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THE LIVED EXPERIENCES OF EMERGENCY MEDICAL TECHNICIANS WHEN SEEKING
AND PARTICIPATING IN INDIVIDUAL COUNSELING SERVICES

by

Ester Joy Hutchinson

A Dissertation

Submitted in Partial Fulfillment of the

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Doctor of Philosophy

Major: Counseling Education and Supervision

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Abstract

This dissertation explored the lived experiences of emergency medical technicians (EMTs) that sought and participated in individual counseling sessions. I examined barriers that EMTs in the United States face, as well as discussed relevant literature from current research. By implementing a phenomenological approach that utilizes convenience sampling, this study uncovers the lived experiences of EMTs participating in individual counseling sessions. I interviewed seven EMTs that had participated in at least three individual counseling sessions to understand their experiences. In this investigation, I discovered that these EMTs believed that seeking therapy might be perceived as a sign of weakness by their peers. These EMTs revealed that they did not feel understood by the therapists they had seen to receive counseling services. When it comes to therapist education, they expressed concern that it was insufficient in meeting their needs. The purpose of this study was to educate counselors and identify areas for improvement when working with this demographic. This study was conducted to contribute to the paucity of qualitative research in the field of counseling in order to bridge the gap in existing literature, as well as to aid in the expansion of counseling services available to this community. The objective of this research is to aid in the development of educational programs for serving this vulnerable population.

This dissertation is dedicated to all the EMTs that allowed me to represent their stories. I hope that I have honored your experience. To my first responder family, I also want to thank you for inspiring me along the way. Those who helped me when learning to be a good medic and those that helped me through my own bad calls, you are my brothers and sisters. I hold you all in the highest regard.

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Chapter 1: Statement of the problem

Emergency medical technicians (EMTs) are tasked with the job of responding to trauma and medical emergencies daily throughout their careers. These repeated exposures can lead to an increased risk of developing anxiety, depression, burnout, and posttraumatic stress disorder (PTSD) (Van Orden et al., 2010). The Centers for Disease Control and Prevention [CDC, (2013)] showed that handling these emergencies could impact the EMT's family life and sleep patterns, leading to more distress. In recent years studies have highlighted the mental stressors that commonly occur in first responders (Bennett et al., 2005; Bocerean, 2014; Fullerton et al., 2004; Geiger, 2016; Haugen et al., 2017); however, I specifically looked at the experiences of EMTs in seeking and participating in individual counseling.

First responders are broadly defined as professionals who are called upon when an emergency arises so they can protect the safety of citizens (Arble & Arnetz, 2017; Substance and Mental Health Services Administration [SAMHSA], 2018). According to SAMHSA (2018), the term first responder generally refers to the police, fire services, emergency medical technicians (EMTs), and military personnel. For this study, the title first responders are used to focus on EMTs. According to the National EMS Scope of Practice Model, EMTs are medically trained professionals with four levels of training: emergency responder (EMR), emergency medical technician-basic (EMT-B), emergency medical technician-advanced (EMT-A), and emergency medical technician-paramedic (EMT-P). Thus, each level of preparation has an established skill set, with paramedics holding the highest level of training and skill development (National EMS Scope of Practice Model, 2022). EMTs are, however, arguably "the forgotten profession" within the emergency and healthcare systems (Lawn et al., 2020).

The field of EMS is in crisis (American Ambulance Association, 2021; Bledsoe, 2019; Williams, 2008; Wolfberg & Wirth, 2008). The number of EMTs needed to meet the public's demands for emergency services is not being met (American Ambulance Association, 2021; Bledsoe, 2019; Wolfberg & Wirth, 2008). Certified paramedics commonly leave the profession after only five years of service (Rivard et al., 2020; Zigmont, 2008). Working as an EMT frequently entails putting one's life and safety in danger daily (National Institute for Occupational Safety and Health [NIOSH], 2019). Long hours, physical strain, mental stress, and constantly bearing witness to trauma stressors are all part of the job of a first responder (Galloucis et al., 2000; McCaslin et al., 2006). The repetitive exposure and lack of time to recuperate between emergency calls result in high rates of depression, PTSD, anxiety, and suicidality (Bentley et al., 2013; Marmar et al., 2006; Stanley et al., 2016).

Depending on the situation, post-traumatic stress disorder rates among first responders can range from 8% to 32%. PTSD rates are further impacted by the possible causes of the crisis, any known available aid, available or utilized mental wellness training, and personal circumstances or outside support networks (Newland et al., 2015; Stanley et al., 2016; Van Orden et al., 2010; Vigil et al., 2018). Chronic stress and unresolved trauma can significantly affect a first responders' job performance, personal relationships, health-related morbidity, and mortality (Botha et al., 2015; Heavey et al., 2015; Marmar et al., 2006; Patterson et al., 2012; Quevillon et al., 2016). Traumatic stress is also associated with dysregulated neurophysiology and has a negative impact on both psychological and physical health (Marmar et al., 2006; Pajonk et al.; 2012).

It is uncertain how the barriers and stigma of the counseling process impact the help-seeking behaviors of first responders (Corrigan, 2004; Haugen et al., 2017; Jones et al., 2019).

Research examining a variety of populations and settings demonstrates that barriers to care can lead to many individuals with mental health stressors never pursuing treatment (Jayasinghe et al., 2005), delaying treatment, not adhering to treatment regimens (Corrigan, 2004), or receiving inadequate care (Griffiths et al., 2014).

Many companies and government departments have instituted mental wellness programs such as employee assistance programs (EAP), critical incident stress management (CISM), peer support, and insurance benefits to cover mental health therapy (National Association of Emergency Medical Technicians, 2019). As shown by Newland et al. (2015), these services are effective but are often underutilized. Newland et al.'s (2015) study determined that 3,447 (86%) of the 4,022 respondents experienced critical stress, 1,383 (37%) of the respondents had contemplated suicide and 225 (6.6%) had attempted to take their own life. Roughly 25% of respondents that did not seek help for their critical stress expressed concern about how they may be viewed at work if they had sought support. Over 40% of participants who contemplated or attempted suicide also listed stigma as why they did not seek support (Newland et al., 2015).

The biggest deterrent to using mental health services, such as an EAP, is believed to be a perceived or experienced stigma, even while there may be barriers such as a lack of time to seek therapy or a reluctance to trust in providers (Haugen et al., 2017). The main reasons given by first responders for avoiding using mental wellness services are that they do not want to look weak, that they do not want to be perceived or treated differently by their peers, or that they are worried about possible career ramifications (Britt & McFadden, 2012; Corrigan, 2004; DePierro et al., 2020; Drew & Martin, 2021; Haugen et al., 2017; Hoge et al., 2006).

Purpose of the study

The purpose of this study was to explore and understand the EMTs' experience of the individual counseling process. I explored the lived experience of EMTs who have entered and engaged in an individual counseling process. As researchers, clinicians, and educators we want to better understand the lived experience (Connelly, 2016; Dahlberg et al., 2018; van Manen, 2015); therefore, I sought to understand the phenomena of individual counseling experiences among EMTs.

The goal of the present study is that counselors and other readers may utilize these lived experiences to improve and create better mental health programs for EMTs. While many EMTs have stated that they would like more mental health programs, there has been an equal response stating that they are not utilizing available services (Hutchinson et al., 2022; National EMS Management Association [NEMSMA], 2016). This study aims to understand the disparity in EMTs' help-seeking behaviors. Through learning about the lived experiences of those EMTs that have experienced individual counseling, I hope that we, as counselors, can work toward healing this community.

Significance of the study

While there have been numerous studies examining mental health issues and stigma for first responders (Bently et al., 2013; Corrigan, 2004; Crowe et al., 2017; Drew & Martin, 2021; Essex & Scott, 2008; Haugen et al., 2017; Page et al., 2005), there have been minimal studies (Jones et al., 2019) that have examined the experiences of EMTs in this way. After reviewing the literature, I discovered just one research that looked at a comparable phenomenon from the perspective of psychiatric nurses (Jones et al., 2019). Jones et al. (2019) interviewed 32 firefighters/ EMTs and found that all participants expressed a need for better education on mental

health. Barriers to seeking mental health services included the fear of appearing weak, confidentiality breaches, negative experiences with therapists, and concerns about family burdens (Jones et al., 2019).

If we as researchers want to understand this phenomenon, we must listen to the people that have lived those experiences. The limited available quantitative research has shown that there is a need for EMTs to receive mental health services due to the emotional toll of their work; however, these services are underutilized (Horan et al., 2021; Jones et al., 2019; Newland et al., 2015).

The findings of this study might have an influence on the mental health, retention, prospective pre-career counseling, and treatment/counseling methods for EMTs whose lives are affected by trauma and pressures associated with their work. The field of counseling will be enriched, due to the phenomenological method that was used by allowing us to understand and address current barriers as perceived by the EMTs (Edwards et al., 2006). Finally, the findings may aid in bridging the gap between EMTs and counselors.

Theoretical framework

My theoretical basis for this study was hermeneutic phenomenology. Through story collections, phenomenology seeks to understand the unique emotions, perceptions, and reality of an experience (Yüksel & Yldrm, 2015). Gillo (2021) asserts that in hermeneutics, the researcher seeks to "understand" a phenomenon by thoroughly reviewing the body of literature already written about the subject under inquiry. He continues by saying that while being open to the originality and uniqueness of the phenomena as witnessed by the participants in the present, scholars must work to understand what has been written about a certain occurrence in the past (Gillo, 2021). Because phenomena are formed by participants who are human, phenomenology is

founded on a constructivist paradigm (Rockmore, 2011). According to Kockelmans and Lourer (1967), a person's thoughts, feelings, and perceptions form the basis of their existence. Max van Manen (1990) stated,

“The essence of a phenomenon is universal which can be described through a study of the structure that governs the instances or manifestation of the essence of that phenomenon... A universal or essence may only be intuited or grasped through a study of the particulars or instances as they are encountered in lived experiences” (p. 10).

While quantitative research has identified existing mental health issues as well as a lack of utilization of present treatments, it does not explain why utilization is low. This can only be described by recounting one's own personal experiences. As a result, employing a hermeneutic phenomenological method enabled the answers to be communicated via the stories of the EMTs who experienced it.

Research questions

When considering my research questions, it was important to ensure that I captured the essence of the lived experience of the EMTs that had chosen to participate. My goal was to understand the EMTs' counseling experiences, from their initial help-seeking behaviors through their participation in individual counseling sessions. The question that I sought to gain an understanding of was “How do emergency medical technicians experience seeking and participating in individual counseling sessions?”

Limitations

Interviewing EMTs about their experience has the potential to cause emotional stress for participants due to an in-group versus out-group thinking process and self-reflection (Tajfel & Turner, 1986). The in-group versus out-group mentality may limit the participants' willingness to

discuss issues directly affecting the EMS population due to any potential status conflict (Creswell, 2007; Tajfel & Turner, 1986).

One of the limitations of this research was the time constraint of the interviews. Since I was not viewed as an outsider because of my credentials of being a paramedic, I was able to connect more quickly. Even with the quick rapport, I believe that this research would have produced richer material with multiple interactions with each participant. The participants became more relaxed and shared more rich information towards the end of the interview, therefore, I believe that multiple meetings could have garnered additional information. Another limitation was the semi-structured interview process that was originally planned. The participants in this research were looking for structure and indicated that they would prefer answering questions or responding to prompts. They asked questions like "Did I answer what you were searching for?" and "Can you tell me what you want to know?" to check whether they were providing the information I was looking for.

Delimitations

While the term first responder is an encompassing term that covers multiple services, this study is only focusing on the experiences of EMTs that have been through therapeutic counseling. Intervention services will not be offered. I am not examining the theoretical approaches that a therapist may use, only the perceptions as held by the EMT.

Summary

EMTs are responsible for the care of the community that they serve during times of crisis (Blakeslee et al., 2013). There are several papers that address mental health difficulties for this demographic as well as the claimed culture of help-seeking behaviors (Arble & Arnetz, 2016; Backberg, 2019; BC First Responders Mental Health, 2017;

Bennett et al, 2005; Bledsoe, 2020; Britt & McFadden, 2012; Dowdall-Thomae, 2012; Hallinan et al., 2021), there is a paucity of research that examines the experience of those that participate in individual counseling sessions. This study seeks to answer the question “What is the lived experience of EMTs that have sought and participated in individual counseling sessions?”

This study utilized a hermeneutic theoretical framework. The term hermeneutic refers to both the Greek verb "hermeneuein" or "to interpret" and the noun "hermeneia" or "interpretation" and to Hermes, the messenger and interpreter of wisdom and understanding to mortals of the Greek gods (Thompson, 1990). Hermeneutics is purposeful in the sampling selection; therefore, participants were targeted with specific criteria for participation. Due to the time restraints of this study, a convenience sample was chosen.

Definition of terms

AWOL- Absence without leave; absent often without notice or permission.

Burnout — A specific occupational stress reaction among human service professionals, resulting from demanding and emotionally charged interactions with recipients (Bakker & Heuven, 2007, p. 424). Burnout is characterized by emotional exhaustion and depersonalization due to chronic emotional strain (Bakker & Heuven, 2007; Heppner, 2007; Pines, 2005). The dehumanization of patients, gallows humor, and blaming the patient for the stressful situation are all signs of burnout (Patterson & Brice, 2009; Pines, 2005).

Cardiopulmonary Resuscitation (CPR) - is a lifesaving technique that is useful in many emergencies, such as a heart attack or near drowning, in which someone's breathing or heartbeat has stopped.

Categories- Categories are concepts that allow the grouping and clarification of data (Miliano, 2005).

Coding- Coding is an analytical approach used to detect major themes or properties that enable the construction of theory used in grounded theory (Leedy & Ormond, 2005).

Critical Incident Stress Management (CISM)- is an intervention protocol developed specifically for dealing with traumatic events (CISM International, 2021).

Emergency Medical Services (EMS)- Emergency medical services comprise the system of professional medical care providers who respond to emergency calls that are received through the 911 dispatching system (Bledsoe et al., 2008).

Emergency Medical Technician (EMT)- a specially trained medical care professional certified to provide life-saving emergency services (NAEMT, 2016).

