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Community Directed Exploration of Expressive Therapy Applications to Combat Barriers to Mental Health for First Responders

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Abstract

First responders are critically under supported in their pursuits of mental health and face a wide gambit of barriers to care. Using an asynchronous online forum, I invited first responders to engage in a community creative process, share their experiences of barriers to care and explore possible solutions to combat these barriers. From my review of the literature in preparation for this community project I surmised that to find effective methods of interventions and support for this population, the development of these should begin with the first responder community itself. The culture that surrounds this community often is avoidant of speaking openly about seeking care as there are consequences with job security and rapport with their peer group. Bringing expressive therapy into this creates the potential of finding communication and outlets through nonverbal and personal creative pursuits. This explored within the online forum brought forth a sense from the participants of potential progress, while also still feeling the weight of the pandemic and sociopolitical stress attached to work that is something larger than a job but for many is an identity. It was found that many first responders practice rituals of superstition that provide a sense of control over an otherwise chaotic workplace experience. Development thereof would be an effective starting point to create interventions or begin to breach the barrier to care via an arts-based support structure.

Keywords: first responders, barriers to care, expressive arts therapy, asynchronous online communities, COVID-19

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to Mental Health for First Responders

I am embarking on this project with the intention of contributing to solutions in combating the barriers to mental health care that first responders face. This population is one near and dear to my heart, I am even married to one. My wife, a paramedic regales me with countless tales of her work. These stories encompass the full spectrum of human emotional experience, and beyond that the vicarious emotional trauma of being the first to arrive to help someone on their worst day multiple times a day for more than 15 years. Her stories can be life affirming as helping a new mother give birth while flying down the highway at 90mph. They can also be as tragic as recovering a 1 year old child, with severe head trauma, from a household where their father struck them with a hammer to stop their crying. These encounters imprint into every first responder I have met: firefighters, paramedics, and police. The work they do shifts their views of themselves and the communities they serve. It drains them and at times restores them. It is an integral part of their identity, and while they act in the role of protector and healer, they often are underserved with mental health support. Now, more than ever, the critical need of mental health support for first responders is evident. The planet's struggle against the COVID-19 pandemic along with continuation of socio-political strains have brought this need to the forefront of the public's mind.

First responders face a vast gambit of challenges in their work, even when a pandemic is not weighing down. They face all emergencies they can, mass casualty incidents (MCI) like forest fires, hurricanes, and school shootings, and in the United States with the opioid crisis. This struggle has been a grinding pressure that has led to compassion fatigue and vicarious trauma, suicidality, substance abuse, and more that lead to a compromise of wellness and safety of

themselves, their loved ones, and the communities they serve (Arble, 2018) Mental health interventions utilized for first responders include critical incident stress management (CISM), cognitive behavior therapy (CBT), cognitive process therapy (CPT), brief eclectic psychotherapy (BEP), and eye movement desensitization and reprocessing (EMDR) (Lanza, 2018) and include peer support and private counseling. While these interventions are effective, a major issue at play is accessibility. A part of that accessibility is a cultural stigma within the first responder community.

> About one in three first responders (33.1%) experiences stigma regarding mental health and that about one in eleven first responders (9.3%) experience barriers to care. The most frequently endorsed stigma-related concerns were fears regarding the confidentiality of services and fears that seeking psychological services would have a negative impact on one's career. The most reported barriers to care were difficulty scheduling an appointment and not knowing where to get help. (Haugen, 2017, p. 223)

The rate of seeking help "among FRs [first responders], this number is unknown, but is expected to be lower because of the emphasis that the FR culture puts on strength and self-reliance" (Jones, 2020, p. 44). Furthermore "the stigma surrounding mental illness continues to pervade society, and particularly this population of FRs, a culture that traditionally prides themselves on self-reliance and strength" (Jones, 2017, p. 212). These barriers to care continue to pervade the culture and it is my imagining that expressive therapy modalities can be utilized to access the previously inaccessible to build self-sufficient methods for the individual and community to utilize to find healing and restoration.

