Prospectus:

The Experiences of First Responders Who Provide Peer Support: A Phenomenological Study

{Student Name}

Walden University
Prospectus:
The Experiences of First Responders Who Provide Peer Support: A Phenomenological Study

Problem Statement
In mid-January of 2015 a 16-year paramedic veteran from a large capital city in Canada committed suicide in the middle of his shift (CBC News, January 27, 2015). Based on symptoms he disclosed, he likely suffered from Posttraumatic Stress Disorder (PTSD) (CBC News, April 29, 2015). At the time, PTSD was not recognized as a workplace injury so First Responders such as paramedics, firefighters and police experienced significant difficulty claiming disability or requesting workplace support for their psychological distress (Wolfson, 2016). The prior nine months had seen 34 suicides amongst paramedics, and this most recent well-publicized event lent political will to acknowledging the correlation between working as a First Responder and significantly increased rates of PTSD and suicide (Cernak, 2015; Roth, 2015). With the political will, legislation has been considered, introduced, or passed at the provincial and national levels with a presumptive clause that PTSD is an occupational hazard for First Responders (Campbell, 2016; Government of Alberta, 2016; Government of British Columbia, 2016; Government of Manitoba, 2016; Government of New Brunswick, 2016; Government of Nova Scotia, 2014; Government of Ontario, 2016; Government of Saskatchewan, 2015; Legislative Assembly of Yukon, 2016; Parliament of Canada, 2016). This means that First Responders no longer needed to prove that PTSD was a workplace caused injury. Along with changes to insurance, Workers Compensation Board, and employment guidelines, there also came the political, agency and grassroots interest in moving forward with developing and expanding previously proposed peer support programs amongst the various First Responder agencies (Canada, 2015; Church, 2016).
Peer support programs developed out of the mental health consumer movement in the 1970’s and have become a major component of social supports and mental health practice in recent times (Tang, 2013). While originally utilizing recovering psychiatric patients to help in the treatment of those in crisis, peer support programs now range from supporting individuals with chronic illness such as diabetes or cancer, for living in ethnically diverse families, for military veterans, and programs such as Alcoholics Anonymous (Peers for Progress, 2016). Such programs may utilize informal and standardized approaches.

The concept behind peer support programs is to provide an authentic, organic, and easily accessible approach to mental health (Peer Support Accreditation and Certification (Canada) (PSAC-C), 2016). The belief is that individuals who work in a given field, or who have had similar experiences, are uniquely equipped to understand and support peers experiencing psychological distress due to current environmental factors (Mead & MacNeil, 2006). The act of sharing distress with a peer who has undergone and recovered from similar experiences may trigger healing, markedly reduce the impact of both immediate and long term psychological challenges (Min, Whitecraft, Rothband & Salzer, 2007). This wellness approach focuses on strength and recovery, rather than diagnosis and illness (Repper & Carter, 2011). The approach also allows individuals who may avoid professional assistance for a variety of reasons (e.g. embarrassment, perceived employment risk, finances, time, etc.) to receive primary mental and/or social health support within their community (Gravel & McKay, 2016). The support provider takes no further action when the peer approach is sufficient, but will refer the distressed individual on to more formal mental health or social programs if concerns continue (PSAC-C, 2016).
In Canada, the last decade has seen several government and non-governmental agencies develop training standards for peer support providers (Mental Health Commission of Canada (MHCC), 2016; PSAC-C, 2016). First responder agencies, such as the Edmonton Police Service (EPS), Royal Canadian Mounted Police (RCMP), Edmonton Fire Department (EFD), and Emergency Medical Services (EMS), are developing and refining various in house peer support programs based on information in the literature, accreditation standards, agency findings from similar programs around the world, and local needs (Alberta Health Services (AHS), 2015; Anderson, 2016; Fire Rescue Services, 2016; RCMP, 2016).