Emergency Medical Responder (EMR): EMRs administer life-saving techniques like CPR and mouth-to-mouth resuscitation while waiting for more qualified medical professionals to arrive. EMRs also aid other medical professionals at the scene of an emergency or during transport. EMRs perform basic interventions with minimal equipment (NAEMT, 2016).

Emergency Medical Technician Basic (EMT-B)- EMTs have the knowledge and skills needed to stabilize and safely transport patients for all calls from routine transport to life-threatening emergencies. They provide treatment onsite and during the ambulance ride to the hospital, such as controlling bleeding, stabilizing breaks, and addressing shock. EMTs perform interventions with the basic equipment typically found in an ambulance (NAEMT, 2016).

Emergency Medical Technicians Advanced (EMT-A): provide the same services as an EMT, plus administer fluids and some medications, and use the advanced medical equipment carried in the ambulance (NAEMT, 2016).

Emergency Medical Technician Paramedic (EMT-P)- provide advanced life support skills—e.g., assesses organ systems, inserts IV catheters, administers emergency fluids/medications, noninvasive airway management, uses defibrillators, manages the emotionally disturbed, obstetric emergencies (NAEMT, 2016).

Employee Assistance Program (EAP)- An EAP is a voluntary, work-based program that offers free and confidential assessments, short-term counseling, referrals, and follow-up services to employees who have personal and/or work-related problems (U.S. Office of Personnel Management, 2022).

In-depth interviews- In-depth interviews allow the story of the lived experiences of the informants to evolve as the researcher develops a rapport with participants by concentrating on the participants' experiences from their point of view (Husserl, 1973).

National Registry of Emergency Medical Technicians (NREMT)- a national certifying agency for Emergency Medical Technicians to establish and standardize training requirements

Phenomenon- The phenomenon is the experiences and knowledge that evolves from key themes in the data and symbolizes concepts in grounded theory (Husserl, 1973; Leedy & Ormond, 2005).

Post-traumatic stress disorder (PTSD)- Post-traumatic stress disorder is a severe and ongoing emotional reaction because of a psychological and/or physical trauma outside of ordinary human experiences (APA, 2000; Carmona, 2007; Muller2009). The DSM 5 (APA, 2013), defined PTSD as a spectrum disorder characterized by persistent intense fear, helplessness, and avoidance traits.

Chapter 2: Relevant Literature

There are 438,160 nationally certified Emergency Medical Technicians (EMTs) in the United States of America, according to the 2021 National Registry of Emergency Medical Technicians (NREMT) database. These EMTs are responsible for caring for between 25-30 million patients (about the population of Texas) per year (NREMT, 2017). In the United States, there are four levels of training for emergency medical services (EMS): emergency responder, emergency medical technician-basic, emergency medical technician-intermediate, and emergency medical technician-paramedic. Emergency responders are volunteers that have been trained in cardiopulmonary resuscitation (CPR) and first aid. Emergency Medical Technicians Basic- (EMT) have received training in CPR and first aid, with the added basic training in managing medical and traumatic injuries. EMT-Advanced (EMT-A) has basic skills as well as training in minimally invasive techniques. EMT-Paramedics (EMT-P) have gone through more rigorous advanced training, including learning about anatomy, physiology, and advanced medical skills (United States Bureau of Labor Statistics, 2011). Each level of preparation has its own established skillset, with paramedics holding the highest level of training and intensive skill development. While this study focuses on EMTs, the term first responder is a broad description that can be used to include all levels of EMS personnel, firefighters, and police officers. Much of the extant research currently focuses on first responders as a broad group or specifically on police officers and firefighters. Absent research regarding EMTs, the literature based on those professions that parallel the line of work of EMTs is also reviewed.

EMTs must be able to cope with a variety of job-related and personal pressures. The nature of the job requires a high workload and time requirements, as well as focusing on patient stabilization, calming terrified or disturbed victims, and loved ones, and ensuring appropriate

continuity of treatment upon patients' arrival at their destination hospital (Essex & Scott, 2008; Roth & Moore, 2009). Furthermore, the task of addressing emergencies might affect family life due to numerous emotional shifts and sleep interruptions (Centers for Disease Control, 2020; Roth & Moore, 2009). Additionally, severe injuries, frightening emergency calls, and the loss of patients or coworkers can all raise the probability of suicidality developing (Stanley et al., 2016; Van Orden et al., 2010). These work-related concerns, alone or in conjunction with home-related pressures, can have a wide range of mental health repercussions (Fullerton et al., 2004; Roth & Moore, 2009; Van Orden et al., 2010).

The examination of EMTs' mental health and wellness began as early as 1985. (Grigsby & McKnew, 1988; Revicki & May, 1985). These early studies include accounts of mental health concerns that occurred and were reported in a broad range of countries. Although societal developments have increased acceptance of individual therapy in many nations, including the United States, Newland et al. (2015) and Hutchinson et al. (2021) found that services were underutilized.

Burnout

One of several potential mental health consequences for EMTs is burnout (Bently et al., 2005; Essex and Scott, 2008; Crowe et al., 2017; Khatiban et al., 2015). According to the Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health (2003) burnout is defined as the following:

Emotional and physical exhaustion results from a combination of exposure to environmental and internal stressors and inadequate coping and adaptive skills. In addition to exhaustion, the person with burnout exhibits a negative attitude toward their job, low self-esteem, and personal devaluation. Causes of burnout often include stressful, even dangerous, work

environments; lack of support; lack of respectful relationships within the work environment; low pay scales; shift changes and long work hours; understaffing; pressure from providing continuous high levels of care over long periods; and frustration and disillusionment resulting from the difference between job realities and job expectations (Miller-Keane Encyclopedia and Dictionary of Medicine, 2003).

Burnout Syndrome is not listed as an official, diagnosable mental illness in the Diagnostic and Statistical Manual-5 ([DSM]: APA, 2013), but it is recognized by the International Classification of Disease-10 in Europe and was recently added to the United States in May 2019 with the recent International Classification of Disease-11 updates. Burnout is a danger for EMTs since it is linked to increased rates of illness-related absences from work and a higher chance of abandoning the EMS profession (Backberg, 2019; Crowe et al., 2017).

Subset elements in burnout include depersonalization, emotional exhaustion, and personal achievement (Maslach & Jackson, 1981). Due to the lengthier exposure to patient care and more years of employment, paramedics may suffer more of all three components of burnout than other EMTs (Bently et al., 2005). According to Essex and Scott (2008), the majority of volunteer EMTs in a United States sample reported greater rates of depersonalization and emotional exhaustion, but these participants also rated high personal achievement, which may be linked to a sense of community service.

This phenomenon is not isolated to the United States. Nearly half of the EMTs in Iran reported emotional exhaustion, and over one-third reported depersonalization (Khatiban et al., 2015). However, among medical professionals in Turkey, paramedics reported less emotional exhaustion than physicians and nurses (Gökçen et al., 2013). In another study, 94% of ambulance staff reported feeling personally accomplished in their professional roles, according

to Beldon and Garside (2021). However, more than 50% of the participants reported experiencing varying degrees of burnout, with 87% exhibiting moderate to high levels of depersonalization towards their work. Complex factors contributed to the causes of stress, including a lack of managerial support, ambulance service abuse by the public, unscheduled overtime, and a lack of work-life balance (Beldon & Garside, 2021).

Another symptom that could arise is compassion fatigue. Compassion fatigue is defined as *physical and mental exhaustion and emotional withdrawal experienced by those who care for sick or traumatized people over an extended period* (Lluch et al., 2022; Merriam-Webster, 2022). This is differentiated from burnout which is caused by exposure to everyday work stresses whereas *compassion fatigue* results from exposure to a traumatized individual (Cocker & Joss, 2016). As a result, the attitude of the EMT, the ability to effectively fulfill their role, and patient outcomes can all be negatively impacted (Rosenstein, 2013).

According to Essex and Scott (2008) and Stefurak et al. (2020), job satisfaction is a contributing factor in why EMTs remain on the job. EMTs face high-stress work environments and are asked to risk their own welfare to serve their community. Their work may be motivated by altruism and public welfare. The idea of helping others gives them a sense of purpose and job satisfaction that keeps EMTs on the job even when burnout is reached in other areas (Essex & Scott, 2008; Stefurak et al., 2020).

Anxiety, Depression, and Posttraumatic Stress Disorder (PTSD)

High turnover rates in EMS have long been associated with the absence of mental health services for the paramedic community, emergency service personnel, and public safety personnel (Pathman et al., 2004). Approximately one-quarter of emergency medical technicians (EMTs) and a third of paramedics are affected by work-related stress (Crowe et al., 2018). Elevated

levels of anxiety and depression can also be dangerous for EMTs (Bennett et al., 2005; Bocerean, 2014). Bennet et al. (2005) showed that among over 600 emergency personnel in the UK, 23% reported clinical levels of anxiety, and 9% reported clinical levels of depression. This large-scale study indicated that emergency work was associated with a negative emotional impact on professionals (Bennett et al., 2005).

First responders frequently report having depression, and different studies have shown different rates and levels of severity. For instance, 6.8% of licensed EMS providers in case-control research reported having depression, with moderate depression being the most prevalent form (3.5%). (Bentley et al., 2013). 21.4% of the medical personnel who responded to the big East Japan earthquake (2011) had a diagnosis of clinical depression (Garbern et al., 2016). 3.1% of emergency room doctors in research conducted in Germany experienced clinical depression (Pajonk et al., 2012). 21.4% of the medical personnel who responded to the big East Japan earthquake (2011) had a diagnosis of clinical depression (Garbern et al., 2016). 3.1% of emergency room doctors in research conducted in Germany experienced clinical depression (Pajonk et al., 2012).

Stress among emergency medical staff has increased dramatically during the COVID-19 pandemic, according to Iiczak et al. (2020), due to previously unknown causes. The fear of contracting COVID-19, a decrease in the level of safety when performing emergency medical procedures, and the marginalization of care for patients who do not have COVID-19 are all predictors of professional stress. Being a woman and working in the healthcare profession are two additional socio-demographic factors that contribute to stress among emergency medical personnel (Iiczak et al., 2020).

First responders have been recognized as a group of people who are frequently exposed to physical (i.e., medical) and psychological hazards and stresses because of their consistently elevated workload and concerns about contracting COVID-19 for themselves or their loved ones (Walton et al., 2020). In fact, during the COVID-19 epidemic, one in five healthcare professionals experience depression and anxiety (Pappa et al., 2020; Shaukat et al., 2020).

According to research by Huang et al. (2022), the high incidence of depression, anxiety, and stress among first responders during medical crises during the COVID-19 pandemic highlight the significance of monitoring their psychological well-being. Early recognition and treatment of minor depression, anxiety, and stress among first responders are essential for preventing the emergence of moderate and severe symptoms (Huang et al., 2022).

Years of service, worry, anxiety, and depressive symptoms associated with COVID were all substantially correlated with medical vulnerability, per bivariate correlations conducted by Vujanovic et al. (2021). Anxiety and depressive symptoms were also connected to COVID-related anxiety. Their findings imply that anxiety and depressive symptoms may be more significantly influenced by COVID-19-related concerns than by COVID-19 exposure. PTSD symptoms are strongly correlated with COVID-19-related anxiety in first responders who have been exposed to the virus (Vujanovic et al., 2021).

The prevalence of PTSD in the general population ranges between 1% and 8% (American Psychiatric Association, 2013), in EMTs it is estimated to be 11% (Petrie et al., 2018). Dowdall-Thomae et al. (2012), reported that over 50% of firefighter deaths were related to stress and exhaustion. Repeated exposure to serious injuries or dead bodies resulted in a higher probability of developing PTSD, depression, alcohol problems, anxiety, stress, and fatigue symptoms (Brooks et al., 2016).

It is evidenced that symptoms of burnout and post-traumatic stress disorder (PTSD) can increase the chances of error in medical diagnosis and treatment on the job (LeBlanc et al., 2005). According to Burke & Pignata (2020), chronic stress and unaddressed trauma can affect EMTs' work performance, relationships, morbidity, and mortality. EMTs tend not to readily accept that they are suffering from symptoms associated with PTSD, as it is often considered to be a weakness in the workplace (Carmassi et al., 2020).

In 2019, at least 26 states considered new legislation addressing workers' compensation coverage for PTSD and other mental health injuries for first responders. A total of 122 related bills were considered in 2019 (National Council on Compensation Insurance, n.d.). Given this recent legislation, additional research regarding first responders' mental health needs and experiences is important and timely.

Vicarious trauma (VT) is another aspect that may affect the mental health of EMTs. VT is learning about another individual's traumatic experience, evoking an empathic response (Hallinan et al., 2021). VT is a compounding factor for EMTs because they must cope with the direct trauma they have experienced, and with the secondhand trauma they experience (Bouchillon, 2018).

Suicidality

Comprehensive national data on EMTs' suicidality does not currently exist. However, some research suggests that EMTs may have higher risks for numerous mental health conditions, including suicidal thoughts and behavior (Marmar et al., 2006; Wang et al., 2010). According to Vigil et al. (2021), EMTs committed suicide at a higher rate than the overall population in the United States.

A comprehensive meta-analysis of 63 quantitative studies indicated that first responders presented with elevated suicide risk when compared to the general population (Stanley et al., 2016). According to the CDC (2015), the national average for suicide contemplation is about 3.7%, but for EMTs Newland et al. (2015) reported suicide contemplation as 37%. When looking at suicide attempts the national average is 0.5% and among EMTs, it is 6.6%.

According to the Centers for Disease Control (CDC), the job of handling emergencies can intrude into one's family life causing emotional changes and sleep disruptions (CDC, 2020). In addition, exposure to painful injuries, fear-inducing events, and facing the death of patients or co-workers can increase the possibility for suicidality to emerge (Van Orden et al., 2010). These work-related issues, alone and in combination with home-life stressors, may lead to a variety of mental health consequences (Fullerton et al., 2004).

Research published by NTHSA (2021) suggests that working in specific professions, such as first responders, may be more likely to commit suicide. Compared to those who die in the line of duty, firefighters, law enforcement personnel, and EMTs are more likely to commit suicide. Members of the public are less likely to do so. Public safety communicators are also in danger; studies have shown that up to 24% of them exhibit symptoms of PTSD and that almost a quarter experience depression. Despite how high these figures are, they are normally underreported (NTHSA, 2021).