The unique access I have to this community, as a spouse and friend to many in the field allows me to get straight to the source. Through this project I engaged directly with a collection

of first responders eager to find and build methods of access to mental health through the expressive therapy continuum. We addressed these questions in their experiences: What resources do they know of? What is their perceived effectiveness? And what is left to be desired? I asked the question, what does wellness look like for first responders? How can intermodal work bring access to healing in collaboration to therapeutic methods previously utilized? What are the barriers that they face, and how can we, with expressive arts combat them?

Literature Review

The need for access to mental health support for first responders today is more essential than ever. First responders carry multiple stigmas. One, a resistance to seeking help and therapy, is internalized (Haugen, 2017; Jones, 2019). Another stigma is brought to them via COVID-19 from the communities they serve, especially early on when less was known about how the disease was transmitted. Many first responders were quarantining away from their children and spouses for fear of spreading the virus and ostracized from social circles for others fear of them being contaminating (Zolnikov, 2020). Prior to the current pandemic this population faced dangerous levels of burnout and compassion fatigue brought on by the continuing opioid crisis in America (Pike, 2018).

> Compassion fatigue, originally called burnout in the 1970's, was made an official term by psychologist Herbert Freudenberger. The term was utilized for diagnosing doctors, nurses and caregivers who would invest a great deal of time and energy into their work at the expense of their own self-care. Symptoms included exhaustion, sleeplessness, and inability to cope with work. (Reim Ifrach, 2016, p. 34)

Adding to this is the unprecedented mass experience of being overstressed in our modern world. This continued activation of the adrenal systems creates another layer to the experience of

burnout this population continues to face (Martin, 2018, p. 2). This continuation of compassion fatigue in tandem with the culture of showing no weakness frequently leads to the development of mental health concerns (Jones, 2017; Reim Ifrach, 2016). Within first responder groups there is a common fear of job security regarding when mental health comes into question (Lanza, 2018, p. 194). Coworkers and supervisors become uncertain of their peers' ability to do the work required if they show the need for support in some circumstances (Jones, 2017). This counterproductive social expectation is a major barrier to seeking out care.

It is documented that first responders face a disproportionate degree of mental heal concerns and high-risk behaviors when compared to the general population. PTSD, alcohol and substance abuse, depression, sleep disorders, anxiety disorders, domestic abuse and neglect all plague this community to a remarkable common degree (Arble, 2018; Flannery, 2014; Jones, 2017; Lanza, 2018). Eamonn Arble (2018) discusses two categories of coping strategies. These are approach strategies and avoidance strategies. According to Arble, "approach coping strategies connote a conscious effort to recognize and process aversive physical or psychological experiences…Conversely, avoidance coping connotes a strategy of avoiding direct consideration of emotionally troubling thoughts or concerns" (p. 613). He goes on to discuss the detriment of avoidant coping leads to "alcoholism, obesity, marital conflict, low self-esteem, emotion dysregulation, depression, poor sleep, chronic fatigue and reduce quality of work performance" (p. 613). I believe this avoidance strategy stems from fear expressing vulnerability "MH [mental health] problems are viewed as signs of vulnerability. Telling peers about personal mental health problems can lead to mistrust and raise questions about personal safety of others within FR settings" (Jones et al., 2020, p .44). If a first responder avoids and escapes through substance use

or other means, their issues can feel like they do not even exist, and if they can stay busy, they can feel like the issues at play will never catch up to them.

Instead of avoiding, if a first responder is to face the issue head on and have an approach-based strategy using common interventions we would hope to see support and an improvement in the quality of life of them and the communities they serve. However, follow through with treatment is often lacking.

Even if counseling were sought their reality of the work would leave limited time for processing one critical incident before a second call… Much of the experience distress is often self-medicated through substance abuse and the basic trauma issues remain unaddressed. (Flannery, 2014 p.262).

