A Case Study: Factors to Consider When Doing 1:1 Crisis Counseling With Local First Responders With Dual Trauma After Hurricane Katrina

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This article focuses on local first responders dealing with dual trauma (the collective experience of having both occupational exposure as first responders/rescuers of their families, friends, and neighbors as Hurricane Katrina as well as personal exposure as citizens of the same [or neighboring] communities, whose lives have been interrupted by Hurricane Katrina). The focus of this article is on 5 revised factors to be used with local first responders with dual trauma. The 5 revised factors (personal factors, predisposing factors, peridisposing factors, postdisposing factors, and protective factors) were used to assess and gather information while doing 1:1 crisis counseling with local first responders with dual trauma. A case study is presented to illustrate how these 5 revised factors were used to gather information and to assess while doing 1:1 crisis counseling in New Orleans with one local first responder with dual trauma. [Brief Treatment and Crisis Intervention 7:91–101 (2007)]

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We went to one of the hospitals and found patients all by themselves on one of the upper floors. We had to carry them down four flights of stairs. We used backboards to carry them. Some were too large to put on one board, so we just tied them together. We made do, you know. [Pause] Some were on respirators, so we bagged them. [Pause] You know, using an Ambubag. I can tell you, that’s rough on your hands. We did one in each hand. We took turns. Your hands get very tired quickly. We had no way to transport them, as we had lost our own vehicles. The military would not stop. We yelled at them, but they just kept on going. So we took a truck. Yeah, we just took it. What else could you do? We had to get these people out of there. We put them in the back of the truck and drove them to the nearest hospital, which said they wouldn’t take them. We told them we had to go back because there were other people to rescue. Eventually they took them . . . [Pause] We knew we had to find food and water. We couldn’t keep on going without water and food. We knew we could sleep on any dry
surface, even the ground. That was not so important, but we had to find water and food. Most of my men and women eat once a day, so yeah, we got dehydrated all right. I tell you these men and women gave it their all to save the people of New Orleans. [Pause] I am proud of them. They just kept on going even though many of them had lost everything, just like those that they rescued. Yeah, I am proud of them. It is an honor and privilege to have worked with them.

—One local first responder’s account, 2005

One of the worst natural disasters in U.S. history occurred in New Orleans in 2005, when on August 29, Hurricane Katrina, a Category Four storm with 145 mph winds made landfall. The next day, the death toll in Mississippi was more than 100. The situation was made worse when two levees broke in New Orleans, leaving a 500-foot gap and resulting in water quickly covering about 80% of the city, rising to 20 feet in some areas. People were forced to escape by climbing onto their roofs, trees, or anything that was higher than the water, which resulted in the need to evacuate an estimated 50,000–100,000 people from the city of New Orleans. Altogether, 248,431 people were evacuated and housed in 22 states and the District of Columbia; however, families often were separated during the evacuation process and ended up in separate shelters. During that time, many children were reported as missing, although in the first few weeks, 600 children were reunited with their families, but many more remained missing, and the National Center for Missing and Exploited Children got involved in the reunification process. The death toll was first estimated to be 10,000 (although it turned out to be 1,836). Of New Orleans’ 180,000 houses, over 110,000 were flooded, with over half of them under 6 feet of water for days or weeks (Pomfret, 2005). It was estimated that between 30,000 and 50,000 houses were beyond salvaging, and many others were expected to be saved, often with expensive repairs (Pomfret, 2005). Four weeks after Hurricane Katrina, recovery efforts were still underway, and the city was no longer under water, although toxic mud had created another ongoing challenge (Associated Press, 2005).

Some New Orleans local first responders, as so many other New Orleans citizens, were stranded on rooftops and trees when Katrina first struck and the two levees broke. Often, they were rescued by fellow local first responders, only to then turn around and rescue others. Some left their duties only long enough to get their own families to safety and then returned to assist with rescuing civilians. Others were unsure of the whereabouts and safety of their families, or only knew that they were scattered in different shelters across the country, as were so many other families. These local first responders worked tirelessly, often combating their own fight, flight, and freeze responses. They generally were also dealing with hazardous working conditions (e.g., flood waters, toxic mud, downed power lines) and limited resources (e.g., rescue boats, helicopters, food, water) making rescue efforts more difficult.