Barriers to Treatment, Stigma, & Social Construction

According to Haugen et al. (2017), stigma and barriers to care are experienced by a sizable number of first responders creating delays in treatment. These treatment delays can potentially lead to increased rates of post-traumatic disorders for EMTs (Haugen et al., 2017). The EMT culture values strength, self-reliance, and helping others (Erich, 2014). This

may make it difficult for individuals to seek care, perpetuating poor mental health outcomes in this vulnerable group (Jones et al., 2018).

However, even when mental health options are available, we are aware that fewer than 40% of people in the general population who have mental health symptoms seek professional assistance (Institute of Medicine, 2015). This percentage is unknown among EMTs but is anticipated to be lower given the EMTs' culture's focus on fortitude and independence (Erich, 2014; NVFC, 2008). There is limited research on the rates of assistance-seeking and service use among EMTs with mental health issues, but according to public personal stories (such as magazine articles and blogs), mental health issues are seen as indicators of vulnerability. In EMT situations, disclosing mental health issues to peers can breed distrust and cause people to worry about each other's physical safety (Henderson, et al., 2016).

Geiger (2016) refers to the stigma that is associated with help-seeking and how EMTs are more likely to use dark humor and lean on camaraderie amongst first responders than they are to speak to a therapist. Newland et al. (2015) performed a quantitative study to examine if company employee assistance programs (EAP) were successful. Their findings show that they are successful over 53% of the time they are utilized, yet only 11% of their participants had utilized the services (Newland et al., 2015). According to the CDC (2020), half of United States companies offer an EAP to their employees. Newland et al.'s (2015) study reflect the gap in understanding the barriers to utilizing the mental wellness services offered.

Employment factors and Help-seeking behaviors

News amongst EMTs is quickly shared, often it pertains to feeding the belief that they will be penalized for reporting mental health issues such as PTSD. A veteran in Montgomery County Tennessee sued the sheriff's office for a violation of civil rights after he was fired from

his job following an on-the-job incident that triggered symptoms of PTSD (Rodriguez v. Montgomery County, Tennessee, 2021). A Georgia firefighter who was prevented from returning to duty after taking stress-related medical leave is suing his department claiming disability discrimination (Smallwood v. Forsyth County, Georgia, 2018).

EMTs are more action-oriented, self-contained men and women in a culture where "complaining" is not acceptable behavior and seeking mental health treatment for difficulties related to one's profession is unlikely to be accepted (Flannery, 2015). Seamark and Gabriel (2016) examined the help-seeking behaviors and avoidance factors of young adults. They interviewed 6 UK psychology students from two different classes. They found several influential factors that suggest several barriers, such as *Gender roles, Awareness and Perception of Help, Social and Cultural Influence, and Fear of Stigma and Rejection* (p. 125). The purpose of this study was to attempt to fill the gap left by quantitative studies in examining help-seeking behaviors (Seamark and Gabriel, 2016).

Geiger (2016) used phenomenology to study Israeli police officers and their responses to critical incidents. She interviewed 11 Israeli police officers and discovered through in-depth interviews, that with the rate of terrorist attacks and critical incidents that these officers managed their emotions by putting aside their feelings and just responding to the incident. It was reported that the officers would not return to feeling emotions until they were on their way home and then would experience a mix of professional pride and sorrow over the dead. They would attempt to move beyond this by doing "normal" activities. These first responders later revealed an "intense awareness and vivid traumatic memories of the scene which they seldom shared with family members or therapists" (p. 427). These Israeli police first responders displayed a preference to live in denial rather than confront the emotions that were involved with the trauma that they had

just endured. The hero subculture that is attributed to these police first responders has shown that treatment was rarely sought since it would entail stigmatization (Geiger, 2016).

Commonly used therapeutic approaches

First responder therapy research is still in its infancy, and numerous fundamental difficulties must be addressed in future studies (Flannery, 2015). Currently, the evidence is inconsistent when comparing which coping styles may prove to be most preferable at certain points following traumatization, although Norris (2001) has noted that minimizing the event or avoidant coping strategies have consistently been associated with poorer outcomes.

Numerous therapeutic approaches claim to be successful in treating trauma such as trauma-focused cognitive-behavioral therapy (TF-CBT), Eye Movement Desensitization and Reprocessing (EMDR) therapy, Rapid Resolution Therapy (RRT), Dialectical behavioral therapy (DBT), and more (APA, 2020; Anxiety and Depression Association of America, 2021; National Institute of Mental Health, 2019; Watkins et al., 2018). Several medications can be prescribed for treating trauma, and more recently there has been a shift toward the use of psychedelics as a treatment (Krediet et al., 2020; Doblin, 2002; Healy et al., 2021). There is no one approach that is exact in treating this population.

Summary

In summary, numerous factors can be attributed to delays in seeking mental health services, such as employment concerns, social support, or stigmatization (Smallwood v. Forsyth County, Georgia, 2018; Flannery, 2016; Geiger, 2016). EMTs are suffering in a way that is causing preventable death (Van Orden et al., 2010; Newland et al., 2015; Marmar et al., 2006; Wang et al., 2010). One way to serve this population is to listen to their experiences and learn ways to communicate and break down barriers.

First responders are always on the scene as soon as an event or tragedy occurs, safeguarding the public's safety and welfare (CDC, 2020; Van Orden et al., 2016). However, according to SAMHSA (2018), they run a serious risk of being exposed to highly stressful events that might endanger them or the individuals they are responsible for. First responders are at significant risk for mental health issues including stress, PTSD, depression, drug abuse, and suicidal thoughts and attempts because of this (CDC, 2020; SAMHSA, 2018; Van Orden et al., 2016).

Chapter 3: Methodology

In this chapter, I discuss the rationale for using a qualitative phenomenological approach. I provide a brief history of the hermeneutic phenomenological approach along with the research question. I outline my role as the researcher along with my assumptions going into this study. Finally, I discuss the procedures I used to select participants and instrumentation, collect data, store it securely, and analyze it.

Research Question

What is the experience of EMTs when seeking out and participating in individual counseling?

Purpose

This study aims to understand and share the lived experiences of emergency medical technicians (EMTs) who sought and participated in individual counseling sessions. Extant research about EMTs is quantitative in nature, therefore leaving out the nuances that contribute to the understanding of the individuals that experience the process of seeking and participating in therapeutic counseling services.

I chose a phenomenological research design because it allowed me to explore and illuminate the personal meanings and experiences of EMTs who sought and participated in individual counseling sessions. Phenomenology is a research methodology that is compatible with counseling because it is an extension of our professional practice to evaluate specific information about the experience. It also has a solid philosophical foundation and is the best method for figuring out how people generally experience a phenomenon. Phenomenology, according to Max van Manen, is distinct from nearly every other discipline of science in that it

"attempts to gain insightful descriptions of the way we experience the world pre-reflectively, without taxonomizing, classifying, or abstracting it" (van Manen 1997, p. 35).

Phenomenology seeks, among other things, to investigate the breadth and significance of participants' lived experiences. Phenomenologists specifically aim to comprehend how people intentionally and consciously think about their experience and the collective and individual intrinsic experience of a phenomenon of interest (Wertz, 2005). Using a reflective phenomenological approach allows for a phenomenon to be examined through a holistic lens (Dahlberg et al., 2008).

Dahlberg and Dahlberg (2019) explained that due to the subjective nature of meaning, the meaning of meaning can be challenging to convey in phenomenology. Consequently, the meaning of a phrase is not always obvious but rather depends on the speaker and the situation (Dahlberg & Dahlberg, 2019).

Van Manen (1997) asserts that the goal is to verbally capture the essence of the lived experience so that the reader can gain knowledge from their lived experience. This is done by putting the essence of the lived experience into writing. By giving routine activities a reflective quality, limiting categorization, conceptualizing how we experience the world, and humanizing routine actions, phenomenology seeks to help people understand what it means to be unique and fully understood (van Manen, 1997).

Although there have been numerous studies outlining the need for mental health services amongst EMTs (Burke & Pignata, 2020; Grigsby & McKnew, 1988; Marmar et al., 2006; Wang et al., 2010), there have been very few that have examined the experiences of the EMTs who have undergone individual counseling (Jones et al., 2020). The most effective method for capturing expressive information about beliefs, values, feelings, and motivations that influence

behavior that cannot be expressed in quantitative data is qualitative research. To document this phenomenon, it was important to gather the retelling of the experience from those that lived it. Phenomenology is not only about discovering the phenomenon but also an attempt to understand how one experienced the event (Creswell, 2013; Dahlberg et al., 2008; van Manen, 2015).

Researcher Positionality, Biases, and Assumptions

I approached this study having a significant amount of experience working as an EMT-P alongside other EMTs. This experience influences my social position, and this section serves to communicate my goals and biases as a researcher. I have an associate degree in emergency medical services education, and I continue to hold my Nationally Registered Emergency Medical Technician-Paramedic (NREMT-P). I am also a Nationally Certified Counselor (NCC) and have a master's degree in clinical mental health counseling. I have presented on the issues surrounding the mental health of EMTs at numerous national, state, and regional conferences.

My fieldwork as a paramedic has informed the assumptions I bring to this study. Hearing the many unfavorable accounts of counseling experiences from colleagues inspired this study. There have been more unfavorable than favorable accounts of counseling in the stories I have heard from friends and coworkers. Their retelling of negative counseling experiences may contribute to the EMTs' community stigma about participating in counseling services. My hope is that the results of this study will improve and inform how counselors and employers could assist EMTs seeking counseling services. Working with EMTs, I anticipated discovering a significant need for education in the counseling field. I hope that by sharing their stories, counselor educators can gain a better understanding of the cultural needs of this community and incorporate it into coursework.

Creswell (2007) and Neuman (2006) suggested that when discussing a participant's reality is subjective in nature, it is important to make clear the researcher's influence on the research. Exploring this phenomenon was important to me because of my past experiences working as a paramedic who sought counseling services. I had experienced a need for counseling while working as a paramedic and struggled with finding a counselor. During my time as a paramedic, I needed counseling but had trouble finding a counselor. The mental health coordinator at the company I worked for did not respond to my email for three months after I had asked for assistance. I also struggled to find a counselor who was available within the network and had difficulty navigating the EAP system. I was unsure of what to do. Later, I discovered that many of my peers shared my struggles, sometimes only after their passing. These experiences shaped this research.

Many researchers opt to *bracket* their assumptions for the research study and the findings. A preliminary act in phenomenological analysis known as bracketing or epoché is what Husserl (1977) conceptualized as the suspension of faith in the objectivity of the world. It involves putting aside all doubts about the physical or objective nature of an object, as well as any doubts about the object's actual existence. Text interpretation, according to Gadamer (1971) and Heidegger (1962), is constructivist in nature, which means that it is created during the reading process as carried out by the researcher or interpreter. Additionally, others have asserted that it is untrue for researchers to always act instinctively when attempting to decipher the meaning of a text (Connolly et al., 1988; Dahlberg et al., 2008). Therefore, I opted to *bridle* my experience into shaping the research question and methodology (Dahlberg, 2006).

Dahlberg (2006) defined bridling as a process where the researcher adopts a neutral stance, considers how they are involved in the phenomenon, and frequently thinks about how

meanings emerge during the research act. Bridling is a reflexive action that deviates from the popular phenomenological strategy of bracketing one's prior beliefs and provides another way to envision a less deterministic view of validity in phenomenological research. Bridling is essentially a continuous investigation of one's own conceptualization, presumptions, and presuppositions. By interacting with our perception and knowledge patterns, we can prevent them from operating blindly, or from assuming this or that understanding without first questioning it. Bridling is said to have three components:

1. Restraining one's pre-understanding: "personal beliefs, theories, and other assumptions that otherwise would mislead the understanding of the meaning and thus limit the research openness" (p. 129-130).
2. Not making definite what is indefinite: "Researchers should practice a disciplined kind of interaction and communication with their phenomena and informants, and "bridle" the event of understanding so that they do not understand too quickly, too carelessly or slovenly" (p. 130).
3. Pointed forward: "While "bracketing" is directed backward, putting all energy into fighting pre-understanding and keeping it in check "back there", not letting it affect what is happening "here and now", "bridling" has a more positive tone to it as it aims to direct the energy into the open and respectful attitude that allows the phenomena to present itself" (p. 130).

Research Design

Qualitative data consists of detailed descriptions of lived experiences, interactions, and peoples' perceptions (Mertens, 2005). Phenomenological research can be used to understand the social constructs of first responders' attitudes toward mental health-seeking behaviors by

examining their first-person experiences. Research is often motivated by a desire to fill a gap that appears to exist between theoretical knowledge and practical function or to make changes with evidence-based clinical practice by implementing research results (Lowenstein, 1994).

This study specifically utilized a phenomenological design while examining help-seeking behaviors. According to van Manen (1997), a conversational interview should be opened with a prompt that allows the storyteller to share the narrative in a way that they choose. I allowed for prompts to help me get to the heart of the experience considering that the primary research questions are about what it is like to seek and engage in individual counseling.

Participants

In hermeneutic phenomenological research, the goal of participant selection is to choose subjects who have had the experience that is the subject of the study, are willing to discuss it, and are sufficiently different from one another to increase the likelihood of them telling rich and distinctive stories about it (Fuster Guillen, 2019; Polkinghorne, 1989; van Manen, 1997). Creswell (2007), Ellis (2016), Patton (2003), and Mertens (2005) noted that the appropriate sample size for phenomenological inquiry is 6–20 participants or until saturation due to the vast amount of information elicited during the interviews. The term "data saturation" is used when a research process has reached the stage where all the data required to draw the necessary conclusions has been gathered and further data collection will not result in new, insightful information (Fusch & Ness, 2015). The final figure was determined by the number of EMTs who met the requirements and were open to sharing their personal experiences and stories of seeking help in one-on-one counseling sessions.

With seven participants, this study reached data saturation (Hill et al., 2014; Jackson et al., 2015; Middlemiss et al., 2015) when the experiences were not producing new information.

According to Saunders et al. (2017), saturation is frequently viewed from the perspective as being distinct from and occurring before formal analysis, saturation can be found early in the process. The researcher's interpretation of what they hear during interviews is frequently the basis for decisions about when additional data collection is unnecessary; as a result, this decision can be made before coding and category development (Saunders et al., 2017). The seven interviews brought forth experiences of struggle, leading to the five themes with subthemes discussed in chapter four.

