First Responder Culture: Implications for Mental Health
Professionals Providing Services Following a Natural Disaster

Mindy Kronenberg, PhD; Howard J. Osofsky, MD, PhD; Joy D. Osofsky, PhD; Michele Many, LCSW; Melissa Hardy, GSW; and James Arey, PhD, LPC
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CME EDUCATIONAL OBJECTIVES

1. Assess why a culturally sensitive approach is important in providing mental health treatment to first responders.
2. Identify key elements of post-disaster mental health treatment for first responders.
3. Discuss specific interventions utilized for first responders following Hurricane Katrina.

ABOUT THE AUTHOR

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Dr. Kronenberg, Dr. Howard Osofsky, Ms. Many, Ms. Hardy, Dr. Joy Osofsky, and Dr. Arey have disclosed no relevant financial relationships.

INSTRUCTIONS

1. Review the stated learning objectives of the CME articles and determine if these objectives match your individual learning needs.
2. Read the articles carefully. Do not neglect the tables and other illustrative materials, as they have been selected to enhance your knowledge and understanding.
3. The following quiz questions have been designed to provide a useful link between the CME articles in the issue and your everyday practice. Read each question, choose the correct answer, and record your answer on the CME REGISTRATION FORM at the end of the quiz. Retain a copy of your answers so that they can be compared with the correct answers you choose to request them.
4. Type your full name and address and your date of birth in the space provided on the CME REGISTRATION FORM.
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EDUCATIONAL OBJECTIVES OVERVIEW
The psychological effects of the stressors and trauma associated with Hurricanes Katrina are far from resolved. In this issue of Psychiatric Annals, the reader will learn about the effects of the hurricane on evacuees, first responders, physicians, and other survivors.

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Hurricane Katrina made landfall on August 29, 2005. The storm surge caused multiple levee breaches and left 80% of New Orleans1 and most of St. Bernard Parish underwater. Metropolitan New Orleans was in a state of chaos. First responders worked in the streets and at shelters of last resort to provide care for the remaining citizens. They engaged in crowd control, dealt with looting and gunfire incidents, and focused on rescue and recovery. During this time, all communication systems failed. First responders had no radio or telephone contact and were left isolated without backup. Multiple first responders described New Orleans and St. Bernard as “war zone(s).” Several first responders, who were also military veterans, reflected that the experience was worse than that which they had endured in Vietnam or Iraq.

Recent research has focused on the impact of trauma on first responders. Symptoms of depression and PTSD have been well documented in first responders impacted by natural disaster.2 Symptomatology is associated with disaster-related events such as exposure to dead bodies1 and additional personal stressors such as loss of family or friends.4 Given this research and the disastrous impact of Hurricane Katrina, it was clear that mental health response for first responders would be necessary. This article discusses how mental health professionals used cultural sensitivity in order to successfully meet the psychological needs of first responders following Hurricane Katrina, a national disaster of unprecedented size and consequence in the United States.

A CULTURALLY SENSITIVE INTERVENTION FOR FIRST RESPONDERS FOLLOWING HURRICANE KATRINA

Louisiana State University Health Sciences Center (LSUHSC) Department of Psychiatry was called in to address the mental health needs of first responders within days of the hurricane. Mayor C. Ray Nagin asked that Dr. Howard Osofsky, Chair of LSUHSC’s Department of Psychiatry, facilitate services for first responders within New Orleans. LSUHSC clinicians had a longstanding working relationship with first responders throughout the New Orleans area. Prior to Hurricane Katrina, LSUHSC had worked with first responders by providing direct mental health assessment and treatment to first responders and by serving as a referral source in the community; first responders frequently referred trauma victims or witnesses to violence to LSUHSC for mental health treatment. Additionally, LSUHSC collaborated with the New Orleans Police Department (NOPD) on community projects such as a summer camp for at-risk children in underserved areas. These working relationships built trust and familiarized first responders with LSUHSC clinicians and services and placed LSUHSC in a unique position to provide mental health services to first responders following the hurricane.

The devastation of infrastructure, including loss of headquarters, buildings, and offices for both first responders and mental health clinicians, and the extraordinary stressors, both immediate and chronic, that first responders faced, led LSUHSC to recognize that an effective intervention would need to be tailored. Clinicians relied both on preexisting literature and resources as well as the knowledge of the local first responder culture to foster mental health and resilience in New Orleans area first responders.

Sensitivity to General First Responder Culture

Research has clearly demonstrated that cultures within occupations exist.5,6 This is especially true for first responders. Woody6 reviewed the literature on police culture and noted that police culture has rigid values; once individuals become officers, they may isolate themselves from family and friends in favor of their occupational peers. Additionally, the isolation of the police officer may lead to negative psychological outcomes, including mistrusting non-first responders. Firefighters may isolate within their occupation as well. They provide a clear distinction between themselves and the general population. For example, when a firefighter meets a mental health professional, a firefighter will often explain, “We’re all crazy; we run into a fire when everyone else runs away.”