During the weeks after Hurricane Katrina, as things slowed down, with rescue efforts being completed and recovery efforts well underway, the local first responders who stayed and performed their duty to save and/or take care of New Orleans civilians often dealt with dual trauma. Dual trauma can best be described as the collective experience of occupational exposure as first responder in one’s own community as well as having personal exposure as a citizen of the same (or a neighboring) community whose life has been interrupted by a trauma event such as a natural disaster. Dual trauma is experienced only by local first responders and, more specifically, local emergency personnel (fire and police) and those locals who provide care for victims of trauma, such as
emergency medical technicians, paramedics, physicians, and nurses. The 1:1 crisis counseling, along with other psychological “first aid” and support, was provided to help New Orleans local first responders with dual trauma. Although it is believed that many of the local first responders successfully managed unaided to deal with the dual trauma, others were in need of some aid. These individuals’ normal coping skills had been overtaxed, and they were struggling with high levels of distress.

Hurricane Katrina has brought to the forefront that local first responders may be dealing with dual trauma, with some struggling with high levels of distress and in need of aid. Existing research has generally focused separately on the occupational exposure of the first (sometimes local) responders to such things as high impact disasters, severe injury and death, and reactions to child victims (Boxer & Wild, 1993; Dyregrov & Mitchell, 1992; Leffler & Dembter, 1998). Much of the research has attempted to identify aspects that might impact the first responders’ coping ability, focusing on age and job responsibilities (Marmer, Weiss, Metzler, Ronfelt, & Foreman, 1996), and perception of the world (McCann & Pearlman, 1990), operating from an internal, versus external, locus of control (Solomon, Mikulincen, & Avitzur, 1988; Solomon, Mikulincen, & Benbenshity, 1989), trying to cope through avoidance (McFarlane, 1989; Shalev, Peri, Canetti, & Schrieber, 1996), keeping feelings to themselves (Evans, Carman, & Staney, 1993), and resiliency (Walsh, 1998). Other research has focused on citizens exposed to trauma events such as terrorism (Jordan, 2002), school shootings (Jordan, 2003), natural disasters (Jordan, 2006), and posttraumatic stress disorder (PTSD) (Pfefferbaum, 1997; Yule et al., 2000) and resiliency (Melzal, 1997), to name only a few; however, thus far, there has been no focus on the joint occupational exposure and personal exposure of local first responders. Therefore, this single case study will focus on a local first responder with dual trauma who was in need of aid. For the purpose of this study, psychological first aid was limited to 1:1 crisis counseling.

The 1:1 crisis counseling lasting from 15 min to 2 hr and not exceeding three sessions was used to assist the local first responders to achieve short-term mastery of his/her overwhelming affect and develop some idea of what to do next. When doing 1:1 crisis counseling with trauma survivors, five factors were used to guide the crisis counselor in the assessment process. These five factors included (a) personal factors (Hettler & Cohen, 1998; Pine & Cohen, 2002), (b) predisposing factors (Brewin, Andrews, & Valentine, 2000; Epps, 1997), (c) peridisposing factors (Jordan, 2005), (d) post-disposing factors (Mitchell & Everly, 2003), and (e) protective factors, which involve resiliency (Ursano, 1981; Walsh, 1998) and stress buffers (Cleary & Kessler, 1982; Thoits, 1982). These five factors have previously been described when used with citizens after a trauma event (Jordan, 2005) and were revised to serve as an informational and assessment guide for dealing with local first responders with dual trauma. As part of the single case study, each of the five revised factors is described in detail. The name and identifying information of the person in the case example was changed to protect his identity.