The aim of this study was to better understand the lived experiences of the participants. The therapeutic alliance in counseling develops in the first five sessions of therapy, usually peaking around the third session (Ardito & Rabellino, 2011). Therefore, only EMTs that had participated in at least three counseling sessions were considered for participation in this study. No interventions or tests were provided that could have altered the participants' responses.

I used a purposefully selected convenience sample of EMTs. This type of research frequently uses a convenience sample, which is a term for people who are easily reachable. Because qualitative research does not aim to be generalizable, the sample does not need to be representative of all EMT groups who have encountered the specific phenomenon.

Participants were recruited using a snowballing technique through Facebook postings on social media sites. With a purposeful convenience sample, participants are chosen based on criteria and their willingness to participate. I advertised the study's recruitment on Facebook pages catering to this demographic to reach participants from various US regions. To determine fitness for this research, individuals interested in participating were asked to complete three screening questions. Participants who met the initial screening requirements were asked to provide their email addresses, and those who did so were sent a demographic questionnaire and

asked to select a Zoom meeting time. Eligible participants were given twenty-dollar gift cards in exchange for their time in the interview process. Completion of the interview was not tied to the monetary gift.

Initially, 30 interested participants filled out the brief preliminary screening survey and provided their email addresses. Four of the thirty participants were ineligible because they had not attended at least three individual counseling sessions. The demographic questionnaire, which allowed them to choose a time to meet and a pseudonym, was emailed to 26 eligible people; legal names were not collected. Out of the 26 EMTs who met the initial screening requirements, seven completed the demographic questionnaire and scheduled a Zoom meeting. The Zoom link was emailed to the seven participants, and the virtual face-to-face interviews took place over the course of four weeks. All interviews were audio recorded using Zoom and later transcribed. Before the call for participants, consent forms were approved by the Institutional Review Board (IRB) committee through the University of Memphis.

The participants were from six states and the District of Columbia: New Jersey, Louisiana, Texas, Wisconsin, Kentucky, and Montana. Three participants identified as men, and four identified as women. The majority (five) identified as White, one as African American, and one as mixed race. The participants' ages ranged from 21-60 years old with a mean age of 37. The years of service ranged from 3-40 years on the job, with the mean being 14.5 years. Four participants were Paramedics (EMT-P), two were Basic EMTs (EMT-B), and one was an Advanced EMT (EMT-A). While there were several geographic and demographic differences in the individuals that participated, there were many similarities in their experiences; both will be highlighted in chapter 4.

Ethical Considerations

There are inherent risks with any research such as triggering memories, stress, emotional distress, inconvenience, and possible loss of privacy and confidentiality associated with participating in a research study. My study was reviewed and approved by the IRB of The University of Memphis and adhered to ACA guidelines. The participants could elect to discontinue their participation at any time without penalty before the completion of this research. All participants were given pseudonyms to protect their identity and provided a safe environment for the retelling of their experiences.

Before and after the interview, I provided referral sources to the participants to address any unresolved feelings that might have evolved through the retelling of their experience. Written notes, transcribed and recorded interviews, and identification sources were kept in a locked file in a private office and destroyed within seven days of completion of the defense, including revisions, of this dissertation. Recorded electronic interviews were stored on an encrypted system with password protection.

Data Collection

Phenomenological research seeks to elicit recollections of lived experiences from participants who experience a similar phenomenon, a group ethos, and a shared sense of living (Creswell, 2013; Husserl, 1970; van Manen, 2015; Wertz, 2011). The gathering of these recollections was accomplished through open-ended interviews (Leedy & Ormond, 2005). The open-ended interviews continued until the information was gathered or the participants felt they had finished telling their story, with prompts provided to aid in the facilitation of the storytelling (Leedy & Ormond, 2005). The list of prompts in the appendix were not used as questions nor

were they required for every participant. The interview prompts allowed for natural conversation while still eliciting each participant's complete story.

Data was collected over six weeks beginning with the dissemination of the demographic questionnaires and individual interviews. The main source of data came from the open-ended interviews and participant observations. Interviews lasted between 46 minutes to 64 minutes. Each interview was audio-recorded and transcribed immediately to secure accuracy and understanding of the interviewee's response and emotional content. Transcription services were employed to expedite the process. The interviews were open-ended to allow the participants to express their sentiments about their experience seeking and participating in individual counseling sessions. The participants were encouraged to explore any pertinent points that arose within the interview process.

Trustworthiness

Phenomenology requires a level of trust when building rapport (Di Ciccio-Bloom & Crabtree, 2006; Quinney et al., 2016). My previous work in this area helped me establish rapport and communicate with the language, jargon, and terminology that are frequently used in this industry. The participants were given control of the process and encouraged to continue sharing with the use of prompts that encouraged further exploration of the phenomenon. My self-reflection continued throughout the data collection and review by utilizing peer debriefing and reflective journaling as earlier outlined. The interviews remained conversational in format.

The interviews lasted from about 45 minutes to over one hour. The interview length varied based on participants' interaction, trust, and willingness to share details of their stories. All interviews were included for coding. Some participants appeared to feel more comfortable and eager to share their experiences quickly, while others appeared guarded and slower to

disclose. Many participants indicated that they had never been asked to discuss their experiences for anything that had purpose or value before this experience. The participants were provided with the opportunity to end the interview at any point and encouraged to share their stories only for as long as they were comfortable.

Credibility, authenticity, transferability, dependability, and confirmability are other terms for trustworthiness or validity (Amankwaa, 2016; Connelly, 2016; Creswell, 2013; Shenton, 2004). The degree of confidence in data, interpretation, and methods used to protect a study's quality is called trustworthiness (Shenton, 2016). Because qualitative research is based on subjective, interpretive, and contextual data, it must be scrutinized and questioned more rigorously. Due to this scrutiny, I did the following to ensure the accuracy of the data (Creswell, 2013; Shenton, 2004): I used verbatim reporting of data findings, detailed participant descriptions, a field journal to record any personal feelings that came up during the research process, and peer debriefing as outlined by my IRB. Transcripts were provided to all seven EMTs for review prior to coding to ensure trustworthiness and credibility in the interview. Although participants were provided the opportunity to provide feedback, none participated in member checking.

Finding a way to balance remaining open to one's own interpretation with remaining open to the phenomenon and new insights is difficult (Anderson, 2010). I am aware that my past experiences have shaped the way that I see the world therefore, I maintained a field journal to document all thoughts, emotional responses, and questions that arose from the interviews as well as maintained documentation of all preconceived ideas. I used a graduate student for peer debriefing who had also taken at least one qualitative course and participated in coding for qualitative research teams. This was done after removing all personally identifiable information,

as outlined in my IRB. To maintain objectivity in my research, I looked at my self-awareness and diligently reflected.

Data Analysis

The research methodology and gaining access to the EMT population presented inherent difficulties (Corrigan, 2004; Creswell, 2007; Drew & Martin, 2021; Jones et al., 2019). All open-ended interview sessions were audio recorded and transcribed verbatim by a hired transcriptionist to gather the experience of EMTs. I checked each transcription for accuracy upon receipt.

The data was organized, coded, and assessed to identify themes using the Dedoose version (9.0.85), a computer-assisted qualitative data analysis (CAQDAS) (Salmona et al., 2019). This program was used to highlight ideas that emerged while reading and rereading the transcripts and store them for future review. The third time through, I began to look for patterns in the data that appeared in the narrative, which helped me develop the codes. Those patterns consisted of social stigma and general feelings about the experience of seeking and participating in individual counseling. Despite the fact that Dedoose is a program with a wide range of capabilities, it was only used to save transcripts and identify patterns that were eventually combined into the themes listed below. I used a phenomenological reflective method based on thematic analysis (Manen, 2015). According to van Manen (2015), the use of themes gives events context and gives the intangible a physical form. Themes are a more detailed description of an observed phenomenon that emphasizes the importance of the encounter (van Manen, 2015).

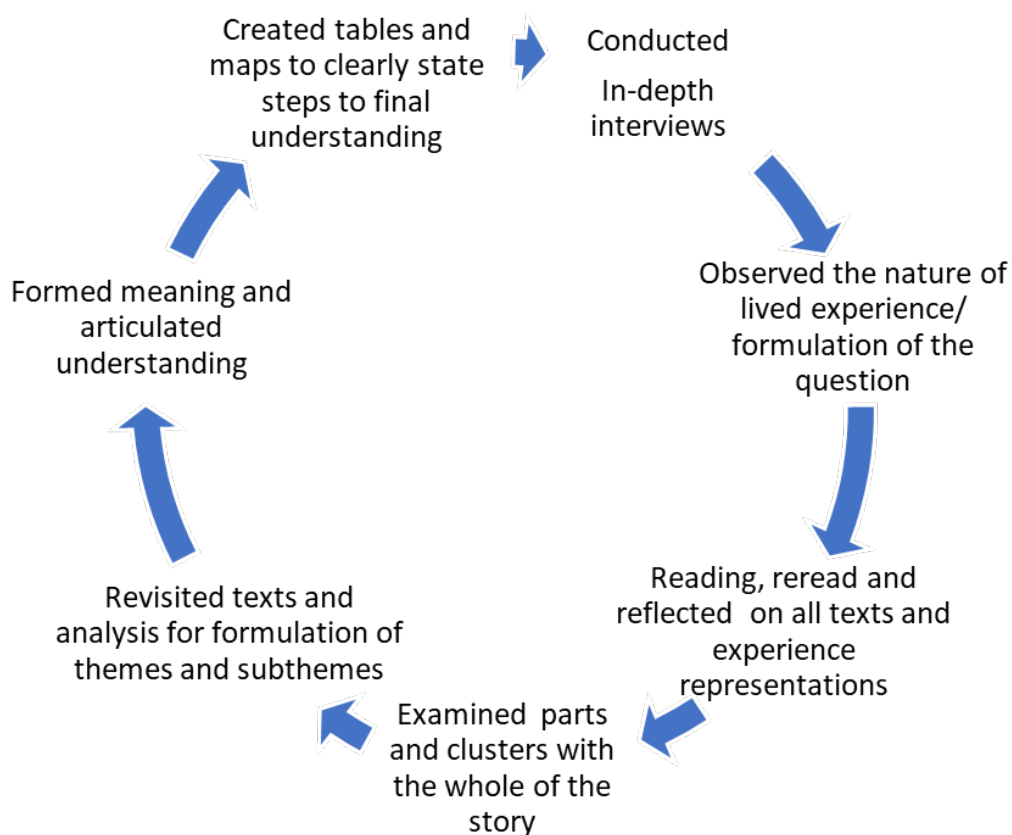
The data were analyzed using van Manen's six-step phenomenological method. This method entails: (1) examining the nature of lived experience, (2) examining experience as we experience it, (3) considering the key themes that define the phenomenon, (4) describing the

phenomenon in the art of writing and rewriting, (5) maintaining a strong and oriented relationship to the phenomenon, and (6) balancing the research context by considering the parts and the whole (van Manen, 2006; Heinonen, 2015). In this process I read and re-read the transcripts while simultaneously listening to the interview, making notes on voice inflection, pauses, congruence of the subject, and the response. I maintained a journal on personal feelings that evolved throughout the process. I kept track of emotions before, during, and after the interview as a method to refine ideas, beliefs, and my own responses to the research in progress. I utilized a data analysis audit trail as listed in the appendix. These emotions consisted of nervousness, concern for safety, and the struggle between researcher and counselor identities.

All transcripts were coded individually with their own meaning units. In an interview transcript, the researcher frequently highlights a word, phrase, sentence, or even an entire paragraph that describes a specific phenomenon. This word, phrase, sentence, or paragraph is a meaning unit (Roller & Lavrakas, 2015). Then, those codes were compared between participants to examine any common themes that may exist. These transcripts provided the data necessary to gain an understanding of how these seven EMTs experienced seeking and participating in individual counseling.

Theme analysis was carried out using a line-by-line coding method. Each sentence or sentence group was examined for any themes that emerged in the respondents' responses. As outlined by van Manen (2015), I questioned, "What does this sentence or sentence cluster disclose about the phenomena or experience being represented?" There was the importance of performing both macro and micro analyses of the data, considering potential changes in the data over time, and ensuring that the analysis stays within the hermeneutic circle (Herzog et al., 2020; Whitehead, 2004; Yin, 2016). The hermeneutic circle symbolizes the steady, mindful, circular

movement of part and whole as understanding deepens and significance is understood (Gadamer, 1988). For example: I discovered the fear of being perceived as weak or less than their peers while conducting microanalysis. The macro effect is reflected in the general distrust that outsiders can understand their professional stressors and identity. Gadamer (1975) reformulated the hermeneutic circle as an iterative procedure for gaining a fresh perspective on a whole reality by examining the intricacies of life. According to Gadamer, comprehension is contextually mediated and develops through interactions with other people during which reality is discussed and an agreement that denotes a new understanding is reached. After completing the hermeneutic circle, I went back to the text to glean fresh insights and put what I already knew into context.



In the first coding cycle, themes examining social construction were isolated using a line-by-line approach. Although hermeneutic phenomenology is not fundamentally constructivist, it does examine meaning as it is experienced on a personal level. A constructivist framework seeks

to theorize the sociocultural contexts and structural elements that support the individual accounts because, in the constructivist perspective, meaning and theory are socially produced and reproduced (Braun & Clark, 2006). These themes consisted of behaviors within the culture of EMTs, iconic statements, or morals from participants' stories (Saldaña, 2021). This procedure necessitated consideration of participant meanings. In general, I concentrated on the links and similarities between topics, as well as the type of interaction that may exist between them. These topics included interactions with peers and therapists. It is suitable to employ phenomenological data theming in a phenomenological study since it investigates the participants' worldviews, constructions, identity formation, and emotional experiences (Giorgi & Giorgi, 2003; Wertz et al, 2011).