Lanza (2018) argues, "prevention of responder trauma starts prior to exposure. It starts with psychoeducation of potential risks of harm to self, resilience-building and comprehensive training on trauma reduction, such as self-care, self-compassion, and accumulation of protective factors" (pp. 196-197).

The need for psychoeducation is remarked upon multiple times through many sources. Sara Jones (2020) uses ethnographic qualitative interviews to boil down the major factors that prevent and provide access to mental health care. She highlights the cultural dissonance experienced between the general public and first responders. Observing how often first responders are compared to military service members she takes the time to distinguish the unique first responder experience.

Their culture is different, as well. They live together during prolonged times, and when they return home they are expected to function in daily living. Additionally, first

responder's tenure is ongoing. That is, they may serve in-line for 30 years or more, which

increases their risk for trauma exposure. (p. 44)

Considering this Jones suggests the core of the community work this thesis is fueled by: "Implemented interventions without first responders' input and 'buy-in' would have been a large disservice for first responders. Hence we needed first responders' direct input to identify factors that influence their help seeking behaviors" (p. 52).

This need for first responder influenced/focused research is shared widely, and it's current spartan status of quantitative data on effective interventions is highly criticized (Flannery, 2015; Lanza, 2018; Martin, 2018; Reim Ifranch, 2016). To find more accessibility for this population the question is posed: How can expressive therapies be a resource?

Stress reduction is measurable through creative art therapeutic practices, but while this is true it is also true that there is insufficient research to establish exactly why that is (Martin, 2018, p. 14). It is essential for intersectionality of the lived experience of the participants of this work to be honored and explored (Reim Iranch, 2016, p. 35). "It might thus be worth looking at specific and common gestures of the individual creative art therapy, delineating them from mere arts intervention and starting to relate them to features of populations and context" (Martin, 2018 p. 14). Upon review of this collection of literature is has become apparent that this population is resistant to verbalizing their need for support for fear of social and employment consequences (Jones, 2020; Haugen, 2017). "Using expressive therapies offers and non-verbal means to communicate can reduce the feelings of stress and stigma around this kind of professional sharing" (Reim Ifrach, 2016, p. 35). Sources of strength in unexpected places can also be explored. Even through vicarious trauma first responders can experience traumatic growth in contrast of the burden of PTSD (Killian, 2017; Martin, 2018). While experiencing vicarious

trauma care providers have access to the ability to reframe their perceptions of themselves, to find vicarious resilience and post traumatic growth (Killian, 2017).

> Post traumatic growth (PTG) refers to a phenomenon of stress producing a positive transformation within the self. A person who undergoes a traumatic event or injury may experience significant level of disruption to their assumptive world and personal narrative, resulting in changes in the way a person experiences everyday life.
>
> (Killian, 2017 p. 24)

This reframing through PTG leads to the development of vicarious resilience, an internal fortitude to resist the effects of trauma (Killian, 2017). This tool could be a powerful asset to future efforts. Though the exploration of this community project there is opportunity to contribute a piece of the puzzle, that is, how can we, as expressive therapists better serve this population that serves us?

Methods

This community driven exploration focused on a small group of first responders that include paramedics, basics, fire fighters, police officers, and ER nurses. It was held in an asynchronous format via a private online forum hosted through a service system called *Discord* (Discord Inc. 2020) for a duration of 3 weeks. The forum held several features that included select channels for posting from participants on various topics and voice/video channels to provide a live discussion when participants were available.

Participants

The participants were brought into the project initially through word of mouth by my own established social circles within the population. Eleven initial potential participants expressed great interest in the development of this project. These individuals' preferred contact information

was collected, and an initial introductory e-mail was sent. Via e-mail potential participants were introduced to the topic of focus and informed of the goals of this project's exploration of combating barriers to care for first responders through expressive therapy. This introduction highlighted the value of each participant's lived experience and the need for their input to assess the resources, or lack thereof, for mental health firsthand. Initial introductions to expressive art therapy as a tool focused on principles of person-centered therapy and humanistic principles as presented by Natalie Rogers (1993). Of the initial 11 interested persons six followed the prompt to join the private forum via Discord.

