First Responders and Operational Stress Reactions

From *The First Responder Healing Manual*[1] by Chris & Rahnella Adsit
Pages 20-21

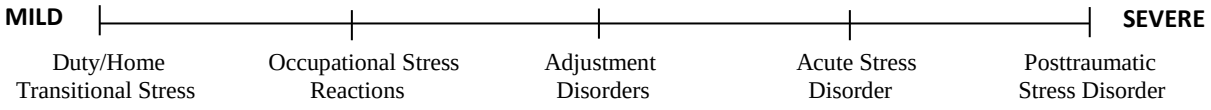
"Operational Stress Reactions" describes a continuum of distressing responses that a person may have when they experience a horrific event, a series of events, or a long period of stress. Everyone involved in the emergency service occupations is regularly exposed to stressful and traumatic situations. Some will experience anxious reactions and improve quickly without any outside help, while others will get "stuck" at a certain reactive level and won't get better for a long time – or ever.

Our country is awash with stress. According to the American Psychological Association, up to 90% of all visits to medical doctors are stress-related complaints.[2] Obviously, unresolved stress in first responders can be extremely debilitating, career-threatening, and even life-threatening.

One cannot classify or assign absolute values to the severity of traumatic events, but we all have a general sense that incidents involving children, multiple fatalities or a personal near-death experience shake us up a lot more than transporting a drunk to jail or rescuing a cat from a tree. Nevertheless, it's not the incident itself that generates stressful reactions, but our perception of or reaction to the event. Everyone is wired differently and responds differently.

For public safety professionals, personal history, repeated trauma, and long-term stress can also wear down our psychological and spiritual defenses, making us more susceptible to stress reactions. But experiencing a traumatic incident does not automatically mean we will develop full-blown Posttraumatic Stress Disorder (PTSD). Our actual responses can fall anywhere along this spectrum, from "Mild" on the left to "Severe" on the right:

Operational Stress Reaction Spectrum



- **Duty/Home Transitional Stress** – Tension resulting from on-duty stress or traumatic events which the first responder brings home; difficulty shifting from cop/paramedic/firefighter mode to spouse/daddy/mommy mode. Symptoms include irritability, angry responses, impatience, self-isolationism, sleep difficulties, jumpiness, etc. These symptoms are relatively mild, and often dissipate within a few minutes or hours, or may trend up or down depending on conditions on the job.[3]
- **Occupational Stress Reactions** – Emotional or behavioral symptoms that develop due to exposure to the characteristically stressful elements of normal first responder employment; when environmental stressors exceed a person's capabilities and resources, leading to negative outcomes:[4] These reactions can develop from three categories of stressors:
    1. **Critical Incident Stress** – Negative psychological reaction to sudden, unexpected events that have an emotional impact sufficient to overwhelm an individual's usually effective coping skills.[5] Some of the most significant stressors are: line of duty death or injury, suicide of a working partner, injury or death of a child, prolonged exposure to a victim who dies, a multiple injury/fatality accident, and catastrophic events.[6]
    2. **Cumulative Stress** – Negative psychological reaction due to chronic and frequent exposure to stress-producing incidents over an extended period of time. In addition, long-term burdensome shift work, on-going conflicts with co-workers or command, exhausting work

tempo, inadequate or interrupted sleep, rapid technological advances, increased specialty responsibilities, position insecurity, and reorganizations can break down a first responder's resiliency.[7]

3. **Derivative Stress** – A non-medical term describing strong, long-lasting emotional reactions which derive their impact from trauma that happened to another person.[8]
    a. **Secondary Trauma** – The natural consequence of caring between two people, one of whom has been initially traumatized and the other of whom is negatively affected by the first's traumatic experiences (even though they did not actually experience them) often mimicking their symptoms.[9]
    b. **Burnout** – A negative emotional reaction created through long attendance in high stress workplaces, characterized by physical, mental and emotional exhaustion, depersonalization, decreased motivation and apathy.[10] Often experienced by those in "helping" contexts such as counselors, dispatchers, emergency room personnel, doctors, nurses.
    c. **Compassion Fatigue -** The emotional residue or strain of exposure to working with those suffering from the consequences of traumatic events.[11] Often experienced by those who are particularly empathetic, compassionate and self-sacrificing. Secondary Trauma + Burnout = Compassion Fatigue.

If not addressed, Occupational Stress Reactions can worsen and shift to the severe end of the spectrum. But with proper, intentional care and with God's help, these reactions will abate, and the first responder will return to a place of strength, stability and resiliency.