I "coded the codes" (Saldaña, 2021) in the second cycle of coding by grouping or separating the codes assigned in the first cycle of coding. This process condensed similar meaning units into more manageable lumps for analysis to take place. Second Cycle coding processes can code the same units, longer passages of text, or even a reorganization of previously generated codes (Saldaña, 2021). For example, the descriptors "felt connected to the therapist" and "felt understood by the therapist" were combined to create a singular code of "understanding from the therapist." The primary goal during the second cycle was to develop thematic categories and create an organization from the first cycle codes. This reorganized initial codes into smaller, broader categories with the same or similar collective meanings (Saldaña, 2021). The goal of coding in qualitative research is not to develop a perfect hierarchical outline or list of fixed codes but to examine the themes and how they fit within the context of the individual's experiences.

I began with 27 meaning units on the initial coding. Each code was created as a result of my prior experiences, research, observations, and listening to, reading, and rereading the

interviews. Codes that were similar in nature and were merged in the second round of coding producing five main themes and subthemes:

Theme 1- Desperation and Seeking

Hopelessness

Alcohol as Coping

Personality Changes

Traumatic Calls

Validation

Theme 2- Fear/ Stigma

Weakness

Cultural Stigma

Theme 3- Not knowing where to look for help

Affordability/ Employee Assistance Program (EAP)

Specialized Care

Theme 4- Not Feeling Understood

Mistrust

Understanding/ Knowledge of EMTs

Theme 5- Counselors' Lack of Education Specific to First Responders

Education Specific to Career

Fear of Trauma Experiences

There were two codes cut during the second round due to inconsistency within this research study. Those codes pertained to spirituality and counseling provider type. While those

findings were interesting, they were not consistently reported by the participants. The final themes were developed organically from the current data.

Summary

Chapter 3 is a description of the phenomenological qualitative research study design and methods used in this research. Seven EMTs who had participated in at least three individual counseling sessions were interviewed. Each interview was audio-recorded through Zoom to preserve the integrity of the essence of the interviews and lasted between 40 minutes to over one hour. This document is an examination of EMTs' experiences in the counseling process to better inform counselors that wish to work with this community. While performing, analyzing, and writing this research I documented all personal experiences and responses to the interviews to maintain the integrity of the research. I employed a peer-review process to maintain trustworthiness throughout this research.

Chapter 4: A Dialogue on the Experiences of Seeking and Participating

The purpose of chapter 4 serves to discuss the data collected when researching the phenomenon of the lived experiences of emergency medical technicians seeking and participating in individual counseling. I employed a hermeneutic phenomenological approach to interview and analyze shared stories. In doing this, the information was examined as a retelling of the experiences of everyone who shared their time. The themes that emerged in the analysis of these stories, such as stigma, support, and understanding from the employer and counselors are discussed.

The fourth chapter describes the data and themes that were identified to investigate the essence of the EMTs' experiences when seeking and participating in individual counseling. EMTs with at least one year of experience in the field of EMS provided the data. The findings relate to the primary research question, "What are the lived experiences of EMTs seeking and participating in individual counseling?" and are supported by current literature in the fields of public safety and counseling.

The purpose of Chapter 4 is to present the results of the phenomenological data analysis. The accounts of the participants' realities are reported verbatim and without reinterpretation (Husserl, 1934/1970). As a result, this phenomenological investigation provides insight into EMTs' experiences seeking and participating in individual counseling.

Narrative Report

The in-depth interviews have been summarized for analysis of the EMTs' accounts of their lived experiences with the goal of answering the following research questions: What is it like seeking and participating in individual counseling? Each participant was from a different

state and region in the United States, yet each of them expressed overlapping experiences. This section outlines the themes identified during the open-ended interviews.

Participant Profiles

McFluffy

McFluffy is a 37-year-old, White man that currently works as an EMT/ firefighter for a rural service in a Northwestern State. He described himself as “highly divorced” but stated that he is currently in a healthy relationship. When speaking of his previous marriage he stated, “*you could very much label me as battered wife syndrome.*”

He has 23 years of service in the first responder field. He started his service with four years as a cadet at the age of 14 and has an additional 19 years working professionally. McFluffy served in the United States Army as an EMT/ firefighter and was deployed to a combat zone in 2011. He explained that he initially began therapy with the Veterans Administration (VA) after his deployment to the Middle East.

A fellow EMT/firefighter explained that “if you stay in this career field long enough, it's a matter of when, not if, you will need help” at the start of his career. His story was unique because he began volunteering as an EMT and firefighter before he was old enough to drive and has a history of military deployment. “*I first got really serious into therapy, which is post-2011, so post-military toxic that I needed to step back. That’s when I first started going to therapy.*”

He conveyed that he enjoyed his first therapist at the VA, but she had to leave abruptly due to the discovery of serious health issues. “*I was reassigned. The way that they explained it was like she had level 69 cancer. She’s gonna be dead within a week.*” He did not react as well with the new counselor assigned to him. McFluffy expressed his frustration with not being understood or heard. “*She was coming off as, like she had been a housewife all her life, and then*

all of a sudden hit that point where, I'm gonna become a therapist because people say I'm good to talk to." He ended that therapeutic relationship. "I went through a period that I didn't see anybody." It was 10 years before he began attending counseling again at the recommendation of his girlfriend.

He expressed that he did not feel fully supported in his therapeutic journey. He explained that it was not discouraged but more treated as required support. "*Well, we're supporting you because we're being told we have to support you. We really need you at work on Tuesday.*" His struggle with mental health was described as "*I have basically realized at this point I have a tremendous love and hate respect towards being a first responder because I'm also realizing it's very much following the patterns of a domestic response. I absolutely love the job, but it's absolutely destroying me.*" He is now working in a service that allows him to take mental health days.

McFluffy struggled with scheduling and making our appointments. We had to reschedule twice to make the interview work with his busy schedule. During the interview, he was engaging and very talkative. He expressed concern that he was getting distracted and off-topic, needing reassurance that his story was important and deserved to be heard.

Ali

Ali is a 21-year-old White woman with three years of experience working as an Advanced EMT. Her husband is a member of the United States military. She has worked with a variety of emergency medical service providers due to her frequent relocations. She is currently employed in a state in the northwest.

Ali began counseling when she was in high school. She explained that she was depressed and had started therapy after attempting suicide. Due to her frequent relocations, Ali has only

seen her current therapist on a sporadic basis for the past seven years. Ali stands out from the other research participants due to her ongoing counseling relationship. Despite maintaining a relationship with her counselor, she stated that she had not addressed work trauma in counseling for more than a year.

“I have depression and anxiety. Actually, when I was in high school when I was 16, I tried killing myself. Yeah, that’s, it was kind of preventative from that, and then since then, it’s kinda been maintenance”

Ali was distracted by text messages from someone picking up an item when we began our interview. She began with short responses and required more prompting during the interview, but as rapport grew, she became more relaxed. She grew increasingly personable and provided more detailed responses. Throughout the interview, Ali was soft-spoken and mild-mannered, until she was asked to deliver a message to counselors who wanted to work with first responders. Ali appeared to light up and be excited to share her thoughts.

Grace

Grace is a 27-year-old White woman who has served in the Mid-South for four and a half years. She is a mother of three and is engaged to a police officer. Grace is currently an EMT-P in the advanced Critical Care Paramedic (CCP) role. Grace had struggled with anxiety and had been in counseling on and off since high school to treat it, however, she chose to wait one and a half years to get help for work-related stress.

“I’ve been in and out of counseling a lot since high school. I struggle with anxiety already anyways. When I got into EMS, there was a whole stigma of we’re the strong ones. We’re not supposed to have any problems, even if we have bad calls.”

Grace had logged into our session while driving, but I rescheduled it for 30 minutes later so she could be at home. Grace's responses were initially reserved. When discussing her experiences at the end of the session, she appeared more relaxed and engaging. As the interview progressed, her responses shifted from short and guarded to engaging and relaxed.

Grace discussed her struggles with balance and family because both she and her husband are first responders. She explained that she does not have a lot of time to devote to self-care. She has little time to focus on mental health because she is juggling work and family life with three children.

Jesus

Jesus is a 36-year-old White man who serves as an EMT-B in the Southwest of the United States. He has 5 years of experience working for a busy private company in an urban setting. Jesus is now engaged, but he sought counseling when attempting to save his previous marriage. He began therapy with his wife in couple's sessions, but after one session, he switched to individual therapy when she decided to discontinue and pursue divorce.

Jesus also has Brugada Syndrome, which has landed him in the hospital. Brugada Syndrome is a rare condition that affects the transmission of electrical signals through the heart. It can cause the heart to beat dangerously fast, which can be fatal.

“I didn’t really care. It was like, I wouldn’t even know if I was still alive right now. It was whatever. They gave me a pitch to go get some counseling cuz I don’t really give a shit what’s happening right now. My wife at the time was really sad. I was looking at my kid, and I didn’t even care if he was fatherless. I don’t know if being an EMT was contributing to that or not, but I tried counseling.”

Jesus stated that he took part in this research study because he wanted to help but was not sure if his story would be beneficial. He admitted that he only responded to the call for volunteers after seeing it several times. He would respond to prompts quickly and ask if he had answered well enough. He was open and shared freely throughout the interview. Near the conclusion of the interview, I explained the next steps and that he would receive a gift card for participating and he appeared slightly disappointed. He stated, *“Now I feel bad doing this. Like I was getting paid to. I don’t—whatever. Thank you.”*

Ashlynn

Ashlynn is a 48-year-old White woman from the Deep South. She began her service career as a firefighter in 2000. She is also married to a firefighter. Ashlynn served as an EMT-P in a metropolitan area setting for both the public and the private sector. She admitted to having dealt with anxiety and anger issues throughout her career. In 2020, she left emergency services to work in an office setting providing IV infusion therapy to patients.

Ashlynn is a mother and grandmother. When she spoke about her family, she exuded pride. She explained that her husband provided her with healthy support and that they openly discuss mental health and point out when they appear to be struggling. She stated that she had seen a few therapists over the years, but none felt like a good fit or understood her role as a first responder.

“I’ve been to several counselors in my career. When I was a firefighter, I was going to counseling. I was having a rough time as a firefighter. I was getting treated differently. I went and talked to somebody about it, but I had to go an hour away for that because I couldn’t find anybody nearby. That specialty wasn’t there.”

Ashlynn waited 12 years before accessing mental health services again.

“In my mind, I thought that they would think that I was weak. That I wasn’t a strong medic. Cuz we’re supposed to, we’re supposed to handle all this. Just their thoughts of me, I think, bothered me the most. What people, their perception of who I was bothered me. I didn’t want anybody to know.”

Over the course of the interview, Ashlynn appeared relaxed. She was animated and eager to tell her story. She needed some prompts in the conversation, but only to encourage a shift to talk about topics not covered in the research.

Alex

A 60-year-old single man named Alex identified as being of mixed racial heritage. He served as an EMT-P in a busy hospital setting in a Northeastern state. Alex described having severe anxiety symptoms as a result of his job stress. When the stress became too much for Alex, he was fired from his job. Alex hasn't worked as an EMT since 1987, when he suffered a "nervous breakdown."

“I was gonna save the world. I was asked to do things I didn’t think were correct, like science stuff. The anxiety level went up like the mercury in a thermometer. Then I was let go. Everything unraveled.”

As soon as the interview began, Alex captivated my attention. He stated that he wanted to share his story in order to prevent others from becoming "fractured" as a result of job stress. During the interview, Alex's thoughts were scattered and tangential. Despite having been removed from the field in 1987, he showed signs that his trauma was still very active in his current life. He expressed dissatisfaction with the field and a lack of preventative measures and therapists who he felt understood the EMT culture.

Lauren

Lauren is a 31-year-old single Black woman. She has served as an EMT-P for over 12 years in a busy metropolitan fire department in a Northeastern state. Lauren reported that she struggled with mental health concerns for many years before seeking help.

“I began to suspect that I was neurodivergent in the early 2010s, whatever. I was 20 years old.”

About 20 minutes into the interview, Lauren stated that she has struggled with alcohol abuse and addictions. Lauren waited five years before she accessed counseling services. She was struggling with a relapse into alcohol abuse and had been terminated from her “dream job” as a paramedic with the fire department. She secured another job at a “less than” department and only sought help after she was near termination from that job.

Lauren mentioned a friend she made while undergoing academy training. She described that this woman had grown to be one of her closest friends. Lauren revealed that her friend committed suicide while they were in training and that it frustrated her because she could not understand why her friend had not invited her to do the same.

“I wasn’t in a good mental health place at that time. It went, when she ended up doing that, I was thinking, like, wow, you didn’t tell me? You didn’t invite me? I was mad at her at first. Yeah. We were close like that. At the same time, I just... That’s depression in my life.”

Lauren was eager to share her experiences in the interview, but she was not sure how it would benefit others. Throughout the interview, she returned to previous statements and worked to clarify them. During our meeting, she was friendly and engaging, and she expressed her hope that her experience would contribute to future change.

Themes Pertaining to Seeking Counseling

The purpose of this section is to present the themes that emerged from the qualitative analysis of the interview questions. Phenomenology focuses on the search for intentionality (Husserl, 1970). I read the transcripts from the recorded interviews many times, searching for the essence of the EMTs' experiences. Then, transcripts were re-read and highlighted for further analysis of the underlying themes within the participants' stories of their experiences. The evaluation revealed similarities, such as desperation, stigma/ fear, not knowing where to look for help, not feeling connected/ understood, and not feeling the counselors were trained in understanding their needs. Differences, and nuances within each EMTs dialogue were examined to look at the underlying meaning. The essence of their lived experiences is stated in their own words. Therefore, the themes were individualistic and subjective as they were coded (Creswell, 2007).

Theme 1- Desperation

The first theme that emerged was desperation. The desperation reported by participants related to (a) marital problems, (b) personality changes, (c) alcohol abuse, and d) traumatic events. The participants reported a desperate need to change what they were feeling and the negative coping strategies they had developed. Jesus reported experiencing all four of the desperation sub-themes phenomena. Lauren reported experiencing personality changes, alcohol abuse, and trauma. McFluffy experienced personality changes, trauma, and marital problems. Ashlynn and Alex reported experiencing trauma and personality changes. Grace and Ali reported experiencing trauma symptoms. All participants expressed that they did not seek counseling prior to the buildup of symptoms becoming noticeable to other people, including participants that had prior counseling experiences.

