health Intervention for First Responders/Protective Service Workers Including Firefighters and Emergency Medical Services (EMS) Professionals. In M. Luber (Ed.), *Implementing EMDR Early Mental Health Interventions for Man-made and Natural Disasters: Models, Scripted Protocols and Summary Sheets*. New York: Springer Publishing Company

Continue with sets of BLS until the client's responses indicate that he/she is at the end of a memory channel. At that point, the client may appear significantly calmer with no new disturbing material is emerging. Then, return to the target by having the client evaluate the progress.

Say, *"When you think about that incident we first talked about today, what happens now?"*

Note: Remember first responders may not show affect because of the culture of stoicism.

There may be no more disturbing material for them to access or describe about the target memory. After the client recounts his/her experience, add a set of BLS.

Say, *"Go with that."*

If positive material is reported, add one or two sets of BLS to increase the strength of the positive associations before returning to target.

Say, *"Go with that."*

If the therapist assesses that the client has reprocessed the critical incident because the material reported is neutral or positive then say the following:

Say, *"When you go back to that incident we talked about today, what do you get now?"*

No matter how the client responds, add a set of BLS.

Say, *"Go with that."*

If no change occurs, then check the SUD.

Say, *"On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"*

35 Adler-Tapia, R. (In press). Early Mental Health Intervention for First Responders/Protective Service Workers Including Firefighters and Emergency Medical Services (EMS) Professionals. In M. Luber (Ed.), *Implementing EMDR Early Mental Health Interventions for Man-made and Natural Disasters: Models, Scripted Protocols and Summary Sheets*. New York: Springer Publishing Company

Use a set of BLS and then repeat this statement until the PC is at a 7.

Say, “Go with that.”

Say, “What do you get now when you think of the incident (or picture), how true do those words _____ (clinician repeats the positive cognition) feel to you now on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?”

1 2 3 4 5 6 7

(completely false)

(completely true)

Once the positive cognition is installed, the final phase of trauma reprocessing is the body scan.

Phase 6: Body Scan Phase

This phase focuses on the first responder’s physiological response to the critical incident. Many first responders learn early in his/her career to disregard personal body sensations while in the line of duty. The Body Scan Phase may be surprising and even disturbing to first responders who have never experienced or dealt with even personal exposure from the career. Since many first responders use dissociation and have to learn to ignore physical sensations, paying attention to those for the first time may be difficult and even alarming. The therapist needs to teach the client mindfulness while also helping him/her to understand what is happening.

Say, “Close your eyes and keep in mind the original memory and the positive cognition. Then bring your attention to the different parts of your body, starting with your head and working downward. Any place you find any tension, tightness, or unusual sensation, tell me.”

Then use another set of BLS.

Say, “Go with that.”

Continue until the client reports a clear body scan. Once the critical incident has cleared,

therapists may need to determine if the first responder wants to continue with additional trauma work or if EMD for this one event is sufficient. No matter what the decision point is at this point in the treatment process, the therapist needs to remind the first responder about learning and using resources to cope with the wear and tear of the career.

Say, *“It is important that you continue to practice the resources we previously identified between sessions in order to cope with the wear and tear of your career.”*

Phase 7: Closure

Complete as much work as time and circumstances allow, leaving adequate time for closure and debriefing. With first responders, the therapist needs to ensure that activated material is sufficiently contained especially if the individual will be continuing to be in the field during EMDR.

(This is the standard one – do you add anything else?)

Incomplete Session

If the session is incomplete, remind the client of the Container Exercise and other relaxation techniques to prepare for ending the session. Skills for first responders were discussed earlier in this chapter. Remind the individual to practice relaxation skills and containers in order to continue being successful in the line of duty.

Say, *“You’ve addressed a great deal of intense issues today and reprocessing could continue over the next few days. Remember to use your container that we talked about earlier and the relaxation techniques we’ve practiced in your sessions. Feel free to contact me if you need additional support.”*

If you have completed the session, say the following:

Say, *“Things may come up or they may not. If they do, great. Write it down and it can be a target for next time. You can use a log to write down what triggers, images, thoughts or cognitions, emotions and sensations; you can rate them on our 0-to-10 scale where 0 is no disturbance or neutral and 10 is the worst disturbance. Please write down the positive experiences, too.”*

“If you get any new memories, dreams, or situations that disturb you, just take a good snapshot. It isn’t necessary to give a lot of detail. Just put down enough to remind you so we can target it next time. The same thing goes for any positive dreams or situations. If negative feelings do come up, try not to make them significant. Remember, it’s still just the old stuff. Just write it down for next time. Then use the tape or the Safe Place exercise to let as much of the disturbance go as possible. Even if nothing comes up, make sure to use the tape every day and give me a call if you need to.”