Case Study

A New Orleans local first responder, a police officer, was referred for 1:1 crisis counseling after he had gotten very agitated and walked out during a formal debriefing session. According to his supervisor, he had been observed becoming more and more agitated in the days after Hurricane Katrina. He also identified that this was unusual behavior for the local first responder.
Personal Factors

These can best be described as the local first responder’s personal, familial, relational, and cultural history (Nader, 1994) as well as spiritual and/or religious beliefs, values and practices (Hettler & Cohen, 1998; Woodcock, 2001), age, gender, race, ethnicity, and socioeconomic status (Pine & Cohen, 2002).

Case Example. John was a 54-year-old, African-American single male who described himself as not a religious or spiritual person. He has lived all his life in New Orleans, could not imagine living anywhere else, and lived in the same house he grew up in. He reported that his parents died over 10 years ago, that he inherited their home after their deaths, and that he has lived in the home ever since. He had a younger, married sister who lived in Atlanta, and his relationship with her was estranged for many years. He described himself as being healthy and having worked out regularly. He reported having always been a social, outgoing person, who in the past liked to have a couple of beers to “chill out.”

Predisposing Factors

These factors involve, but are not limited to, past experiences of trauma such as exposure to aggression and violence (actual and vicarious, chronic and acute) (Epps, 1997, p. 49) both in professional life (e.g., police officer recently involved in a shooting that killed somebody) and in personal life (e.g., having been a victim of child abuse and/or witnessing or experiencing other acts of family violence). Additional predisposing factors are “personality disorders, poor coping abilities and strategies, difficulty learning from previous experiences, low self-esteem, unstable work history as well as lack of finances, chemical dependency, legal problems, chronic mental health issues (e.g., obsessive compulsive disorders, anxiety disorders, paranoia, PTSD, depression), past and/or present legal problems, impulsivity, and all-or-nothing thinking” (Wiger & Harowski, 2003, pp. 50–51) as well as anger management issues, a lack of professional training and skills, limited years of experience and dissatisfaction with one’s job, and poor working relationships (e.g., conflict laden, highly stressful working environment).

Case Example. John reported that he liked his job as a police officer and recently had been promoted to a supervisory position. He reported often feeling responsible for his men and having a good working relationship with colleagues. He reported enjoying a beer with his friends to chill out but was clear that he had no substance-abuse problem. He denied having any mental health issues and described his overall health as good. He reported having been in the hospital about a year ago because he got shot (“just a flesh wound”) and denied having been emotionally impacted by the shooting and said he is not dealing with any residual effects of it. He reported that his many years of experience have helped him deal with this and other routine frontline risks and duties that police officers deal with daily; however, he identified having been much more challenged by organizational and management stressors.

Peridisposing Factors

These factors relate to both the local first responder’s professional function (as one involved in the rescue and/or recovery process) and personal function (as a parent, spouse/partner, other family member [daughter, son, etc.], friend, neighbor losing one’s own home, community, etc.), in which the local first responder’s experience is often very intense and overwhelming (personally and professionally). More specifically, it refers to the proximity, duration, severity, and potential hazard of the
disaster that the first responder’s family, friends, neighbors, and community are exposed to as well as the tasks and responsibilities the first responder is engaging in his/her community or a neighboring community. The closer-in proximity (both geographically and emotionally) to their own home and neighborhood, the more significant is the impact. The duration and severity of the disaster also impact the first responder. In addition, first responders who are repeatedly in situations in which their own lives are at stake and who must repeatedly overcome their own fight, flight, or freeze response are believed to be more impacted. In addition, it is believed that first responders who are uncertain about the whereabouts and/or safety of their family, friends, and/or neighbors or had to rescue their own family members, friends, or colleagues, as well as those whose homes, neighborhoods, or whole communities are affected or destroyed, are more impacted than those not emotionally connected to the victim or community. Difficult working conditions, including such things as limited resources (e.g., a failing generator, lack of rescue equipment, lack of vehicles, and a lack of food and water); inability to rescue those needing it or inability to provide health services to those needing them; needing to repeatedly make life-and-death decisions (e.g., leaving people behind and not being sure if they would be back to rescue them, needing to choose who to assist); engaging in recovery versus rescue efforts (especially recovery of children); functioning in isolation as a result of separation from colleagues and superiors; and having been both victim and first responder all within a short time frame, are believed to impact local first responders after the disaster.