Hopelessness

Throughout the interview process, hopelessness was a recurring theme. This is exemplified by Jesus' story about his struggle with suicidal ideation. He struggled with abandonment, loneliness after his wife left with his daughter, a rare heart condition, and alcohol abuse. The retelling of his experience trying to find help illustrates his story of hopelessness.

“I called the number at 3 in the morning, after I had a gun in my mouth. Then they answered and that person wasn't a counselor but was a person that sets up counseling. Like one of those websites where you go in there and they find your counselor for you or near you. I don't know what those are called. I didn't tell him what was going on, but he was like, yeah, well, give me your location and all that stuff. They set me up with a counselor and it took two more days for them to call me back, and then finally found a counselor near me. I didn't care what their credentials or specialties were. I just kinda—picked one. That's when it took like a month later for me to actually get one. Then I had to set up my name on the website or whatever. Then I don't know.”

Lauren furthered the feelings of hopelessness when she explained that she had a history of depression and alcohol abuse. During her training, she had a classmate commit suicide and she expressed sadness that they did not invite her to join in the act. *“I wasn't in a good mental health place at that time. It went, when she ended up doing that, I was thinking, like, wow, you didn't tell me? You didn't invite me? I was mad at her at first.”*

Alcohol as Coping

Alcohol as a coping method was not uncommon for Lauren. The desire to numb painful feelings was found as expressed by Lauren describing having been in a downward spiral of

alcohol and was fired from her dream job for showing up at work while still feeling the effects of alcohol.

“My vice of choice is alcohol. I am, what? Two and some change sober now, so that’s great. Yeah, it got really bad in the early 2010s. Then quit. Then got that dream fire job. And then like, okay, cool, everything’s back to normal, so I can drink again. I’m making it in life. Yeah. And then that spiraled out. A couple AWOLs later, they said, no, we don’t need you no more. Then almost got fired from the next job for AWOLing, which is absent without leave, not showing up to work. That’s when it kicked in. This is really a problem because this is like a bottom of the barrel gig. If I’m seriously getting put on notice here, there’s a problem. That was kinda my driving force and what keeps me motivated today.”

Personality Changes

Some participants reported that they experienced personality changes that led to seeking counseling services. Ashlynn explained that she had become negative and angry at small things. People at work were afraid to be her fill-in partner when her regular partner would have to take off work.

“I found that I was too snappy with people. I was known as a cold-hearted bitch, too. It wasn’t who I wanted to be. People were scared to work with me. My husband would say that I was very mean at home cuz you have to deal with people all day long. You have to put on a good face. By the end of the day when you come home, it’s gone. You just can’t do it anymore. You let all of your frustrations out on everybody. Yeah, I was probably not the nicest person to be around at times.”

Alex described himself as having a *mental breakdown* when he sought counseling. He explained that he had reached a point of stress and anxiety that he could no longer sustain and

that he was fired as a result of that experience. He has not been able to work a steady job since then.

“I was gonna save the world. I was asked to do things I didn’t think was correct, like science stuff, and the anxiety level went up like the mercury in a thermometer. Then I was let go. Everything unraveled. This is January of ’87, and I said to myself, oh, my god, I went through a complete personality change.”

Traumatic Calls

Grace and Jesus described their desperation as being related to the traumatic calls that they had responded to while working. Grace explained that her experience was related to a traumatic call that had her on edge. She had become friends with one of the ER nurses there and she was married to a counselor that had worked as a first responder. It was the following interaction that made her realize that she was not holding things together as well as she had thought.

“We had a pretty rough call, and it was actually, the friend that recommended the counseling is the wife of the counselor that I saw, cuz she was the nurse at the hospital which I transported this patient to. We had become decent friends, just me handing over patient care to her multiple times. After that call, she was like, hey, I know you’re probably not gonna talk about it, but if you need to talk about it, here’s my husband’s card, and you should set something up with him.”

Jesus echoed the sentiment of repeated exposure to traumatic calls as being one of the struggles of desperation. *“I would get a pediatric arrest for SIDS or something like that, and then afterwards, I’d start to feel like a little [sniffles] cry was coming on. Then I’d just, neh. I’ll just*

drink something. I was suppressing it pretty well. Not pretty well, but suppressing it. I went, like, two years before I actually decided to get counseling. I felt like I was just so cold.”

Validation

It can feel isolating when juggling the traumatic calls, family stressors, and mood changes. McFluffy was looking to find that his emotional turmoil was not because of something wrong with him. He needed validation that his feelings and thoughts were not just in his head, “*Verification that what I’m feeling is real.*”

Ali stated, “*I just need to talk and kinda just need somebody to listen.*” She explained that she felt that mental health is overlooked in EMS and that she benefitted from having someone that she could talk to and know that it was confidential. She followed up with “*Yeah, I guess kinda just like it’d be nicer if people would just kinda talk about it a little bit more and just have it around more.*”

Both McFluffy and Ali expressed the sentiment of feeling alone and looking for greater connection and understanding of their emotions. In each unique story of desperation, the participants expressed a need to change what they were experiencing. Each participant described the feeling that they sought counseling after their other coping skills had no longer worked for their life. All participants explained that they had reached a point in their lives where others suggested that they seek help. Alex, Jesus, and Lauren described their intervention as being recommended by their employer. Jesus and Lauren were referred for interventions to cope with their alcohol use, not showing up for work, and job performance. Alex further described his counseling intervention as the result of a “complete personality shift and nervous breakdown;” as a result, he has not worked since 1987.

Theme 2- Fear/ Stigma

According to Sloan (2018), when working as an EMT, there is a culture of being strong and not needing help. Many believe they are supposed to be supernatural in their response to daily trauma (Sloan, 2018). This culture of strength could impede EMTs' ability to express emotions (Härtel et al., 2005; Steen et al., 1997). This culture of strength was evident when conducting these interviews. Several participants feared they would be seen differently by peers and employers if they sought counseling.

Weakness

Weakness in emergency services can be seen as very damaging to one's status. When considering the concept of weakness in EMS, it is perceived dependability rather than physical strength that is lacking. EMTs must be able to help each other at all times to maintain safety because they work together in frequently dangerous environments. This necessitates a certain amount of trust in one's partner. The ability to work as a cohesive team is hampered if one EMT is thought to be unreliable or weak. In extreme circumstances, EMTs may ask to be partnered with another EMT.

Grace conveyed her sentiments about the culture of strength in the environment in which she works.

“When I got into EMS, there’s a whole stigma of we’re the strong ones. We’re not supposed to have any problems, even if we have bad calls.”

Ashlynn described feeling as though she would appear unprofessional and unreliable if she expressed any emotions associated with her pain.

“In my mind, I thought that they would think that I was weak. That I wasn’t a strong medic. Cuz we’re supposed to, we’re supposed to handle all this. Just their thoughts of

me, I think, bothered me the most. What people, their perception of who I was bothered me. I didn't want anybody to know."

Jesus expressed that his fear of seeking counseling was related to the possibility of losing his right to bear arms.

"Oh, yeah, that's another thing I was worried about at one point. Even though I, it was a tool to whatever, but I didn't wanta lose my right to carry. I'd asked somebody about that."

Cultural Stigma

The stigma associated with counseling is not limited to work culture. Many religious, ethnic, and social cultures associate the need for counseling with having an illness (Choi et al., 2019). Lauren described her stigma as coming from a family that did not believe in and a work culture that did not believe in openly acknowledging mental health struggles.

"My family doesn't really believe in mental health. I don't think my peers could've cared less. Like the overall vibe in the DC area is go to therapy, but don't talk about it. Everyone tell you to go, but don't talk about it because nobody cares"

Mental health and the right to bear arms have been a long-standing debate in American culture. Jesus expressed that his fear of seeking counseling was related to the possibility of losing his right to bear arms.

"Mental health and the right to bear arms have been a long-standing debate in American culture. Jesus expressed that his fear of seeking counseling was related to the possibility of losing his right to bear arms."

Theme 3- Not Knowing Where to Look for Help

The participants explained that their barriers did not stop with fear/ stigma. Once they overcame that barrier, they struggled, not knowing where to find the services they needed. Financial burdens are a concern for EMTs when seeking mental health (Jones et al., 2019). Several participants explained that they needed to find someone covered by their insurance or EAP due to financial restraints.

Affordability/ EAP

Jesus explained that he struggled with finding how to access the EAP provided by his employer. He had spent several hours looking through the company website to find someone but struggled to navigate the site. He eventually asked a supervisor for help, and he said the supervisor had to get back to him at the end of his 12- hour shift because he also struggled to find the information.

“Then their employee assistance program was like hidden on the website. It took me so long to find it. My supervisor didn’t know how to find it at one point. Finally, it took, what really got me into it is we had 24 hours shifts, and I was going to a station that we really didn’t see anything cuz I was part-time, so I was moved around to whatever was open. The one I was going to; we had never had a call. We’d just sleep, the whole 24 hours. I had gotten drunk the night before, went to work, and you could still smell it on my breath. He knew kinda what the situation was I was going through with my ex-wife. He just went there and, on the computer, and searched up how to find it. He was the one that gave me the employee assistance thing. Anyways, that’s what got me into that. It took him so long to find it.”

Lauren explained her struggles were related to feeling limited by the choices that her insurance provided.

“I was kinda limited by the Healthcare system, which is an HMO, and they do everything between their urgent cares and their designated hospitals. Contracted hospitals. I would like, unique to first responders is our ability to not need things necessarily sugar coated or greased in.”

Specialized Care

Ashlynn chose her counselor based on affordability and insurance network. She did not know that anyone would be able to understand her stressors, but she knew that she needed help.

“That was the main criteria, was my insurance. I called my insurance to see who was in my group basically that I could use. It was affordability. I didn’t know who would understand the field in which I was in. There are family counselors, there are marriage counselors, but I really didn’t fit into that category. It was very hard to find somebody who understood where I was coming from.”

Grace expressed a similar sentiment that counselors would not understand her as an EMT. She had been to several other counselors and had struggled with trusting them after multiple negative encounters.

“I really think the biggest thing was just not knowing where to go. Like I’d mentioned, I’d had the other failed, not great experiences, and I didn’t know where to go cuz I had a new, I had a different mindset with getting into the first responder role, and I didn’t, a lot of counselors and therapists don’t understand that our minds are dark and dirty, and that’s just how we operate sometimes. We have to get through all the dark and dirty

humor in order to get to what's real. Not wanting any of that to interfere with what other counselors saw. It was really, a big thing was just the lack of resources and not knowing where to go to get somebody who would understand more of what was going on."

After years of service, these EMTs had become overwhelmed by feelings of despair, diminished self-worth, and not knowing where to turn for help. These are some of the factors contributing to the high risk of suicide among first responders. Although these EMTs had conquered the reported obstacles in seeking counseling services, many of them were unsure of what to anticipate in the counseling session, complicating their journey.

Themes Related to Participating in Individual Counseling

Theme 4- Not Feeling Understood

The EMTs that took part in this research expressed that they did not feel understood by many of the counselors they visited. The participants in this study expressed a general mistrust of outsiders among many first responders when it comes to seeking counseling. This finding is consistent with prior research reports (Johnson & Faller, 2011; Jones et al., 2020; Kronenberg et al., 2008). Their stories bring to light the experience they lived.

Mistrust

McFluffy discussed going to the VA-provided therapist including how he did not believe she was sincere.

"She was coming off as, like she had been a housewife all her life, and then all of a sudden hit that point where, I'm gonna become a therapist because people say I'm good to talk to. She's asking me, beginning of the session, this is like first, second time me talking to her, and she's asking me for a 0 to 10 rating on how much I miss my kids. I'm like, I'm not gonna give you that."

Lauren had found that the counselors did not know how to work with her. She felt that they were too focused on what they were comfortable with instead of the trauma that she experienced.

“We ended up working on mindfulness the whole time, which was useful in and of itself, but didn’t really solve the issues I was seeking to solve. We did that for a while, and then ultimately parted our separate ways when I really just got tired of going. We were making progress, but it just, I’m literally just as depressed as before, so why? I’m not getting better. I’m getting more irritated. We’re digging stuff up. Literally doing nothing with it. Bye-bye. I don’t need that in my life.”

Lauren revealed that she was turning the conversation into a test for the counselors with whom she worked. She admitted that she had a talent for getting people to talk about themselves more than she did. When she spoke about it, she blamed mistrust as one of the reasons she did not feel connected to the therapists.

“Part of it is my fault because they’ll start trying to pry into me, and then I’ll make it about them.”

Understanding/ Knowledge of EMTs

Grace explained that she had seen multiple counselors and did not find a good fit until she met with one that had worked as a first responder before becoming a counselor.

“The former state police and paramedic and whole nine yards counselor, so he understands the first responder brain a little bit. Other counselors I’d been to focused really hard on the anxiety, or I had done Christian counseling before, and that, a lot of it was, oh, you just need to pray more and everything’s gonna be okay. I was afraid of those kinds of responses again and not actually getting good help, I guess.”

Ashlynn did not believe her counselor was able to fully understand her needs. She explained that they were able to connect in a way of aiding in being a woman in a field that was primarily male but did not understand the type of work or the driving force to do that work.

“I’m not sure that they ever did understand my needs. When I was a firefighter, she understood about females being treated differently. I mean, she helped me kinda work through all of that so I could, I guess, accept it a little bit more, that this is how I’m gonna be treated.”

During her second counseling experience, she did not feel that it was helpful or that he connected.

“Honestly, I felt like it really wasn’t helping me because I can talk about it to my husband and get the same feeling that I did when I talked to the counselor. I just didn’t feel like he understood at all.”

Theme 5- Counselors' Lack of Education Specific to First Responders

The final theme that emerged was that the participants did not feel that their counselors were prepared for working with EMTs. Many participants in this research reported that they thought that the counselors were nice and that they saw the value in counseling, but that they did not appear to understand the culture or needs that they had for therapy.

Education Specific to Career

Grace had tried several counselors and struggled with not feeling that they understood her needs. She explained that she was not sure how to find someone that could help her.