Phase 8: Re-evaluation

With each new session the therapist obtains feedback on experiences/observations since last session. The client continues to check the Parade of Faces for new traumatic or positive events. The therapist needs to check the SUD and VOC on the previous incident, and for any unprocessed material from previous sessions and probe for any new material that might have emerged.

Say, *“When you think about the incident we worked on last week, what do you get now?”*

After the client responds, say, *“On the SUDS scale, what do you get now?”*

If SUD rating on previous week’s incident is greater than 0, continue reprocessing.

Say, *“Bring up that incident, those words _____ (repeat the negative cognition), and notice where you feel it in your body.”*

Begin BLS.

If the SUDS is zero, but the VOC rating for the previous week’s incident is less than 7 continue to reprocess this target.

If the previous week’s target appears to be resolved (SUDS = 0, VOC = 7), then complete the body scan, then move on to the next target on the treatment plan target list OR move on to target current triggers associated with the critical incidents.

(What about future template?)

This provides a scripted protocol for proceeding through the eight phases of the EMDR Protocol specifically focused on working with first responders and protective service personnel.

Summary

This chapter provided an overview of how to organize mental health services for first responders who experience daily exposure to critical incidents and traumatic events. Services may be offered for training as pre-incident services. Other services may be requested during a critical incident or post-incident. The first responder is a perpetual witness to the suffering of others while at other times the first responder may also become a victim when responding to a critical incident. Significant research documents the physical and psychological consequences of a career as a first responder. With this foundation, first responders need on-going self-care and the efficacious mental health services in order to weather the storm of the career. Responding to the needs of first responders requires familiarity with the culture, respect and earning the trust of the community, awareness of the complicated forensic issues, and adjustments to mental health services such as have been offered with EMDR. Mental health professionals can provide invaluable services to protect the first responder and his/her family.

Resources for First Responders

- A Manager's Guide: Traumatic Incidents at the Workplace, United States Office of Personnel Management, OWR Publication 20 | February, 2003.
http://archive.opm.gov/employment_and_benefits/worklife/officialdocuments/handbooksguides/trauma/index.asp
- American Red Cross – www.redcross.org
- Centers for Disease Control and Prevention (CDC) - www.bt.cdc.gov/disasters
- Center for the Study of Traumatic Stress – www.cstsonline.org
- Critical Incident Stress Management (CISM), Office of Work-Life Programs, U.S.

40 Adler-Tapia, R. (In press). Early Mental Health Intervention for First Responders/Protective Service Workers Including Firefighters and Emergency Medical Services (EMS) Professionals. In M. Luber (Ed.), *Implementing EMDR Early Mental Health Interventions for Man-made and Natural Disasters: Models, Scripted Protocols and Summary Sheets*. New York: Springer Publishing Company

Department of Homeland Security, United States Coast Guard

http://www.uscg.mil/directives/ci/1000-1999/CI_1754_3A.pdf

http://www.uscg.mil/worklife/critical_incident_stress.asp

- Defense Centers of Excellence (DCoE) for Psychological Health and Brain Injury – www.dcoe.health.mil/default.aspx
- Federal Emergency Management Agency (FEMA) – www.fema.gov
- Insure You Can Save a Life! – www.lifeinsure.com/education-center/life-insurance-tips/insure-you-can-save-a-life
- International Association of Firefighters (IAFF) – www.iaff.org
- International Critical Incident Stress Foundation – www.icisf.org
- National Fallen Firefighters Foundation – www.firehero.org
- National Institute for Occupational Safety and Health (NIOSH) www.cdc.gov/NIOSH
- National Integration Center (NIC) Incident Management Systems Integration Division (FEMA) www.fema.gov/national-incident-management-system
- Navy and Marine Corps Public Health Center Portal - www.med.navy.mil/sites/nmcphc/Pages/Home.aspx
- Navy Operational Stress Control (OSC) Official Blog Site – www.navynavstress.com
- Psychological First Aid: Field Operations Guide
http://www.ptsd.va.gov/professional/manuals/manual-pdf/pfa/PFA_2ndEditionwithappendices.pdf ¥ Substance Abuse and Mental Health Services Administration (SAMSHA) <http://www.samhsa.gov/index.aspx>
- The Stress Continuum http://www.uscg.mil/worklife/docs/pdf/stress_continuum.pdf
- U.S. National Response Team (NRT) <http://www.nrc.uscg.mil/nrsinfo.html>
- U.S. Office of Personnel Management (OPM) - *A Manager's Handbook: Handling Traumatic Events*, February 2003 - <http://www.opm.gov/policy-data-oversight/worklife/reference-materials/traumaticevents.pdf>