> Discord servers are invite-only places where you can talk, collaborate, and share. Conversations on servers are only with people you choose to talk to and about the topics you want to discuss. In this way and many others, Discord is not a traditional social media platform. There is no algorithm deciding what you should see. There's no endless scrolling, no news feed, and no counting of likes.
>
> (Discord Inc., 2020)

The purpose of using an online forum through a Discord server as opposed to video conference calls or group meetings was with consideration to the current pandemic as well as the difficulty of finding coordinated times of availability for all participants who serve in several different towns and services. It was my conclusion that a sustained medium would serve as an effective method of communication and sharing.

Project Design

Within the server I allocated several text-based channels for a variety of purposes. The initial channel, labeled as *Welcome*, provided initial expectations of the use of the forum. This channel restated the intention of this project as well as it's duration and alert to confidentiality of

content there-in. The Welcome channel also acted as an announcements board for coordinating voice/video chats. In conjunction with the Welcome channel was the *Resource* channel. This channel acted as a place of sharing information of interest between myself and participants. It often contained books and articles of interest as well as relevant news articles and additional mental health resources local to participants.

Welcome and Resource channels acted as introductory spaces within the forum. Following them were the *Discussion, Gallery*, and *Music-Sharing* channels. Discussion was frequently used to follow up on video/voice calls and include all participants into continued dialogue about topics broached in voice chat. The goal of this was to ensure that everyone was able to participate as much as they could within their comfort. The Gallery channel was used as a place to share art making and art appreciation. Participants were offered opportunities to explore expressive art therapy experientials and had the option to post their creations and experiences within this channel. The Music-Sharing channel served as a way of sharing mood and compiling music resources from the participants.

Outside of these text channels, there was a voice/video channel. Coordinating through the Welcome channel participants would be invited to join voice/video conferences that I would host through the weeks the forums were active. Discussions would be initiated by prompts that would evolve into organic discussions. Often these discussions would lead to a Discussion channel prompt and a sharing opportunity with Music-Sharing or the Gallery channels. While the live chats held the driving force behind the activity on the forum, I believe that the text-based channels acted as a less vulnerable space where participants could feel more comfortable sharing and allowed for more flexibility in availability.

The benefit of this forum format was that all communication outside of the live chats was retained within context and allowed for quick and accurate recollection for record keeping. After each live chat I documented emerging themes and concepts by personal notation. These notations often evolved into discussion prompts shared in the Discussion channel.

Given the flexibility of this method for participants I imagined each participant would have a uniquely 'their own' experience within it. It would be a fair speculation to imagine some who joined the server may not participate as fully as others. Based on the literature review for this project it would be understandable if discussions on barriers to mental health would take a focus (Flannery; Jones 2020; Lanza 2018) and I do have concerns for the effectiveness to look beyond the problem to see solutions.

Results

Of the potential participants invited, six first responders joined the server. They were a collection of fire fighters, ER nurses and emergency medical technicians. They ranged in years of experience from 5 to 20 years of service. At the time the server went live, a live voice/video chat was hosted. Three of the six participants within the server were able to attend and participate in initial discussion and introductions.

In this initial virtual meeting, I presented myself on video and reintroduced the intention of the server to act as a means to asynchronously investigate barriers to mental health for first responders and see if expressive arts therapies could have application to combating said barriers. Initially time was taken to introduce participants to how to interact with the forum and its features. How to post contributions, use the voice/video chat feature, and adjust their user's alias if desired. Expectations of behavior for the forum were shared, establishing confidentiality and participation based on personal comfort. These expectations and instructions were posted for all

participants who could not attend the initial meeting. Discussion swayed organically into what methods of mental health support were already present in the participants' sites of service. Employee assistance programs (EAP), initial employment orientations that briefly highlight crisis hot lines or crisis debriefing were brought into focus. However, these resources were not lingered on too long in conversation. Participants were quick to dismiss these interventions and expressed dissatisfaction at their effectiveness.