“I really think the biggest thing was just not knowing where to go. Like I’d mentioned, I’d had the other failed, not great experiences, and I didn’t know where to go cuz I had a new, I had a different mindset with getting into the first responder role, and I didn’t, a lot

of counselors and therapists don't understand that our minds are dark and dirty, and that's just how we operate sometimes. We have to get through all the dark and dirty humor in order to get to what's real. Not wanting any of that to interfere with what other counselors saw. It was really, a big thing was just the lack of resources and not knowing where to go to get somebody who would understand more of what was going on. Not just tell me to pray more or flip out at the first semi-sketch thing that I said and call 9-1-1 because, oh, this person is mentally unstable."

Similar sentiments were expressed by Ashlynn regarding counselor education, specifically understanding the culture of EMTs.

"I definitely think we need counselors that specialize in what we do. Whether it's they came from the field, like you and you decided to go into counseling, or what do we do? What do we do to educate these counselors to understand that we are a different breed of people? I think if you really and truly are the counselor who doesn't understand this, I would hope that these counselors would not waste our time and money and be like, I can't help you. I don't understand where you're coming from. Let me find somebody who does."

Ali believed that there was already counseling training available. She had the impression that counselors were trained on the EMT culture prior to working with this population.

"I'm sure that there is probably some, but it'd be kinda nice if there were specific continuing ed classes that were kind of focused on first responders specifically. I think this is kind of a good idea for everybody"

Grace echoed the sentiments.

“I think being able to learn and gauge where our mental, where we actually stand emotionally and with our mental health rather than just judging it by what they’ve learned in the textbook. We all know it’s never textbook perfect.”

Fear of Trauma Experiences

Lauren stated that she believed counselors were afraid to delve deeply into the trauma.

“Unique to first responders is our ability to not need things necessarily sugar-coated or greased in. No, that’s not to take away from the patience to figure out the problem. The best the counselor can do is nudge you in the right direction. The same time, don’t be afraid to dive into hard topics. It’s something we see on the regular, and you’re not, you’re doing a dis, you may be doing us a disservice by racing into it over some time or using light words as opposed to the heavier, aggressive tones that we’re more used to.”

According to Ashlynn, her time in the session was spent on reflection, deep breathing, and long walks to relieve stress. She did not believe the therapists understood that the trauma was not only in the gruesome calls but rather in the mundane events on the job.

“The byproducts of being in that line of work. Because it’s not just the job. It’s the way that everything else goes. It’s the time away from home, away from our kids. It’s that build-up of all the things. All the mental conditions. I mean, not mental, physical conditions that go along with aging, and then I’m overly concerned about getting dementia. I think I might be getting dementia. I don’t remember this. Why can’t I remember that? I think that type of thing, counselors need to see. It’s we’re all consumed by all of this, where other patients, yeah, they probably are having financial problems or marital problems. We’re different. We, on top of financial problems and marital

problems and, you know, any other everyday problems, we have all these other problems that we carry.”

EMTs in this study experienced barriers such as stigma and a lack of knowledge when searching for a counselor that impeded the process of seeking help. Each of these participants was successful in attending at least three individual counseling sessions. These are just a few stories from those who overcame this phenomenon. In each retelling, a theme of desperation appeared to have been the driving force in attending the counseling sessions. It was the driving factor in overcoming each of the barriers they had faced.

Summary

This chapter presented the analysis and findings in the voice of the seven EMT participants. The findings provided a better understanding of the participants' experiences as each EMT shared their lived experiences and reflections of being an EMT that sought and participated in individual counseling. These EMTs' stories spoke of desperation when deciding to seek out counseling services. The EMT participants have suggested that stigma, and not knowing where to find counseling that did not cause financial strain were barriers to participating in counseling sessions. Several common themes emerged from the data, and each theme is reflected in the lived experiences described by the participant.

These findings and the conclusions that will be discussed suggest that the needs of EMTs are not being met to ensure healthy mental wellness. Furthermore, participant responses in this study highlight the need for improved mental health programs including preventative care and specialized counseling services for this population, and the entire public service field. The final comments and findings are discussed in the next chapter. Chapter 5 reflects upon the results from

this study in the context of current research in the public service field and counseling content areas to offer further research recommendations.

Chapter 5: Results, Recommendations, and Conclusions

This chapter discusses my interpretations, conclusions, and recommendations for counselor educators, clinicians, and EMT employers regarding the five main themes that emerged from the study: *Desperation; Stigma/ fear; Not knowing where to find suitable counselors; Not feeling understood; Need for counselors to be educated in working with EMTs.* This chapter further highlights these accounts to facilitate conversation, education, and research implications. The subsequent presentation and discussion of the study's findings make clear that while some mental health initiatives are in place, they are difficult to use and are not widely known to be available.

Discussion of Results

Throughout this investigation, five key themes emerged. Those themes included *feelings of desperation, stigma/ fear, lack of knowledge when seeking, not feeling understood by counselors, and lack of counselor education for this population.* These themes are consistent with the literature about similar phenomena of police and firefighters (Corrigan, 2004; Haugen et al., 2017; Jones, 2017; Jones et al., 2019).

These EMTs in this study provided descriptions of the stages of help-seeking behaviors that were in line with DiClemente and Prochaska's Stages of Change Model, including pre-contemplation, contemplation, preparation, action, and maintenance (1983). This served as an observation of the available data rather than as a framework for the investigation. In each of these situations, the EMTs described signs and symptoms they had been dealing with for months or even years before discussing them with a professional.

Theme 1- Desperation

Each of the seven EMTs had experienced a level of desperation before seeking counseling services in their quest to "feel better." Even though Ali and Grace had been receiving counseling since they were teenagers, they both admitted that they had waited more than a year to schedule an appointment for work-related stress. Lauren had avoided seeking treatment for years due to worries about her mental health and alcoholism; she did so only when she was about to lose another job. Lauren also acknowledged that she struggled with the urge to die. Jesus was going through a divorce, in danger of losing his job due to alcoholism, and struggling to deal with the trauma he had endured at work to the point where he was considering suicide. Alex only sought services after he suffered a mental breakdown and was fired from his job.

Mental health struggles and turning a blind eye are open secrets in EMS (Backberg, 2019; The Code Green Campaign, 2022). This is amplified by Lauren's earlier statement, *"Everyone tell you to go, but don't talk about it because nobody cares."* Many of the individuals in this research delayed getting help until they lost their job, marriage, family, and almost their lives. During this period, each of them had waited until it was abundantly obvious, and others spoke to them about seeking help.

Participants, on average, spent five years before going to therapy after realizing they needed help. Alex experienced the shortest delay, seeking assistance immediately due to what he described as a "mental breakdown", but did not continue his treatment. The longest delay was for Ashlynn, who waited 12 years to get assistance. Lauren had been released from her job and was near being fired again for AWOLs after binge drinking. Jesus had been coping with alcohol and had been approached by a supervisor because of showing up for a shift still intoxicated from the night before. Ashlynn stated, *"People were scared to work with me."* Grace did not pursue

assistance until a nurse at the hospital where she was delivering a patient mentioned their concerns about her mental well-being.

According to NAEMT's 2016 survey, there is still much to be done to persuade the EMS workforce that their issues and concerns matter and to ensure they know where to turn for support in trying times. The NAEMT survey also pointed to the work of the Code Green Campaign as a leader in the growing awareness of mental health needs for EMTs (NAEMT, 2016).

The Code Green Campaign is an organization dedicated to first responders' mental health. Their mission is to raise awareness of the high prevalence of mental illness among first responders and to educate them on several issues. They offer an anonymous forum on their website for EMTs to write in detail about their personal experiences with calls, trauma, and mental health struggles. Most EMTs and supervisors are aware of this open, public forum because of the NAEMT spotlight in their 2016 survey. Although the participants in this study did not indicate whether they or their supervisors used this resource, this type of forum could be utilized as a resource and educational tool. These resources can be an integral part of training supervisors in awareness, recognizing symptoms, and approaching employees that may not know where to turn for help.

Many companies have not trained supervisors in having uncomfortable conversations about mental health with employees or peers (BC First Responders Mental Health, 2017; Dutton, 2019; Gayed et al., 2019). Another issue that was highlighted by Grace is that her supervisor did not promote these mental health initiatives as they were provided in her new employment packet. Her statement exemplified that sentiment, *“With employers when you get hired on in your orientation, hey, these are our options. This is where you can go. Not presenting options once*

something has happened.” During the mental health training I have led, I have seen managers leave the room, sending a message to the staff that they do not value or attach importance to mental health issues.

At the onset of an EMT’s training, they recognize the job requires long hours and offers less pay than other healthcare professions (BC First Responders Mental Health, 2017; Blakeslee, 2020; Bouchillon, 2018). These EMTs are also aware they will be witnesses to people’s trauma, rarely showing up on a good day for the public they serve (Bledsoe, 1997; CDC, 2020). They learn it is essential to protect themselves on a scene because the patient may not survive when they themselves are harmed (Bledsoe, 1997). However, EMTs are not prepared during their training how critical it is to maintain their mental health or that even the strongest among them are susceptible to mental injuries (Magee, 2018; SAMHSA, 2018).

Theme 2- Fear/ Stigma

Stigma was a common theme that caused delays; there was a fear of “appearing weak” (Brewis & Godfrey, 2019; Halpern et al., 2009). There is a belief that “if you need help, then you are not strong enough for the job” (NAEMT, 2016; The Code Green Campaign, 2022). Ashlynn reiterated this sentiment in her statement, *“In my mind, I thought that they would think that I was weak. That I wasn’t a strong medic. Cuz we’re supposed to, we’re supposed to handle all this.”* Grace also described the culture of stigma present, *“When I got into EMS, there’s a whole stigma of we’re the strong ones.”* Ali, Jesus, and Grace revealed that they found others in the field who were in treatment only after beginning their own therapy. This prompted them to wonder why it was not discussed more openly.

Conversations related to mental health are difficult for most people, even those that are working in the mental health field can sometimes struggle with uncomfortable topics (Waalkes,

2022; Wilson, 2019). EMTs and supervisors are not properly equipped to address mental health among their peers (Minnie et al., 2015). According to Gayed et al. (2019), when trained properly, many mental health concerns can be addressed early because of the supervisor's confidence in addressing concerns.

There is a need and desire for early intervention (NAEMT, 2016). When minimal training is given, these conversations can be difficult for people to have with a coworker or a supervisor (Gayed et al., 2019). This group may profit from more frequent, ongoing monitoring by a mental health professional (Fader, 2022). In each of these circumstances, stress and health risk may have been reduced by early intervention and appropriate coping techniques.

Based on the existing literature at the time I began this study, I anticipated discovering a barrier to obtaining therapy due to concerns about being disciplined at work (Britt & McFadden, 2012; Corrigan, 2004; Drew & martin, 2021; Haugen et al., 2017; Hutchinson, 2021). I did not find clear evidence of that in these interviews. Even though these individuals did not express any fear of punishment, they did report that they did not feel generally supported in terms of their mental well-being. Grace expressed *“employers don’t want their employees to go off the deep end, but it’s not very much talked about.”* Ali stated *“I guess also just looking back, I’ve had coworkers that you can tell are burnt out. It’d be kind of nice if employers could pick up on that more.”* Despite the lack of evidence supporting a fear of punishment, Ashlynn claimed to be afraid of being "seen differently" by the people she worked for. Ashlynn stated,

“Just their thoughts of me, I think, bothered me the most. What people, their perception of who I was bothered me. I didn’t want anybody to know. I guess I was more worried that they would—I don’t know—that I would be treated differently.”

Theme 3- Not knowing where to look for help

Respondents noted having a difficult time gaining access to their EAP benefits. Jesus explained that he had to ask for help searching the company website, *“their employee assistance program was like hidden on the website. It took me so long to find it. My supervisor didn’t know how to find it at one point.”* Ali stated that she felt discouraged as if being “put on the spot,” and implied that this may have been done on purpose to cause embarrassment and silence the discussion of mental health.

“They always asked around a bunch of people kind of, so it wasn’t like... I probably would’ve been fine saying that, but I feel like other people might not have wanted to be like, oh, yes, I need some help around a bunch of people.”

Another issue that emerged was financial strain (Britt & McFadden, 2012). Some smaller departments do not offer any health or mental health benefits (King et al., 2018; National Highway Traffic Safety Administration [NHTSA], 2014). In companies that did, the EMTs were often unaware of the benefit until after they had sought help on their own or struggled with finding how to access the resources offered. Ashlynn initially paid for services privately because she was unaware that it was available. She stated *“Later on, I did find that out. It was never really brought to my attention, hey, we have this assistance program. It’s not gonna cost you anything.”* The financial strain of treating mental health can be a delay in seeking therapy (Britt & McFadden, 2012).

According to Ling, mental injury is also not recognized as an on-the-job injury (OJI) in some jurisdictions, which means EMTs will be unable to afford time off for therapy or have therapeutic services offered to them in the same way that physical therapy would. According to a study published in 2021 by service provider Optum Workers' Comp and Auto No-Fault, more

than half of states have established PTSD laws or made policy adjustments since 2018 (Ling, 2022).

Employers may acquire workers' compensation insurance to cover diseases and injuries stemming from their job, according to national insurance statistics. Many states require companies with five or more employees to provide insurance, although the specifics vary by jurisdiction. According to the Insurance Information Institute, states determine what injuries are covered, how impairments are assessed, how medical treatment is delivered, and the extent of coverage. Workers' compensation may cover mental health issues, such as psychiatric injuries caused by one-time traumas like post-traumatic stress disorder (PTSD) and long-term illnesses like severe depression and anxiety (Ling, 2022; NCCI, nd; NFIB, 2019).

Theme 4- Not Feeling Understood

When participating in counseling services, more than half of this study's participants did not feel that they were understood by their therapist. Ashlynn stated, *"I didn't, I didn't know who would understand the field in which I was in."* Lauren expressed *"yeah, finding people to actually help treat me has been a problem all across the board."* According to Tajfel and Turner (2004), there is a group thought that outsiders will not understand. Negative attributions are given to outsiders or out-group members, thereby creating an "us versus them mentality," commonly leading to feeling like others will not understand (Tajfel & Turner, 2004). The theme of not feeling understood by counselors consistently emerged during this research. It was also worth noting that reports of feeling understood only occurred when the counselor had a prior first responder service background. Grace explained that she felt understood by the counselor because of a shared background, *"he is former state police and paramedic and whole nine yards, so he*

understands the first responder brain a little bit.” This is significant for counselors to understand when working with this population.

