

Psychological health  
determinants in  
responder  
populations essay  
sample



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As with all populations, myriad determinants of mental/behavioral health in emergency responders include: perceived level of support from leadership and coworkers; education, training and/or prior experience in disaster response; social and economic parity; home and family life; family and/or personal history of psychopathology (i. e., mood and anxiety disorders) or childhood trauma exposure; intelligence; access, willingness and ability to seek treatment; dependence on drugs (illegal or prescription) and/or alcohol; extreme evaluations of one's naturally-occurring post-trauma symptoms—either catastrophizing or interpreting them as weakness; and, most importantly, quantity and duration of exposures to psychological trauma. With so many peripheral influences, managing

Responder Mental Health Knowledge. The majority of emergency responders have expertise in areas other than mental/behavioral health. Primarily, responders deploy to disaster sites because they are uniquely skilled to aid in clearing the affected community of infrastructure damage and destruction, protecting against further damage and safety hazards, and providing access to clean water, sanitation and health care.

The collective education, training and experience is vastly comprised of structural, mechanical and bio-environmental engineering and associated technical work; mortuary affairs; human and veterinary medicine and surgery; fire safety; and civil protection, order and security (phe. gov and fema. gov). In general, this responder population has little-to-no formal education and training with regard to managing their own or anyone else's mental and emotional well-being.

Even amongst federal responders, the individual, him/herself, is provided guidance and information—through in-processing or other required computer-based training—through which they can mine for more extensive knowledge, skills and training; but is otherwise left unaware of trauma-mitigating techniques and therapies s/he can employ amongst team members. Figures XX and XX provide examples of general federal behavioral/mental health protection guidance provided to disaster responders.

At the state level, governments more experienced with disaster preparedness and response appear to take a more proactive approach to protecting responder mental health. For example, New York, Florida, Louisiana and California (especially Los Angeles County) have developed robust systems for providing individual responders, their supervisory chains and, ultimately, lead organizations with evidence-based/-informed tools, training and experience germane to monitoring mental, emotional and behavioral responses to psychological trauma in themselves and others.

The Florida Center for Public Health Preparedness employs a training course, Bioterrorism Trauma Intervention Specialist Training, primarily focused on administering to the disaster-affected population, provided hundreds of its trainees with audio CDs used for mitigating compassion fatigue. Following four back-to-back hurricanes in 2004, a “large majority” of those 4, 323 personnel felt more confident in their response duties, put their disaster mental health skills training to use in the field and within their own homes (Reid, et al; 2004).

In Los Angeles County, the Barriers to Mental Health Care in Responder Populations. While actual data is scarce, federal Disaster Behavioral Health experts and policy makers understand emergency responders, much like combat veterans, are resistant to acknowledging their own mental/behavioral struggles and are much less likely to identify themselves as such to their supervisory chain. The prevailing social construct for members of these career fields is one of a solitary hero who rescues the suffering while never becoming affected nor requiring respite, themselves; and resuming that role over and over again.

Unfortunately, while mental illness is increasingly normalized as a medical—versus moral—affliction within American media and the general population, military and responder populations prove that old paradigms die a slow death (SAMHSA even campaigned, through HHS administrative channels, to destigmatize the word “ stigma”), personnel under the federal responder umbrella continue to stigmatize themselves by remaining silent through their own suffering for fear of losing colleagues’ respect and/or confidence, losing extra pay, being transferred to another position or losing their job altogether, and ultimately losing a specific security clearance.