"It's the bare minimum from management, the least they can do. Lots of them worked on the truck before they moved up. They didn't get support, so why should that change now?" (paramedic)

It was at this point a collective silence held a beat and all participants in the voice chat echoed and validated the sentiment. At this point I raised the question: Where does effective support come from?

To this prompt I received two sources of strength named by the participants: partners they trust and their families. Family was highlighted as a grounding force when coming off shift. "They don't always get what it's like," said a paramedic about her children, "but that's not important, they keep me grounded." The utility in partners as a resource depended on the strength of the relationship that was established. It was expressed that their immediate accessibility on shift, shared lived experience, and the high stress of the work create a strong bond and sense of security. However, when this rapport is not present a poorly matched pairing can be an isolating and even dangerous experience on shift. "It's all about trust," said a fire fighter/EMT "a mutual getting of each other's back." In this conversation mention of a "bully culture" emerged from an EMT basic, "The old eat the young." This expression was extrapolated to mean that there is a presence in the work force of older first responders who create a toxic

environment. An example of sexual harassment and stalking was brought into discussion by a paramedic. The incident resolved in a change of shift by the paramedic to avoid the offending coworker. This incident was met with acknowledgement from other participants, unsurprised and supportive of the paramedic.

Highlighting self and the surrounding environment I brought expressive therapy into the discussion. Citing Natalie Rogers (1993) I shared the humanistic principle that "all people have an innate ability to be creative" (p.7) and person-centered therapy as a means of taking internal inventory. Participants were offered an opportunity to participate in a small experiential on their own time at the end of our discussion as described in Appendix A. A summary of the video/voice chat was posted in the discussion channel and a prompt for any participants to add to. There were no additional postings in response to this discussion.

The following day the three participants who were present for the voice/video chat posted their self-circles. The next voice/video chat time was posted. At this time, I also prompted participants to share links to music they find empowering or uplifting to share with each other and by request of participants a channel was created to share images of pets.

In the second voice/video chat two participants were able to attend. These participants had joined in the previous voice/video chat as well. This discussion's theme emerged as burnout and grief. The strain of the pandemic on participants was made clear by a firefighter medic. "The responsibility is shattering," he said, "I'm constantly asking if I did the right thing, and sometimes I didn't." It was expressed the constant exposure was not something they were prepared for, "When this [pandemic] ends, I need to find a different job, but I don't know what I could even do. I'm tired of being disposable." A recent suicide came up in discussion and an immediate reaction of "Why do they have to say, 'commit suicide?' as if death isn't enough. Now

they're labeled a criminal?" Another participant responded, "Whenever I hear someone died, I assume is was suicide, an MI [myocardial infarction], or accident." A mourning tradition was shared that was referred to as *last call*. After a first responder has passed a station may call their truck and name over the radio from dispatch as a farewell. Anyone on shift can listen to hear a last goodbye on their radios. At the close of the discussion participants were invited to share a song to the playlist that reminded them of a partner they had a strong bond with and were invited to participate in another expressive therapy experiential as described in Appendix B. A review of the themes of the discussion was posted in the server prompting response from other participants. No responses were posted.

During the next few days music was added to the play-list and participants posted their Timelines. Another voice/video chat time was posted. Discussions were posted in the forum that shared recipes used at a local firehouse and there was a shared bonding that occurred between some of the less vocal participants over cooking and food.

The last group voice/video chat was attended by three participants. The emerging theme from this discussion focused on hesitancy to utilize therapy, the powerful presence of ritual, and superstitions. I prompted discussion: what does it take to pursue therapy for first responders? General response was positive to pursuing therapy with a hesitancy to be first, "I don't feel safe being the first," said a firefighter, "seeing others do it makes me feel like less of a target." It was expressed that there is a desire for visibility in peers to use mental health supports. Discussion changed to superstition and rituals around them. This was prompted from the train of thought of seeing other first responders practice self-care on shift and superstition seemed to be the most visible, aside from eating and sleeping when able. Some of these rituals were as simple as never saying the word '*quiet*' but rather "the Q word" or avoiding it all together to ensure a gentle shift.