Case Example. John reported that after Hurricane Katrina had passed, he was a survivor of Hurricane Katrina and, as a police officer, also served as a rescue worker. He paused and then said that he thought at first that New Orleans had once again escaped the destruction of a hurricane. He further reported that after the two levees broke, it felt like he was “in the twilight zone.” He reported that nothing felt real and that he could not really put into words what it was like to sit for hours and hours on the roof of a building with no one in sight to help him and later engaging in the seemingly never-ending and challenging rescue efforts of civilians. He told the crisis counselor that everyone who lived through this experience understood what it was like and that it was useless to try to explain to those who did not experience it. He also stated that he hoped he would never have to experience this again. John said that he knew when he was stranded on the roof of a building for several hours that he had to rescue himself and that he could no longer wait for others to save him. The escape was tiresome, as he had to swim from roof to roof, sometimes resting when he was too tired to go on. Eventually, he was rescued and dropped off on one of the overpasses where hundreds of people of all ages were waiting while more were dropped off by rescuers. He reported that he was glad to be safe, but that his happiness was short-lived as he quickly realized that his job now was to rescue others. Somehow, he connected with one of his coworkers and they found a boat and started rescuing others. Their own safety was repeatedly compromised. When John and some others tried to rescue people from the roofs of a nearby neighborhood, some tried to be rescued first by bribing the rescuers, asking them to leave children, women, and the elderly behind and save them instead. When the rescuers did not respond to these bribes and kept on working systematically at their rescue efforts, they were yelled at and some were shot at, making the hazardous rescue efforts even more challenging. John had to leave the safety of the boat repeatedly in order to help the very young and
very old. He said that there were times when
the drive to just save himself seemed over-
whelming and that it was an ongoing struggle.
He also identified another stressor, that of as-
suring the safety of his coworker because as
his supervisor, John felt responsible for him,
so it became an additional burden. He did
not recall all those he rescued, and some stood
out more than others. Some rescue efforts were
complicated and seemed impossible, but some-
how they managed. Of all these things, the most
difficult thing was the repeated decision mak-
ing about who to rescue and who to leave be-
hind, all done on the spur of the moment. He
struggled with the uncertainty that some of
those left behind might have died or if they
were lucky, were rescued by others. Some,
he knew, were dead. He blamed himself for
leaving some behind when the boat was too full
to carry any more. The face of one person he
had left behind seemed to stick in his mind, af-
fecting his work and sleep. During the day, he
was haunted by the image of a young woman
with a lifeless child in her arms. He could
not shake that image. At night, he fell asleep
quickly, only to wake up an hour later unable
to return to sleep. He reported feeling agitated
and impatient with others and feeling hopeless
at times, but denied suicidal ideation.

**Postdisposing Factors**

These factors have to do with the local first res-
ponders’ loss or lack of support and assistance
on both personal and professional levels. On
a personal level, local first responders will be
impacted by the loss of loved ones, friends,
and neighbors, as well as the uncertainty of
whether they are safe and inability to connect
with them. Additional stressors in this process
are displacement of the responders and/or their
families, and family reunification can help in
the healing process. In addition, the destruction
of their own home and community, which can
range from partial destruction with the possi-
bility of some clean up to total destruction of
whole communities, also creates additional
stressors such as ceasing of operations in
schools and businesses. Depending on the se-
verity of the destruction, rebuilding may be
a prolonged process, keeping local first res-
ponders in temporary, often crowded living
conditions, and resulting in additional stres-
sors, which might lead to a higher incidence
of child and spouse/partner abuse. Relocation
can result in a sense of uprootedness, which
can prolong the healing process as well. In ad-
dition, difficult and/or delayed access to Fed-
eral Emergency Management Agency (FEMA)
assistance and/or homeowners insurance can
add additional stress and prolong the healing
process. On a professional level, it is important
to remember that first responders’ professional
socialization requires them to develop skills in
controlling affective responses in trauma events
and other tragic situations. More specifically,
they learn to act personably, but in a detached
manner, and expression of emotions is denied
to them. Emotional control allows them to be
effective, as it is expected by the public and
those they are working with. Research has
shown that first responders with a particularly
high sense of toughness are at risk of develop-
ing psychological problems after a traumatic
event, when normal coping skills are taxed
(Stephens, Long, & Miller, 1997); therefore,
local first responders should be given the op-
portunity to access available peer support,
debriefings, and/or 1:1 crisis counseling. In ad-
dition, accessibility to educational materials
about traumatic stress, acute stress disorder,
and PTSD can be valuable to the local first res-
ponders and assist in the healing and recovery
process (Duckworth, 1991). All of these resour-
ces are very important, since.