Assessment Tools

There are many assessment tools available on the United States Department of Veterans' Affairs website at:

http://www.ptsd.va.gov/professional/pages/assessments/all_measures.asp

It is important for therapists to assess for suicidal ideation, trauma exposure, and trauma symptoms.

Suicidal Ideation

Modified SAD PERSONAS Scale Pearls: Revised 'SAD PERSONS' helps assess suicide risk (*Campbell*) downloaded 03/02/13.

<http://medicine.missouri.edu/psychiatry/uploads/Psychiatric-Interview.pdf>

Trauma Exposure

Impact of Events Scale <http://www.ptsd.va.gov/professional/pages/assessments/ies-r.asp>

Life Events Questionnaire (LEQ) <http://nurseweb.ucsf.edu/www/LifeEventsQues.pdf>

Trauma Symptoms

- Peritraumatic Stress Inventory

<http://www.info-trauma.org/flash/media-e/triageToolkit.pdf>

- PTSD Checklist – Civilian Version (PCL-C)

http://www.mirecc.va.gov/docs/visn6/3_PTSD_CheckList_and_Scoring.pdf

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Appendix I: Hand-out, “How to Find a Mental Health Professional

45 Adler-Tapia, R. (In press). Early Mental Health Intervention for First Responders/Protective Service Workers Including Firefighters and Emergency Medical Services (EMS) Professionals. In M. Luber (Ed.), *Implementing EMDR Early Mental Health Interventions for Man-made and Natural Disasters: Models, Scripted Protocols and Summary Sheets*. New York: Springer Publishing Company

How to Find the Right Mental Health Trauma Specialist?

1. First, decide if you want to use your Employee Assistance Program (EAP), insurance, and/or pay privately for services.
2. Many people want privacy and don't want anyone to know he or she is seeking mental health treatment. HIPPA (Health Insurance Portability and Privacy Act) protects you. Any mental health provider should know how to help you do that; however, if you use your insurance, your records are more vulnerable.
3. If you're comfortable, ask for referrals from people you trust.
4. Decide if you want to do individual treatment or group treatment.
5. Check out the provider on-line if they have a website.
6. If you feel comfortable talking with the person on the phone, schedule an initial appointment, but still pay attention to how you feel with the mental health provider. Not everyone likes chocolate ice cream, but that doesn't mean chocolate ice cream is bad.
7. If you don't feel comfortable with the first person you meet, try again because you're worth it.
8. Remember you don't have to tell the mental health provider everything on the phone or even the first few times you meet them. It is the mental health provider's job to know how to help you feel comfortable.
9. Allow at least 3 sessions to establish a relationship with the mental health professional.
10. Make sure you set goals and objectives with the therapist.

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Potential Questions to Ask a Mental Health Provider

1. Are you licensed in the state where you practice?
2. How long have you been in practice?
3. What is your degree? The degree does not mean the provider knows trauma and especially with fire fighters, law enforcement, or EMS personnel.
4. Understanding credentials of mental health professionals
5. Master's level:
 - Licensed professional counselor (LPC),
 - Licensed clinical social worker (LCSW),
 - Licensed marriage and family therapist (LMFT)
6. Doctoral level:
 - Licensed psychologist – Ph.D., Psy.D., Ed.D.,
 - Psychiatrist – M.D, D.O.
6. What kind of training do you have to treat trauma?
7. How many trauma survivors have you treated?
8. Have you ever treated fire fighters and/or emergency personnel?
9. What kind of trauma therapy do you use?
10. What do you charge?