While considerable information exists regarding the efficacy, advantages and risks of many types of peer support programs such as those for diabetics, cancer patients, or war veterans (Bird, 2014; Lawton-Smith, 2013; Peers for Progress, 2016; Soki & Fisher, 2016), there is minimal research regarding application and usefulness of peer support programs among First Responders (Dyble, Tickle, & Collinson, 2014; Miyamoto & Sono, 2012; Moran, Russinova, Stepas, 2012). There is no research on the impact of being a peer support provider for First Responders. A series of keyword searches on “peer support,” “First Responder,” “CISM” (a critical incident stress management approach that is often taught to peer support providers (MHCC, 2016; PSAC-C, 2016; Seys et al., 2012) and related words in Walden University’s online library and the largest university online journal database in Canada (University of Alberta, 2017) turned up only five articles from peer reviewed journals published between 1992 and December 2017 mentioning peer support programs for First Responders, and no articles on the experience of being a peer support provider for First Responders. Thus, while many First Responder agencies are developing and promoting their peer support programs as a standard line item in their mental health supports policies, there is
minimal information regarding how First Responder peer support providers have been affected by taking on this role.

**Purpose Statement**

The purpose of this qualitative phenomenological study is to explore the experiences of peer support providers among policing, paramedic, and firefighter First Responders. This study also aims to explore how peer support providers describe the changes in their roles since they began providing services to present time. Finally, the study will explore peer support providers’ recommendations regarding the role going forward in order to perform this task more productively.

**Significance**

First responders deal with a variety of direct and secondary trauma experiences on a daily basis (Haugen, 2012). Traditionally, they have been provided with very few resources focused on sustaining their own mental health, which has resulted in a significant toll on the mental well-being of First Responders. This toll is reflected in higher rates of mental illness, addictions, family breakdown, reduced work performance, staffing turnover, and self-harm than is seen in many other professional fields (Cacciatore, Carlson, Michaelis, Klimek & Steffan, 2011; Reynolds & Wagner, 2007; Sareen, Cox, Stein, Afifi, Fleet & Asmundson, 2007). Despite this, many First Responders have been reluctant to seek out mental health supports due to historical employer non-recognition of workplace induced mental illness (e.g. PTSD), personal embarrassment, or financial difficulty to pay for services (Royle, Kennan, & Farrell, 2009; Wolfson, 2016). Peer support programs are aimed at helping First Responders overcome these challenges, and hopefully reduce the negative psychological, social, and financial impact.
trauma has on this population. It is crucial though, that First Responder peer support provider’s own needs are not overlooked in this process.

First responder peer support providers face a dual challenge. First they must deal with the direct and secondary trauma of their policing, firefighting, and paramedic role. Then, they are also asked to support the psychological distress of their peers, creating opportunity for vicarious traumatization. As a result, it is key that the First Responder peer support provider’s experience is understood, so that support programs are tailored to them to ensure that they do not succumb to the psychological distress they work so hard to alleviate in their peers.

The results of this study may help in several ways. It may provide information to supervisors so that they can be aware of the additional potential challenges peer support providers face; it may inform the development of assistance programs for peer support providers; and it may help normalize the experience of peer support providers so that they seek out assistance for themselves in a timely manner.

**Framework**

Relational-Cultural Theory is founded on the concept that psychological growth and wellbeing is founded on relationship (Miller, 1986). When the relationship allows for an authentic exchange of emotions, a mutual empathy, understanding and support develops. This empathetic connection may pull a distressed individual back from the psychologically damaging experience of isolation, blame, and personal condemnation. Through relationship the individual is able to develop “five good things.” These good things include 1) a greater sense of life zest, 2) empowerment to act and engagement in action, 3) deeper understanding of self and others, 4) increased self-worth, and 5) increased connection to others and desire to further connect.
According to Relational-Cultural Theory, when an individual is in distress and relationships are lacking, or are not robust, people tend to further withdraw or maintain relationships at a surface level (Miller, 1986). The outcome is called a “central relational paradox” (Miller & Stiver, 1997, p. 81), where people block themselves from gaining the very thing they instinctively know will help. Often the withdrawing or self-criticizing behavior is framed in a negative cognition such as “I am not good enough to deserve comfort/love/support” or “I don’t deserve comfort/love/support.” The psychologically distressed person reasons they can minimize the risk of further harm by avoiding a social connection where another confirm their negative self-representations.