The tight-knit community of first responders stems from their need to rely on one another in dangerous situations as well as on their shared experience. Often, first responders cannot discuss job-related experiences due to issues of confidentiality. In addition to considerations of confidentiality, first responders may not want to share their experiences with non-first responders. They may state, “You wouldn’t understand what I’ve been through” or “I don’t want my family to know what I’ve seen.” They often withdraw into their own occupational communities. It has also been noted that first responders are reluctant to seek mental health treatment for fear of be-
ing seen as weak. Other first responders resist mental health treatment because they rely on defense mechanisms, such as avoidance or intellectualization, following a trauma to continue to function effectively in their jobs.

Evaluation of Local Needs

Understanding general first responder culture was important, but it was even more important to understand the specific culture and needs of first responders who had experienced Hurricane Katrina. Upon returning to the city, clinicians noted the extreme physical and psychological toll of the hurricane on first responders. While first responders were working in life-threatening conditions, they were also worried about their own family’s safety, often not knowing whether their family had evacuated successfully. Most had severe damage to or destruction of their homes, and several had friends and family members who were injured or killed.

First responders who completed questionnaires about their feelings reported symptoms of both post-traumatic stress disorder (PTSD) and depression. Difficulty with sleep was the symptom most often endorsed. First responders reported feeling unhappy and cut off from other people. They also reported symptoms of re-experiencing, avoidance, and hyperarousal. As time passed, increased alcohol consumption and partner conflict were reported. The questionnaire also asked first responders if they would be interested in counseling services. Despite the general tendency of first responders to resist mental health treatment, more than 40% requested services. This may have been due to several factors, including the previous relationship that LSUHSC clinicians and first responders shared, the relationship first responders and clinicians built immediately following the disaster, the urgency of the mental health needs of first responders following a disaster that affected them both professionally and personally, and the de-stigmatization of mental health services by the city officials who had invited LSUHSC to offer their services following the disaster.

When first responders completed surveys, clinicians noted specific characteristics common to police, firefighters, and Emergency Medical Technicians (EMT). Police officers initially distanced themselves from clinicians. A period of “hazing,” consisting of deflecting the clinician with deadpan humor, practical jokes, flirting, or exaggerated deference, was not uncommon. Riding out this test with good humor was pivotal in establishing the clinician as trustworthy and reliable. It was determined that the most effective way to gather information that would help clinicians adapt interventions to the needs of the NOPD was to elicit such information from each officer individually. When questionnaires were disseminated, officers were noted to guard their privacy as they completed them.

On the other hand, firefighters generally have a communal and familial culture. They viewed the new clinicians with guarded warmth, and after an initial period of getting to know the clinicians, firefighters welcomed them into their station houses. At that point, discussions became more open and relaxed. In this environment where coworkers eat, sleep, and work together for days at a time, it was more common for them to engage in group discussions of their experiences and struggles. Focus groups were an effective method to gather information that would help clinicians adapt interventions to the group’s specific needs. When questionnaires were done with New Orleans Fire Department (NOFD) personnel, clinicians often observed firefighters comparing notes on how to answer certain questions or joking about one of the questions together. EMTs, while sharing qualities with both the NOPD and NOFD cultures, tended to the more communal style. Being a smaller group, they were housed in a single station, which encouraged allegiance to the whole group. However, they demonstrated some guarded characteristics as well.

Trust and Relationship

Understanding that first responders have a tendency to avoid mental health treatment, it was important for clinicians to gain first responders’ trust. Clinicians wanted the first responders to understand that they were present and available to
meet their needs; however, it was not uncommon for first responders to question if the clinicians had ulterior motives. For example, they asked if clinicians were writing a book to make money from the disaster, and they questioned if clinicians were assessing them for fitness for duty. Confidentiality was of utmost importance. Understanding that most first responders resisted accessing mental health resources due to a realistic fear that doing so would negatively impact their employment, LSUHSC gained clearance from city and departmental leaders to provide counseling services outside of the NOPD, NOFD, EMS and city systems. This allowed clinicians to maintain full confidentiality while providing direct services to police, firefighters, and EMTs. The clinicians’ ability to reassure first responders that they would not share information with administration was a key component in their willingness to discuss their fears, concerns, and anxieties.

Psychological First Aid

After immediate assessment of the situation and later evaluation, clinicians selected Psychological First Aid (PFA) as the most applicable initial intervention given its focus on crisis intervention as well as cultural sensitivity. PFA is a strengths-based intervention that does not assume psychopathology is imminent following a disaster. Rather, PFA focuses on individuals’ needs and is utilized in a nonintrusive manner in order to provide practical assistance and reestablish safety and stability for individuals who have been affected by disaster. Accepting Maslow’s theory that basic physical needs such as food, shelter, and safety must be met before psychological needs are addressed, practitioners of PFA assess individuals’ immediate needs and provide concrete assistance to meet those needs. PFA assumes human resiliency and promotes empowerment by providing information and helping individuals reconnect with their support networks.