11. How often do you see clients? Weekly? Bi- weekly? Monthly?
12. How do you handle emergencies?

Resources to learn about getting help and PTSD

1. <http://www.ptsd.va.gov/public/pages/finding-a-therapist.asp>
2. http://www.ptsd.va.gov/public/understanding_ptsd/booklet.pdf
3. <http://firefighterveteran.com/ptsd-paper.html>

Appendix II: “Parade of Faces Form”

**Haunted: Parade of Faces
The Calls that Haunt**

NAME:

DISTURBING EVENTS “Tell me about the calls that haunt you even now.”	Timeline Weeks/ Months	SIGNIF. REL.	POSITIVE EVENTS/ RESOURCES The calls that reinforce why I do the job. “Tell me about the calls where you felt successful.”
	Before the academy		
	Academy		
	Rookie		
	1		
	2		
	3		
	4		
	5		
	6		
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Chapter 18a: Early Mental Health Intervention for First Responders/Protective Service Workers Including Firefighters and Emergency Medical Services (EMS) Professionals Summary Sheet

(Robbie Adler Tapia; Summary Sheet by Marilyn Lubber)

Check when task is completed, response has changed or to indicate symptoms.

Note: This material is meant as a checklist for your response. Please keep in mind that it is only a reminder of different tasks that may or may not apply to your incident.

The Mission of First Responders – Basic Information for the Mental Health Practitioner

Trauma

Targets of Professional Exposure = targets of professional exposure include death notifications, personal exposure, when professional colleagues are hurt or killed in the line of duty, unique sensory flashbacks, and the residual impact of habitual stoicism, depersonalization and derealization.

Professional Trauma = anything that negatively impacts the psyche and changes the course of healthy development

× *Line of Duty Traumas* = those experienced during work that include witnessing death or near death experiences of individuals in the community, other professionals, or risk to self.

× *Line of Duty Death (LODD)* = deaths that occur when professionals die in the line of duty.

More stressful for other professionals as trying to rescue and treat a comrade.

× *Post-shooting Trauma in Law Enforcement (PSTLE)* = traumas post professional event. The *Official* process that professionals must endure following a shooting. The on-going stress further complicates the treatment process.

Treating Trauma Exposure for First Responders

Service needs for the department may include:

- ⑥ Anniversary Meetings
- ⑥ Command Consultation
- ⑥ Family Crisis Intervention
- ⑥ Follow-up Services
- ⑥ On-Scene Support Services
- ⑥ Pre-Incident Training
- ⑥ Post-Incident Services

Similarities and Differences with First Responders

- ⑥ *Emergency Services Dispatchers or 911 operators* in the U.S. dispatch other professionals to the scene of a disaster when help is needed, but rarely go to the scene. May later struggle with visual creations that occurred when verbally dispatching assistance.
- ⑥ *Law Enforcement Professionals* are more likely to work alone,
- ⑥ *Other First Responders* are rarely alone.

Stoicism, Depersonalization and Derealization

- ⑥ *Stoicism* is a cultural expectation in that first responders are expected to *not* be impacted by the events to which they respond.
- ⑥ *Depersonalization* is experiencing an event, but feeling like it is happening to someone else.
- ⑥ *Derealization* is experiencing an event, but feeling like it isn't real.

The Families of First Responders

The Traditional Family—concerned about the health and safety of family members

The Professional Family—squad and department

Mental Health Professional Roles with First Responders Working with Department and Command to Provide Post-Incident Services

Referrals for Mental Health Services

EAP available

_____ Yes _____ No

EAP internal/external to department

_____ Internal _____ External

Concerns about EAP referral _____

EAP providers knowledgeable about first responders

_____ Yes _____ No

Option to go to private practitioner

_____ Yes _____ No

Confidentiality of therapist's records if legal proceedings

_____ Yes _____ No

How Do Mental Health Professionals Prepare For and Organize a Disaster Response

To What Type of Disaster Are You Responding?

- ⑥ *Natural disaster* (wildland and/or forest fires, earthquakes, a tsunami, hurricane, flood, epidemic, structural collapse)?
- ⑥ *Man-made event* (torture, acts of terrorism, war, drug cartel wars, school shootings, gang warfare, robbery, arson, bombs, etc.)?
Larger or smaller event? _____ Large _____ Small

Who Invited the Involvement of the Mental Health Professional?