**Case Example.** John, who had become home-
less as a result of Hurricane Katrina, reported
that he was housed in one of the cruise ships rented by FEMA for temporary housing. He was told that he would be able to stay on the ship for 6 months. He reported that for the first time in weeks he was having regular meals, a bed to sleep in, regular showers, and was able to wash the few clothes he still owned. He was sharing a small cabin with another police officer, who was very quiet and seemed to be struggling with all he had experienced and witnessed. John stated that he (John) was generally quite talkative, but now struggled with his experiences and some of the decisions he had to make, especially the life-and-death decisions often thrust upon him. He reported evaluating some of the decisions he had made “over and over again” and could not shake the image of the young woman with the lifeless child in her arms. He reported that his colleagues and superiors noticed a change (impatience and escalating anger) in his usual behavior and had spoken with him about it. John reported that he and his coworkers, as well as most local first responders on the ship, maintained silence and did not speak about their experiences. John reported that he broke the silence during the one debriefing he attended and became so agitated during the debriefing session (when they talked about organizational and management issues they had encountered) that he walked out of the meeting.

**Protective Factors (include both stress buffers and resiliency)**

**Stress Buffers.** The stress buffer hypothesis posits that during times of a natural disaster such as Hurricane Katrina, the presence of buffering factors will produce less distress than the absence of those factors. The impact of the buffering effect in situations of a natural disaster “depends on the presence, absence, or level” of buffering factors that local first responders have (Cleary & Kessler, 1982, p. 160). Social support is one such stress buffer. Cohen and Wills (1985) called this buffer “appraisal support,” that is, having others, such as fellow local first responders, available to help appraise stressful situations, is believed to be more effective in dealing with the physiological and psychological impact of a natural disaster. Similar to appraisal support, “positive automatic thoughts” may also serve as a stress buffer (Lightsey, 1994). Other factors that have demonstrated buffering effects include physical fitness (Roth & Holmes, 1985), sense of humor (Martin & Lefcourt, 1983), optimism (Scheier, Weintraub, & Carver, 1986), self-esteem (Witmer, Rich, Barcikowski, & Mague, 1983), self-complexity (Linville, 1987), efficiency (Ben-Sira & Potency, 1985), coping style (Felton, Revenson, & Hinrichsen, 1984; Holahan & Moos, 1985; Suls & Fletcher, 1985), Type A characteristics (Holahan & Moos, 1985), and health practices (Wiebe & McCallum, 1986). It is important to remember that these stress-buffering factors are not contingent on the occurrence of a natural disaster such as Hurricane Katrina. Additionally, these factors do not specifically evoke coping with the natural disaster; however, local first responders who have some of these factors are believed to deal more effectively with the stress associated with their work during the disaster, as well as their personal losses experienced during those times, than those local first responders who lack such factors.

**Case Example.** John reported having always worked out with weights, something he really enjoys. He reported having a good support system in his friends and colleagues and that his sense of humor has been one of his coping skills in the past. He reported eating generally healthy foods, but since Katrina struck, food and water had been a challenge, although it seemed that things were getting better. He reported having been a social person who in
the past had been able to reach out to others—something that had become more challenging since Hurricane Katrina. He reported that he has always dealt with his feelings and that he felt agitated most of the time and often also depressed since Hurricane Katrina struck. He said he did not feel comfortable talking with his colleagues because this is something that they “just don’t do.” He paused and then pointed out that his colleagues seemed bothered during the debriefing when he shared his agitation with organizational and management issues, which made him even more agitated.