- **Adjustment Disorders** – Out of proportion emotional or behavioral symptoms developing as a response to a specific stressor or multiple, chronic stressors (such as financial trouble, divorce, disabling medical condition, etc.). Symptoms are more severe than Occupational Stress Reactions, and include depression, tearfulness, hopelessness, anxiety, anger, decreased performance at work or school, and "disturbance of conduct" (violation of another's rights such as fighting, vandalism, reckless driving, etc.). Once the stressor (or its consequences) has terminated the symptoms resolve within six months.[12]
- **Acute Stress Disorder** – PTSD-like symptoms experienced during or immediately after (within one month of) a traumatic event and lasting at least two days. Dissociative symptoms are common (numbing, detachment, dazed, amnesia), as are flashbacks, nightmares, avoidance of triggering stimuli, hypervigilance, paranoia, startle response, low energy, sleep impairment, etc. Impaired social and occupational function is prevalent. Usually requires intentional counseling to experience progress. If the symptoms don't resolve within four weeks, the diagnosis is changed to Posttraumatic Stress Disorder.[13]
- **Posttraumatic Stress Disorder**– The development of characteristic symptoms (lasting longer than one month) following exposure to a traumatic event or series of events in the following contexts:
    1. **Direct exposure** to a traumatic event(s) such as war, threatened or actual assault or sexual violence, robbery, childhood physical abuse, kidnapping, torture, terrorism, natural disaster, severe vehicle accident etc.
    2. **Witnessing** a traumatic event(s) in person.
    3. **Indirect exposure** by learning that a close relative or close friend experienced a violent or accidental traumatic event.
    4. **Repeated or extreme indirect exposure to horrific details** of the traumatic event(s) in the course of professional duties (e.g. collecting body parts, repeatedly exposed to detailed reports of child abuse, etc.).[14]

The characteristic symptoms are categorized in four clusters:

1. **Intrusion** (or Re-experiencing) – Recurrent, involuntary memories, flashbacks, nightmares, sleep fighting, fixation on traumatic event(s), spontaneous dissociative episodes (one thinks they are actually back in the traumatic situation), panic attacks, phobias, intense or prolonged distress, etc.
2. **Avoidance** – Avoiding anyone or anything that reminds one of the traumatic event(s), self-isolating, anxiety in crowds or traffic, substance abuse to "numb," etc.
3. **Cognitions and mood alterations** – Forgetting key elements of the traumatic event(s), persistent and distorted self-image or world view, persistent and distorted blame of self or others for causing the event(s), strong negative emotions (fear, horror, anger, guilt, shame), diminished interest in previously enjoyed activities (sex, hobbies, exercise), feeling alienated from others, emotionally flat, etc.
4. **Arousal and reactivity alterations** – Irritable, aggressive, self-destructive or reckless behavior, hypervigilant, easily startled, reduced cognitive ability, sleep difficulties, substance abuse to "un-numb," suicidal and homicidal thoughts, etc.

The symptom profile for any individual will include a **unique mix** from the four clusters, not *all* of the symptoms by any means. Social and occupational functions will be impaired. These symptoms may surface immediately after the traumatic event(s), or they may not become apparent for weeks, months or even years.[15]

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[1] Adsit, Chris & Rahnella, *The First Responder Healing Manual* (Eugene, OR: Branches of Valor, Int'l, 2015).

[2] Article by American Psychological Association: Expert commentary: *Stress, Part Two – Getting a Grip*, Nov. 10, 1997. Retrieved from www.discoveryhealth.com/DH.

[3] Various sources**:** "Spouse Battlemind Training," brochure produced by Walter Reed Army Institute of Research, January 2007; "Courage To Care: Becoming A Couple Again" handout by the Uniformed Services University of the Health Sciences (www.usuhs.mil), Summer, 2004; "Roadmap To Reintegration" by U.S. Army Europe found at www.per.hqusareur.army.mil.reintegration, June, 2008.

[4] Article by A. Shirom: *What is organizational stress?: a facet analytic conceptualization.* Journal of Occupational Behaviour, 1982. vol. 3, pp. 21-37.

[5] Article by Jacoba De Boer: *Work-related critical incidents in hospital-based health care providers and the risk of post-traumatic stress symptoms, anxiety, and depression: A meta-analysis.* Social Science & Medicine, 2011. (pp. 316-326).

[6] Jeff. Mitchell, Ph.D. & Grady. Bray, Ph.D, *Emergency Services Stress: Guidelines for Preserving the Health and Careers of Emergency Services Personnel* (Englewood Cliffs, NJ: Prentice Hall, 1990).

[7] Applied research project paper by Suzanne Todd (CA Dept. of Forestry and Fire Protection/Placer County Fire Dept): "Managing Cumulative Stress In Fire Service Personnel: Strategic Management of Change." (National Fire Academy Executive Fire Officer Program, February, 2001).

[8] Non-medical, general term coined by the authors, intended to encompass the three familiar and medically well-defined conditions that are listed.

[9] Dr. Charles Figley, *Compassion Fatigue – Coping With Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (NY: Brunner-Routledge, 1995). p. 11.

[10] C. Maslach & M. P. Leiter: "Stress and burnout: the critical research," in C. L. Cooper (Ed.), *Handbook of Stress Medicine and Health* (Lancaster:CRC Press, 2005). pp. 155-172.

[11] Dr. Charles Figley (Ed.), pp. xv, 2,3,14,15.

[12] American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).* (Washington, D.C.: American Psychiatric Publishing, 2013). pp. 286-289.

[13] Ibid., pp. 280-286.

[14] Note: this does not include exposure through electronic media, television, movies, or pictures, unless this exposure is work-related. (DSM-V Criterion A: Stressor)

[15] American Psychiatric Association: *DSM-5*, pp. 271-280.