- ⑥ Self-referral
- ⑥ Department referral

Note: **Earning individual and group trust is the biggest hurdle to efficacy in responding to critical incidents with first responders.**

Elements of a Mental Health Disaster Response

Location - Where will you implement the response? _____

Demobilization

- ⑥ *Time off post incident before back to work*
- ⑥ *No time off—first responders expected to respond to call*

Participation

Who needs help? _____

Who are team of responders? _____

What are the needs of the group to be helped? _____

Professional Response

How many professionals needed? _____

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Are there enough? _____

Yes _____ No _____

If not, effect on organization: _____

Logistics _____

Duration of intervention? _____

Who organizes food and drink for group? _____

Post Incident Services

After Action Review (AAR)= a meeting of the professionals who responded to an event and later review the events in order to improve services and safety for professionals.

Psychological Component of the AAR – First Responder considers these questions:

- ⑥ *How did it impact me?*
- ⑥ *What do I need to do to care for myself?*
- ⑥ *How do I get closure?*
- ⑥ *Who else is struggling?*
- ⑥ *What if anything do I need/want to do for my brothers and sisters who also experienced this exposure?*
- ⑥ *How does this impact our next call? Our next shift?*

Critical Incident Stress Debriefing (CISD) or Critical Incident Stress Management (CISM)

Focus is to provide “Psychological First Aid” as an immediate debriefing in order to minimize the harmful affects of job stress, specifically in crisis or emergency situations.

CISM services include seven steps (adapted from Everly & Mitchell, 1997):

- ⑥ *Pre-crisis Preparation:* pre-incident stress management training, education, and skill building.
- ⑥ *Disaster or Large-Scale,* as well as, school and community support programs that include demobilizations, informational briefings, "town meetings" and staff advisement.
- ⑥ *Defusing* is a 3-phased, structured group activity that is after or soon after- the event for assessment, triaging, and acute symptom mitigation.
- ⑥ *Critical Incident Stress Debriefing (CISD)* refers to the "Mitchell Model" (Mitchell and Everly, 1996) This is a 7-phase, structured group discussion, usually provided 1 to 10 days post crisis, and designed to mitigate acute symptoms, assess the need for follow-up, and if possible provide a sense of post-crisis psychological closure.
- ⑥ *One-On-One Crisis Intervention/Counseling or Psychological Support* throughout the full range of the crisis spectrum.
- ⑥ *Crisis Intervention and Organizational Consultation.*
- ⑥ *Follow-up and Referrals for Assessment and Treatment,* if necessary.

Self-Referral

Self-referral – what are the expectations?

Department Referral

- ⑥ What and how will confidentiality be managed?
- ⑥ What do the individual and/or department expect?
- ⑥ What is the purpose of the intervention requested?
- ⑥ What and how will confidentiality be managed?
- ⑥ Are on-scene services requested? If so, is there a risk to the mental health service provider?

- ⑥ Does Command/Leadership expect updates about the services?
- ⑥ If so, how will the therapist correspond with the Department?
- ⑥ Are there privacy issues that need to be resolved?
- ⑥ Will there be an Industrial Commission/Workman's Compensation Case?
- ⑥ Are there criminal issues that impact this mental health process?
 - ×Will this first responder have to testify about the call or any other call?

Psychological First Aid (PFA)

- ⑥ PFA Field Operations Manual available online
- ⑥ PFA apps for smart phones available

Assessment and Case Management -

Safety Planning – questions to assess safety

- ⑥ *How to intervene if first responder is still on the job?*
- ⑥ *What documentation, if any, will the department request?*
- ⑥ *Risk to the public, the individual, and/or other first responders, i.e. first responder is armed*
- ⑥ *Are mental health services a requirement for return to duty?*
- ⑥ *What assessment will the mental health provider be asked to provide to the department, if any?*

Fitness for Duty Process = to make case management and clinical decisions with first responders

- ⑥ *Is a safety plan necessary?*
- ⑥ *If so, who needs to know?*
- ⑥ *How do you protect a career?*
- ⑥ *Is a DTO assessment necessary?*
- ⑥ *Is a DTS assessment necessary? How will this occur?*