**Resiliency.** Resiliency can be described as a local first responder’s ability to cope, bounce back, and keep on growing emotionally and psychologically in challenging and traumatic situations of a traumatic event such as a natural disaster (Walsh, 1998). According to McFarlane and others, secure attachment bond serves as the primary defense to trauma such as natural disaster and the effects it has on local first responders (McFarlane, 1988; van der Kolk & Fisler, 1994). Securely attached local first responders are believed to be able to self-regulate their aroused emotions as well as receive comfort from others. Effective coping in times of and after a natural disaster involves dealing effectively with the experiences as a first responder (such as having made decisions about leaving people behind to rescue others and understanding that those decisions must stand and that there is no sense in rethinking them or, worse, wishing that they had made a different decision) along with the ability to understand the importance of needing to take care of themselves (by having the insight and ability to reach out and access social support when one’s own resources are no longer adequate). Resilient local first responders are reported to use natural disaster experiences as a psychic organizer (Holloway & Ursano, 1984) and as opportunities to reorganize their professional life and/or personal life and move toward health (Card, 1983; Sledge, Boydstun, & Rahe, 1980; Ursano, 1981).

**Case Example.** During the first 1:1 crisis counseling session, John seemed unsure what to do next. He reported feeling overwhelmed by his emotions and especially the image of the young woman with the lifeless child in her arms. At the end of the second 1:1 crisis counseling session, John reported that he did not want to leave New Orleans, as it has been his hometown and the only place he had ever lived. He had assessed the damages of his house and realized that he would need to rebuild, which was something he wanted to do. He felt strongly about being part of the rebuilding and reported that he, like many local first responders, felt that New Orleans was “his city.” After Hurricane Katrina, he had thought much about his life and it’s meaning and what really mattered to him. He reported that he realized that he needed to make a conscious effort to reach out to others for support and was optimistic that New Orleans would be rebuilt. He also identified having thought much about all that had happened since Katrina struck and realized that he was most touched by all the children he had come in contact with as part of his rescue efforts, especially those without parents. Some, he reported, he will never forget, such as the young child whose parents were dead, who would not speak. He decided that he wanted to make a commitment to volunteer regularly at a local community center (something he had thought about for a long time but had never acted upon) and reach out to the children there and perhaps even complete his teaching degree. He also had called his sister to mend his relationship with her and accepted an invitation to visit her and her family (husband and three children).

John reported that even though he had previously not accessed counseling or any other
mental health services, he was willing to obtain ongoing counseling in the future should he feel the need. He identified the 1:1 crisis counseling as very helpful for now and that the questions asked by the crisis counselor were relevant to his experience of having been a local first responder. He seemed to especially appreciate that the crisis counselor did not forget that he was also a citizen of New Orleans who had lost everything and had asked questions relevant to his experience and losses as a citizen. He stated that the sensitivity to his experience as both police officer and civilian gave the crisis counselor credibility, as it seemed that she understood that he was professionally and personally impacted. He also reported that the crisis counselor’s knowledge and understanding of the traumatic event made her credible, which was important to him to able to fully engage in the crisis counseling process and not feel like he needed to educate her about it. He said that the 1:1 crisis counseling was very helpful and a “good fit” for him.

Conclusion

As seen in this single case study, it was important and valuable that the crisis counselor used the five revised factors (personal factors, predisposing factors, peridisposing factors, post-disposing factors, and protective factors), when doing 1:1 crisis counseling with New Orleans local first responders with dual trauma. The factors serve as a way to guide the 1:1 crisis counseling and assist in the initial and ongoing information gathering and assessment of both the function and experience of the local first responders, concurrently in (a) their occupational role as local first responders and (b) their personal lives as survivors. As evidenced by the literature, more research is needed in the area of local first responders with dual trauma and in distress, as their normal coping skills have been overtaxed. Therefore, future research should explore this topic further and should go beyond 1:1 crisis counseling. The five revised factors presented in this single case study should also be further researched.

References


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