Clinicians found that, while first responders were initially reluctant to discuss feelings of psychological distress, they would accept concrete assistance when necessary. First responders responded positively when they met clinicians who did not push them to talk about trauma or distress, but who provided practical assistance and focused on strengths and resilience. Increased trust was established through a stable presence, first over months and later over years. The relationships established during this time were of utmost importance. Initially, first responders expressed surprise that the clinician did not forget them and continued to visit district and station houses and offer service. Soon, more and more first responders called for individualized psychological services.

Non-traditional and Informal Interventions

Beyond providing practical assistance, clinicians focused on helping first responders and their families find a sense of normality in a complicated situation. Much of this work was done in nontraditional settings, such as on the two cruise ships used to house the city’s first responders and city workers. Clinicians realized that circumstances demanded that they leave behind the formality of office and appointment book. First responders were involved in a day-to-day struggle and had no time for “counseling.” Clinicians worked on the ships, meeting with individuals and groups of first responders as they ate meals in the common dining area, as they did laundry, or as they took smoking breaks on the upper deck. Such meetings were informal, conversational, but indispensable. Nowhere else did clinicians have the opportunity to talk with first responders about their day-to-day difficulties or how to cope with the ever increasing stressors brought on by the disaster. Other informal interventions included biweekly talent shows, holiday parties, and Saturday night teen and pre-teen activities. These unconventional interventions were very effective in combating the tendency of individuals to isolate themselves, and they encouraged the formation of informal support systems. The activities were scheduled as weekly or biweekly, thus increasing the sense of stability and formation of routines. Further, the interventions were developed through consideration of the local culture, using traditional social activities to promote a feeling of normality and familiarity within the ships.

Many first responders, including those who later engaged in individual psychotherapy, noted that they would not have talked about their mental health issues without first knowing and trusting the clinicians.
After first responders left the cruise ships, clinicians were assigned to each district and station house in order to provide a stable, known presence for each group of first responders. Clinicians attended roll calls and visited stations a minimum of six times per week in the first few months after the storms. Relationships were built, and trust and rapport were established with individual officers, firefighters, EMTs, and administrators at each location. Clinicians spoke informally with personnel, rode along on patrols, participated in meals with firefighters, and periodically spoke to their designated group about the problems that were prevalent at the time. This helped to reassure first responders that they were not alone in their struggles and to educate them about common responses to trauma, indicating red flags that indicated a need for treatment.

**Utilizing the Benefits of First Responder Culture**

**First Responder Resiliency**

Although the first responder culture may foster some mistrust of outsiders, thus hindering them from seeking mental health services when needed, the culture also provides multiple psychological benefits to its members. First responders sometimes refer to themselves as a “brotherhood,” which takes care of its own; this practice is learned early and becomes deeply entrenched when first responders work together in life-threatening situations. Literature on resilience has demonstrated that social support is a protective factor, and in first responders, social support from colleagues is especially strong.

First responders have a history of shared experiences that they often do not share with outsiders. In providing mental health treatment to first responders, it has been imperative to respect the first responder’s need for privacy. Thus, following Hurricane Katrina, it was important to partner with peer counselors and peer support groups already in place in the police and fire systems.

**CONCLUSION**

The mental health interventions utilized to treat first responders following Hurricane Katrina shared several commonalities that were integral in establishing working relationships between mental health professionals and first responders. First, the focus was on resiliency. Clinicians helped with immediate, concrete needs and encouraged first responders to utilize their own personal and professional supports in the process of healing after Hurricane Katrina. Second, meeting first responders where they were, rather than working solely within an office setting, was an effective way to gain their confidence. Several first responders told clinicians that it was important to them that clinicians view their circumstances first-hand, so that clinicians could understand the difficulties they faced. After gaining first responders’ trust in the field, they were more likely to schedule an office appointment when they experienced severe psychological distress. Third, the trusting relationship between clinicians and first responders was a primary mechanism that allowed first responders to feel comfortable seeking mental health services when needed. While maintaining appropriate boundaries, clinicians worked informally, such as sharing meals with first responders. Many first responders, including those who later engaged in individual psychotherapy, noted that they would not have talked about their mental health issues without first knowing and trusting the clinicians. This trust was gained only when clinicians respected and worked within first-responder culture.

In summary, clinicians found that each profession had its own unique struggles with the challenges of life and work in post-Katrina New Orleans. First responders also demonstrated unique strengths and resilience, largely attributable to the cultures of their professions. Understanding and working respectfully within these cultures permitted more sensitive and responsive interventions delivered in the most timely manner.

**REFERENCES**