An example of a ritual commonly seen is checking over the vehicle and gear prior to putting the truck into service. This is an established safety protocol; at this point in the conversation I inquired if the first responder is on the list of equipment to check, and they are not. As an exercise for participants, I encouraged them to consider incorporating themselves into this pre shift check and to check in within themselves and see if they feel ready for their shift.

There were several attempts to continue video/voice chat and engage online with prompts but time, work constraints, and unforeseen health issues for participants limited participation to contributing to the pet and music feed. The server remains up as to share compiled resources for participants still online, but no longer has any active posting.

Discussion

In my literature review I discuss Eamonn Arble (2018) and the coping strategies he suggested are present withing the first responder populations; coping and avoidant. I even suggested that the presence of avoidant strategies of coping was due to the presence of fear of vulnerability. While I still hold that to be true after my time with the online forum, I would now suggest that there is an element of exhaustion that is even more present and powerful. It is this exhaustion that has taken the driver's seat in deciding the method of coping. This select group, when present, was passionate about care for first responders. However, there were many opportunities for interaction that became silent and some participants who never made their presence known. Initially I was disappointed and felt that I had failed to engage them. Looking back on the whole of this project I have a stronger sense of understanding for how much I was asking of them. While this asynchronous online forum of engagement was utilized it was also during their precious few hours of relief as they were not on shift. They chose to engage in difficult work with me, diving into their experiences. It was work and their level of engagement

as a group was not directly reflective of their passion about the project but perhaps their fatigue and burn out limiting the energy they had to bring.

Lanza (2018) suggested that preventative care for first responders starts with psychoeducation. From this group it was evident that the majority of psychoeducation was produced from on-the-job experience or was self-guided. While many of the participants' workplaces offer a form of on-boarding, they unanimously found it insufficient and often given an air of dismissal. Some help hotlines are made available or specific phone numbers to call to set up counseling. However, per the participants, without much visible engagement or discussion at the workplace. This coupled with the burn out, fatigue could lead to the manifestation of avoidant coping strategies (Arble, 2018). The path of least resistance to find comfort seems the most prominent, resulting in maladaptive behaviors at worse or base line avoidance at best.

A phrase was often remarked in passing during the video/voice chats "It's hard of put it into words" or "I don't know how to describe…" and "It's just… I don't know…" These moments of trying to bring words to experience and feelings that defy them were scattered like breadcrumbs on a trail. It struck me that this nonverbal path could be an access point for expressive therapy to find applicability. Reim Ifrach (2016) highlighted the opportunity expressive therapy has that is unique in moments like these. The art received in response to the experiential in Appendix A was helpful for the first responder to decode their own thinking. An example of this was a firefighter who wreathed their circle in flames. Initially a peer within the group questioned "Is your world on fire?" out of sincere concern mixed with a playful jab. The fire fighter replied "No, fire is powerful and so am I." This non-verbal starting point allows participants to engage in a safer personal setting and allowed the firefighter to have time to absorb his own thoughts on identity and power.

This project provided a clear need for follow up. All verbal participants expressed disappointment in support received from management. For further development I would suggest outreach to local workplaces and supervision and explore the resources provided for first responders. This seems to be a major barrier to care and cause of difficulty for the participants who feel under-supported. It would stand to reason the companies responsible for the employment of these workers who are exposed knowingly to high stress and high danger environments, would also be responsible for allocating resources to ensure their work-force's wellbeing. This feels like a daunting task so I would suggest focusing on a singular company that is willing to be a resource to explore with.