Assessment of Individual First Responders

Modified SAD PERSONAS Scale Pearls: Revised 'SAD PERSONS' helps assess suicide risk

- ⑥ ***Sex***
- ⑥ ***Age***
- ⑥ ***Depression***
- ⑥ ***Previous attempt***
- ⑥ ***Ethanol***
- ⑥ ***Rational thinking loss***
- ⑥ ***Social supports lacking***
- ⑥ ***Organized plan***
- ⑥ ***No spouse***
- ⑥ ***Availability of lethal means***
- ⑥ ***Sickness***

×After assessing the risk of danger to self or others, the therapist must make an appraisal of how to manage the risk. This may include immediate intervention, contact with department and staff, referral to a higher level of care, and medication management.

×Referrals for Medication Assessment and Management may be needed

Treatment

Debriefings

- ⑥ CISD/CISM

Individual Psychotherapy

- ⑥ CBP
- ⑥ CPT
- ⑥ PE
- ⑥ EMDR

EMDR With First Responders/Protective Service Workers Notes

Treatment Planning and Interventions: Case conceptualization with EMDR

Important to consider if there are legal issues

- ⑥ Any issues impacting flow of treatment
- ⑥ Will notes be subpoenaed?
- ⑥ Is it prudent to proceed if forensic involvement?
- ⑥ Are your records complete and in compliance with ethical and legal standards
- ⑥ If departmental referral, what are the expectations?

Comprehensive versus Work-focused

- ⑥ Comprehensive
- ⑥ Work-focused

Phase 1: Client History & Treatment Planning

Phase 2: Preparation Phase

- ⑥ *Targets of Opportunity*=most easily accessed and precipitating factor in treatment visit such as targets from recent professional event, personal event or both.
- ⑥ *Target of Professional Exposure*= death notifications, personal exposure, when professional colleagues are hurt or killed in the line of duty, unique sensory flashbacks, and the residual impact of habitual stoicism, depersonalization and derealization.

Diagnostic Challenges

- ⑥ How does diagnosis impact job and career?
- ⑥ With specific diagnosis able to/willing to return to line of duty?
- ⑥ Safety plan necessary?

Resources/Tools for First Responders to Manage the Line of Duty Exposure

EQUIPMENT is an acronym for first responders to remind them to maintain their health while in the line of duty.

- ⑥ Engage your resources and acquire new ones.
- ⑥ Quality of Life is important each day!
- ⑥ Utilize medical and mental health services
- ⑥ Improve your longevity by participating in daily self-care – diet, exercise, and health health
- ⑥ Prepare for survival by practicing and learning new skills

- ⑥ Mentor others by modeling healthy professional behavior both on duty and off.
- ⑥ Educate yourself about the long-term impact of trauma exposure and keep acquiring new resources for coping
- ⑥ Never forget that you are as important as those you protect, serve, and rescue!
- ⑥ Take care of each other - at work and at home.

⑥ *Containers=way to contain intense psychological and physiological experiences from line of duty vs using stoicism, dissociation, depersonalization and/or derealization. Important to remind them that it is not to be closed indefinitely but just to hold the material that would interfere with the work in the present until the job is done*

During Assessment, major decision point for case conceptualization is which protocol do use:

- ⑥ EMD
- ⑥ EMDR

EMDR and First Responders/Protective Service Workers Script (Reminder)

Phase 1: History Taking, Case Conceptualization, and Treatment Planning Important Questions:

× Target Identification of Parade of Faces for First Responders: Parade of Faces Script

The calls that linger include often:

- ⑥ First and worst calls
- ⑥ Child related calls and fatalities
- ⑥ Suicides
- ⑥ Calls where the professional felt personally threatened or was injured
- ⑥ Calls with intense odors and or human remains
- ⑥ Associations with professional's personal life

Questions:

Most difficult call that haunts you: _____

First call that haunts you? _____

Image the calls like a parade that you watch from the first to the most recent call. Those may include calls about suicides, children, severe bodily injuries, and/or body odors such as blood, brain matter, decomposition, burning flesh. When you think about that parade of faces of the calls that haunt you, what's your negative belief about yourself now? Those might be things like, 'I should have done something?' 'I'm powerless?' 'I can't forget or get over it.'"