Peer support groups are founded on the concept that by creating the opportunity for a distressed individual to be in relationship with someone who has similar experiences, the distressed person will no longer feel alone (Mead & MacNeil, 2006). The peer counsellor offers understanding, empathy, validation, and empowerment through the relationship. As the peer is from the same cultural background (they are also a firefighter, a paramedic, or police officer), they have an understanding of the distressing experience, and so do not need to have anything explained to them. Not having to explain takes a significant burden from the distressed person. Rather, the presence and acceptance of the peer support provider offers an opportunity for connection and healing. The Relational-Cultural Theory provides a good framework to understand peer support providers’ experiences. Unlike traditional professional therapy approach, the peer support provider creates change in the distressed persons attitude and understanding through relationship patterns, relational images, and relational awareness, rather than a prescribed set of therapeutic techniques (Jordan 2009).
The Relational-Cultural Theory provides a framework for evaluating the First Responders’ peer support provider’s experience. The culture of being a First Responder, and the sub-culture of each distinct group (e.g. firefighter, paramedic/EMT, police) creates a unique support pool for distressed emergency medical responders to rely on. While traditional evaluation of peer support programs has been focused on the recipient’s experience, this paper will examine the providers’ experiences.

**Research Questions**

1. RQ1. What are the experiences of First Responder peer support providers in the peer support provider role?

2. RQ2. How did the role of First Responder peer support providers change or evolve over time?

3. RQ3. What recommendations do First Responder peer support providers make to further enhance and support this role?

**Nature of the Study**

This qualitative study will use interpretative phenomenological analysis (Pietkiewicz, & Smith, 2012; Smith, Flowers, & Larkin, 2009). Interviews will be conducted with First Responder peer support providers from three different groups (firefighter, police, EMT/paramedic) to gather multiple rich narratives on peer providers’ role. These three groups were chosen as they represent the professions most likely provide initial, in the field response during trauma situations, and as such are considered to be at ‘high risk’ for developing trauma based psychological disorders (Anderson, 2016; Canada, 2015; Fire Rescue Services, 2016).

Interpretative Phenomenological Analysis (IPA) is used to explore how people interpret their experiences (Charlick, Pincombe, McKellar & Fielder, 2016; Pietkiewicz & Smith, 2012).
In the first phenomenological element, the goal is to reduce each participant’s related experience to its core elements. By gathering enough of the core pieces of one participant’s narrative together, the researcher will come to understand as closely as is possible, how that particular storyteller sees the world.

Possible Types and Sources of Data

In Interpretive Phenomenological Analysis data is drawn from a relatively homogeneous set of participants (Charlick et al., 2016). The goal is to provide information that is meaningful to this population in particular, rather than to a broader group as a whole. As a result, the selected participants may not be representative of the greater population of First Responder support providers. Data will be gathered from qualitative interviews with active peer support providers. Decision-making authorities from each of local three identified First Responder branches (firefighters, police, EMT/paramedic) have provided tentative study approval pending confirmation from Walden University. Once approval has been granted, each agency has agreed to assist in the solicitation of prospective research participants through their various communication means (e.g. newsletters, information emails, and presentations at membership meetings). All the subjects will be volunteers. All potential subjects will be provided with a written explanation of the study goals, and will be informed of their right to withdraw at any time without penalty.
References


Legislative Assembly of Yukon. (2016). *Act to amend the Workers’ Compensation Act, with respect to Post-Traumatic Stress Disorder – Bill No. 106*. Whitehorse, Yukon; The Queen’s Printer.