Regarding individual work, I found through this project that ritual is an already used resource. Further exploration into incorporating self-supporting intention into the already present superstitions and ritual could be starting points for future developments of interventions. Ultimately, the effectiveness of any future exploration is dependent on the participant's buy-in. Per Jones (2020), this population is highly self sufficient and prides themselves there-in. There is danger in vulnerability and so to mitigate that anxiety it is imperative that first responders be the driving force in the designs of interventions utilized.

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Appendix A

Experiential 1: Circle Self

With identity in mind, we're going to engage in a simple exercise. All you need is paper and

drawing tools. I recommend markers, but you could use anything even cut images a glue.

1) Draw a circle any size on paper. The space inside the circle will represent you, the space

outside is everything else.

2) Take a moment to check in with yourself and how you are feeling.

3) Fill the circle as completely as you can with images, color, words, whatever comes naturally.

4) Fill the area outside the circle.

5) Try not to judge it, consider writing a brief journal or note to yourself about your experience

during this exercise. (this is just for you)

6) Post your circle in #gallery below.

Appendix B

Experiential 2: Time Line
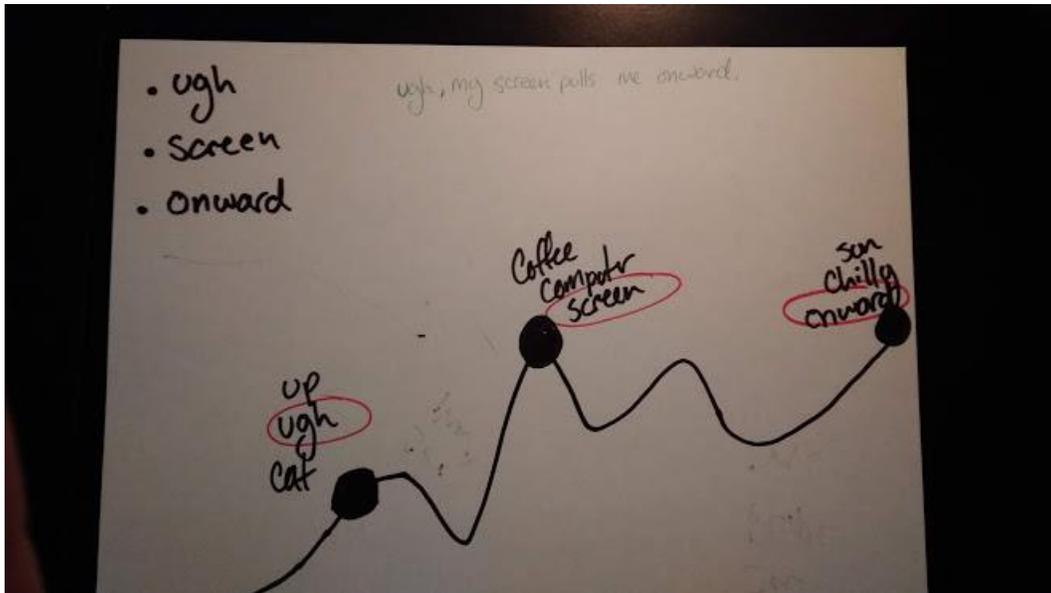
For our next expressive therapy exercise you'll need paper and pencil/pen.

1) Find some time for yourself at the end of the day and think back on the events.

2) draw a single line across the page that will illustration the "highs" and "lows" of the day. This line can have all sorts of shapes in it and loops. It can be simple as simple or complex as you need.

3) Select three points on the time line and mark them.

4) for each mark write a few words 3-5 that come to mind. (don't think to hard just the first that come to mind)

5) Pick one word from each mark and write them in a list, any order.

6) Assemble them in a brief poem. As long or short as you like, each word could be a line or you could fit them all into a sentence. try not to over edit

7) Read your poem and reflect maybe a write a bit about how this project made you feel

8) post in #gallery and share it.

THESIS APPROVAL FORM

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: <u>Donna C. Owens</u>