NC: _____
First call that made you proud about becoming a first responder: _____

Positive belief about yourself when you think of your career: _____

Image the parade of the calls that haunt you on a television channel and you have the remote. What

channel would you put all of the calls that haunt you?"

Channel for Haunting Calls: _____

Channel for Positive Events: _____

Channels for Calls Where Feel Successful and Helpful: _____

Phase 2: Preparation

× Resources

Resources you count on: _____

× Resource review concerning what resources client needs in following areas:

Diet and eating: _____

Sleep hygiene: _____

Physical health: _____

Stress management skills: _____

Spiritual needs: _____

Skills already has: _____

Interpersonal skills for healthier personal and professional relationships: _____

Residual effects from childhood interfering in current life: _____

Residual effects from personal life: _____

Residual effects from professional life: _____

× Resilience and Hardiness

Assessment of current impact of how coping with career and "wear and tear" of career impacts life: _____

Skills and/or tools I use: _____

Skills and/or tools I need: _____

× Professional Grief and Loss Resources

How can get closure since only seeing middle of critical incident: _____

Spiritual and religious needs: _____

Appropriate/helpful to attend funeral services/practice closure/other types of closure: _____

Containers Script

Sometimes we have thoughts, or feelings, or body sensations that get in the way at work or at home. Do you ever have thoughts or feeling like that? I want you to know that if we need to we can put those thoughts or feelings in a container like a box or something really strong that they can't get out. What do you think you would need to hold those thoughts or feelings?"

Next say, "I want you to be able to put all of those thoughts or feelings, or what we worked on today in that container. Sometimes we need different containers for different thoughts or feelings. Sometimes, it helps to draw pictures of the _____ (container) and make sure it's strong enough to hold everything that you need it to hold.

Let's imagine that everything you worked on today is put in the container and we lock it away/seal it away until we meet next time when we can take it out to work on it again. When we get together we will work to empty your container so there's always room for new stuff if you need it. If you start thinking about things that bother you that are too hard to handle or it seems to come out before our next session, you can just imagine putting it into the container and sealing it in there until we meet again."

Phase 3: Assessment

PAST

× **Completed**

TICES (acronym for target, image, cognition, emotion, and sensation).

Target=Critical Incident (see Parade of Faces): _____

Image=worst part of specific critical incident. If multiple images, make chronological list and start with first one specific to critical incident: _____

Cognitions:

NC (elicited during Parade of Faces): _____

PC (elicited during Parade of Faces): _____

VoC: _____/7

Emotions in relation to critical incident: _____

SUD: ___/10

Sensation in relation to critical incident: _____

Phase 4: Desensitization (according to Standard EMDR Protocol/EMD Protocol)

Therapist active in helping client contain other associations and focus on specific critical incident. Document associated incidents for possible use later.

Note: Remember first responders may not show affect because of the culture of stoicism.

Phase 5: Installation (according to Standard EMDR Protocol/EMD Protocol)

PC: _____ × **Completed**

New PC (if new one is better): _____

VoC: _____/7

Incident+PC+BLS

Phase 6: Body Scan

× Completed

Note: First responders learn to disregard personal body sensations while in line of duty so Body Scan may be surprising/disturbing. Help them to be mindful while helping them understand what is happening.

Unresolved tension/tightness/unusual sensation: _____

Unresolved tension/tightness/unusual sensation + BLS

Decision point:

- Ⓞ Continue with additional trauma work
- Ⓞ EMD for one event sufficient

×Remind to practice resources previously identified in order to cope with wear and tear of career.

Phase 7: Closure (according to Standard EMDR Protocol/EMD Protocol) × Completed

Closure:

Incomplete Session

- Ⓞ Use Container Exercise and/or other relaxation techniques to prepare for end of session.
- Ⓞ Remind first responder to practice relaxation skills and containers to continue being successful in line of duty.

Phase 8: Reevaluation

Check Parade of Faces for new traumatic or positive events:

Traumatic material: _____

Positive Events: _____

SUDS of Incident: _____/10

- Ⓞ If > than 0, continue processing.
- Ⓞ If SUD=0 but VoC=<7, continue to reprocess.
- Ⓞ If SUD=0 and Voc+7, complete body scan and move to next target/move to current triggers.

Reprocessd necessary targets:

× Completed

EMDR helpful in daily life:

× Completed