Theme 5- Counselors' Lack of Education Specific to First Responders

This theme was also apparent when participants were asked what they would like counselors to know about working with first responders. Ashlynn explained, *“I definitely think we need counselors that specialize in what we do.”* Most participants wanted to see some formal training created to address daily needs and language. Ali stated, *“it’d be kinda nice if there were specific continuing ed classes that were kind of focused on first responders specifically.”* There are currently no formal counseling education courses known to be offered as an elective in higher education that addresses this population and their needs. However, there are several variations of courses for treating military members and their families. A few certificates are now available online, but they do not appear to address many of the concerns that emerged from this research study. These certificates provide a place to start when it comes to the educational needs of counselors, but they do not address the differences in educational requirements for EMTs.

Even though these EMTs did not report feeling connected and were understood by the counselor, the majority reported that counseling was useful in developing coping strategies. *“We ended up focusing on mindfulness the entire time,”* Lauren said, *“which was helpful in and of itself.”* Several of the participants had recommended therapy to others in the field. Ali reported, *“I always, I recommend therapy and everything.”* Jesus stated,

“I told one of my partners that I was because he started going through a tough time. I told him to try it cuz he went through a similar situation that I did, and he’s in the same field, so I told him to go.”

All the EMTs expressed that they generally liked the counselor they met with; they just did not feel the counselor was able to understand their needs. While this was an expected finding, the degree to which Grace claimed to test the therapist was not anticipated. Grace stated that they would turn the conversation back to the counselor and if they would start telling them about their life, they knew the counselor was not a good fit for them. *“they’ll start trying to pry into me, and then I’ll make it about them.”* Grace also expressed that if the counselor saw them as fragile, it would lead them to think that the counselor was too fragile to help; *“you’re doing a dis, you may be doing us a disservice by racing into it over some time or using light words as opposed to the heavier, aggressive tones that we’re more used to.”*

Recommendations for Clinicians

As counselor advocates, we could investigate this missed opportunity to address EMTs' mental health concerns. By interacting with the neighborhood EMTs and working to end the stigma that still exists, counselors may promote the importance of mental health. With EMS department heads and administrators, clinicians first have to connect and develop relationships. Grace suggested *“sitting down and talking with first responders or even going to first responder conferences. Sit down and have a meal and just listen to us talk and figure out how we work and how our brains are wired. That way, they can figure out better ways to help us in the future.”* Counselors could seek a "ride-along" with their local agencies as an educational experience as well to build rapport and decrease the feeling of being an outsider. This was a frequent proposal made by participants in their need for further counselor training. Ali stated, *“If hospitals could even do like a ride along. Kinda shadow or something. That’s kind of how I started in EMS. Sort of our service had an explorers’ program, so that’s kinda how I got into it.”*

Counselors may want to have a deeper understanding of how EMTs can experience direct and vicarious trauma (Bouchillon, 2018, Halpern et al., 2009). I encourage fellow counselors to be willing to explore how EMTs experience themselves in the world, notably how they believe they are perceived in culture and society. Ashlynn expressed “*We are a different breed of people. We’re gonna be totally different than their other patients. We think differently. We feel differently. We’re not the same as other people.*”

Among the topics to explore is how EMTs may experience counseling as punitive in their employment (BC First Responders Mental Health, 2017; Rodriguez v. Montgomery County, 2021; Smallwood v. Forsyth, 2018). Another factor to consider is recognizing that EMTs will return to the daily trauma that they face and ways to better equip them with appropriate coping mechanisms (American Ambulance Association, 2021; Arble & Arnetz, 2016).

Clinicians that choose to work with this population are encouraged to learn specific communication terminology. Grace described how having a therapist with a similar experience aided her recovery: “*He is a former state police officer, paramedic, and the whole nine yards, so he understands the first responder mindset a little bit.*” There are several books, social media pages, and websites that can help fill the knowledge void (The Code Green Campaign, 2022; Grayson, 2022). Some social media sites give links to anonymous testimony that may aid in understanding the mental processes of EMTs (The Code Green Campaign, 2022).

Recommendations for EMT Employers

This research identified significant areas for improvement in the workplace that employers may want to address. Maintaining a visible presence for any existing mental health programs that may be offered to employees is one of the topics that should be managed. Many of this study's participants reported not knowing where to search for help. This can assist in

reducing the time it takes to access mental health services. Jesus echoed this issue in his story “*their employee assistance program was like hidden on the website. It took me so long to find it. My supervisor didn’t know how to find it at one point.*”

Several EMTs in this study expressed that they did not think that their supervisors were concerned with mental health issues. Lauren amplified this “*no, they just didn’t care. Show up to work and do whatever. Get the paperwork done.*” According to an NAEMT 2016 poll, stigma, and fear of reprisal for admitting mental health issues continue to be major hurdles to EMTs receiving counseling services. Participants in this poll reported believing that management treats mental health as a joke. Comments such as “*they continue to believe that if you cannot manage it, you are in the wrong line of employment,*” were written in the survey. In the workplace, mental health is considered taboo, not to be discussed, and, if discovered, to be a sign of weakness. When people seek help, they are embarrassed, mocked by superiors, and advised to suck it up since it is part of the job. (NAEMT, 2016).

Another fundamental issue to be addressed is peer training for detecting and identifying mental health pressures. Peer and supervisory training could be used to educate supervisors and peers to recognize signs and symptoms quickly so interventions can be provided in a non-punitive manner. Early intervention can improve recovery results by reducing long-term stress symptoms (Petrie et al., 2018).

Recommendations for Counselor Educators

Future counselors are trained by counselor educators. We have a responsibility to educate in a culturally sensitive way. Although multicultural awareness is a focus of our current curriculum, it is frequently taught through the lenses of race/ethnicity, gender identity, sexual orientation, and religious affiliation. While those are significant facets of cultural awareness,

they neglect the complexity of intersecting elements that go into defining a person's cultural identity.

Work culture is a significant part of a person's identity and can influence their thoughts and actions (Curry, 2022). Identity is a cognitive concept that defines "who I am." Shared social beings form a significant part of a person's identity. The social identity that emerged from the workplace has begun to matter more in cultural discussions as work and the workplace frequently take center stage in most people's social lives. Cultural awareness in the context of mental health refers to tailoring support to a client's unique needs while considering their values, beliefs, and norms (Betancourt et al., 2003). Cultural awareness encompasses more than just being aware of the challenges and trauma experienced by EMTs. Instead, over the course of their careers, EMTs' experiences both on and off the job influence their mental health. Although the idea of cultural awareness in mental health is not new, it is crucial to talk about it now because it affects how EMTs are supported.

When considering cultural awareness, counselor educators are encouraged to potentially incorporate the concepts of work culture into the training. Culture is frequently viewed through the lenses of race, ethnicity, region, and religion, ignoring other intersections of identity that exist. The culture of career and social location is frequently overlooked in counselor education. This information could potentially be infused into curricula for Multiculturalism, Career, Crisis Intervention, Group Therapy, and Ethics; five of the program's core curricula.

Implications for Future Research

While this investigation contributes to the existing literature about the experiences of EMTs seeking and participating in individual therapy, it also has implications for future research. Although the focus of this study was confined to EMTs, other first responders may suffer

comparable experiences (Drew & Martin, 2021; Dutton, 2019; Fitch, & Marshall, 2016).

Comparing and contrasting the fields (EMS, police, fire, and dispatch) might lead to a better understanding of the structural impediments to mental health.

Along with limited knowledge of counseling resources, financial concerns, and stigma, many EMTs may have time constraints. According to Rivard et al. (2019), a majority of EMTs work overtime or a second job so they can afford to pay their bills. When EMTs work more than the average 40-hour work week, they struggle to prioritize health needs, such as mental health, until it disrupts their daily living (Rivard et al., 2019). While this was not a stated barrier in this inquiry, it merits future research.

It is difficult for a counselor who is uninformed of their current talents to identify critical areas of growth (SAMHSA, 2016). By incorporating specific post-master's educational training and supervision programs, identification may be able to aid and encourage the improvement of counselor knowledge and skill level for those seeking to work with this population. Participants in this study agreed that educational programs can help counselors learn about first responder careers and how they might help this population. Because each of these professions has a distinct culture with commonalities and differences, recognizing them might assist in the development of rapport.

Developing a quantitative measure of counselors' ability and comfort in dealing with EMTs would be another topic of investigation. Various assessments such as Multicultural Counseling Inventory (Sodowsky et al., 1994), Multicultural Counseling Awareness Knowledge Skills Survey-Counselor Edition-Revised (Kim et al., 2003), and the Cross-Cultural Counseling Inventory-Revised (LaFromboise et al., 1991), could be modified to assess a counselor's familiarity with and expertise of this group. Quantitative research might be used to identify areas

of emotional stress in counselors to investigate during personal interviews (Creswell, 2007). Counselors who address their emotional stress might lessen misconceptions while working with EMTs (SAMHSA, 2016; Wilson, 2019).

Summary

While many of the topics highlighted in this study are consistent with current literature, this study also offered valuable information concerning the counseling experiences of EMTs. The lack of knowing where to locate counselors who understand their concerns, as well as a lack of training for therapists on the requirements of EMTs, were major themes that emerged. Grace and Jesus were just two of the EMTs in this research who both reported alcohol abuse that almost cost them their employment but had no idea where to turn for help from someone who could relate to them. This study lays the groundwork for future research and identifies the need for training for the organizations that employ EMTs and the counselors who serve them.

Counseling and emergency medical services are only two of the disciplines that this research could impact. This study contributes to the understanding of this population's unmet needs. Counselors and EMS employers must both be more cognizant of the mental health needs of EMTs who serve their communities. Many communities are now experiencing a lack of emergency management staff and addressing mental wellness could help retain EMTs by decreasing mental harm (Fitch & Marshall, 2016; Sellberg, 2022; Snyder, 2019).

To establish a better work environment, organizational leadership, and workers must work together. An environment that provides proper training, supports first responders' resilience and health, protects them from overwork and excessive stress, and encourages them to seek treatment when required in order to promote first responders' mental health. Making programmatic changes to inform, support, and safeguard the health and wellness of first

responders would lessen the risk of burnout, fatigue, or other behavioral health issues related to being overworked, uncertain, or stressed out (Fader, 2022; Fitch & Marshall, 2016; Johnson et al., 2020). First responders bear the weight of their own safety and well-being as well as that of those they serve. Through preventative training, behavioral and public health organizations can assist in preventing or resolving behavioral health disorders in first responders.

As counselor educators, we are uniquely positioned to influence change in the care of this population by identifying cultural differences and developing instruction to address gaps. Counselor educators are ready to train counselors to detect those needs and advocate for their well-being. Our community needs and deserves healthy EMTs to serve them. Emergency medical technicians deserve the support that our profession can offer in order to aid in their recovery and raise awareness of mental health issues.

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Consent for Research Participation

Title	The Lived Experiences of Emergency Medical Technicians in Seeking and Participating in Individual Counseling
Sponsor	N/A
Researcher(s)	PI- Joy Hutchinson, University of Memphis Co-Investigator- Stephen Zaskas, University of Memphis- supervising faculty member

Researchers Contact Information	(504)231-7722, jhtchns1@memphis.edu
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You are being asked to participate in a research study. The box below highlights key information for you to consider when deciding if you want to participate. More detailed information is provided below the box. Please ask the researcher(s) any questions about the study before you make your decision. If you volunteer, you will be one of about 6-8 people to do so.

Key Information for You to Consider
<p>Voluntary Consent: You are being asked to volunteer for a research study. It is up to you whether you choose to participate or not. There will be no penalty or loss of benefit to which you are otherwise entitled if you choose not to participate or discontinue participation.</p> <p>Purpose: The purpose of this research is to explore the lived experiences of emergency medical technicians (EMTs) seeking and participating in individual counseling</p> <p>Duration: It is expected that your participation will last 60-75 minutes</p> <p>Procedures and Activities: You will be asked to complete a screening questionnaire online to express interest in participation; upon acceptance, you will complete a demographic questionnaire and choose a pseudonym; sit for an interview lasting approximately one hour.</p> <p>Risk: Some of the foreseeable risk or discomforts of your participation include stress, emotional distress, inconvenience, and possible loss of privacy and confidentiality associated with participating in a research study.</p> <p>Benefits: There are no direct benefits for participating in this research. The researcher hopes to use the information gained to better inform counselors and programs to suit the needs of EMTs.</p> <p>Alternatives: Participation is voluntary, and the only alternative is to not participate</p>

Who is conducting this research?

- Joy Hutchinson, MA, NCC, NREMT-P of the University of Memphis, Department of CEPR is in charge of the study. His/her supervising faculty advisor is Stephen Zanskas, Ph.D. There may be other research team members assisting during the study.

Why is this research being done?

- This study aims to explore the lived experiences of emergency medical technicians (EMTs) seeking and participating in individual counseling

How long will I be in this research?

- The research will be interview format, either in-person or on Zoom. It should take about 60-75 minutes of your time.

What happens if I agree to participate in this Research?

If you agree you will be asked to go to the link provided and answer a short questionnaire.

- Answer a pre-screening questionnaire.
- If selected, a demographic questionnaire regarding race, gender, demographic location, type of service will be sent to participants.
- This research will be an in-person or live Zoom interview process.
- There will be audio recordings collected.

What happens to the information collected for this research?

- Information collected for this research will be used to examine and inform writing a dissertation and later publication based on the experiences of EMTs in individual counseling.
- Your name will not be used in this research, all participants will be given pseudonyms

How will my privacy and data confidentiality be protected?

We promise to protect your privacy and the security of your personal information as best we can. Although you need to know about some limits to this promise. Measures we will take include:

- All participants will be assigned a pseudonym at the beginning of the interview for anonymity.
- Identifiers and data will be stored in separate files on the researcher's password-protected private computer.

Individuals and organizations that monitor this research may be permitted access to inspect the research records. This monitoring may include access to your private information and/or responses. These individuals and organizations include

- Institutional Review Board
- Research assistants
- Transcription services

What are the risks if I participate in this research?

- The risk or discomforts of participating in this research include:
 - You may experience stress, emotional distress, inconvenience, and possible loss of privacy and confidentiality associated with participating in a research study.

What are the benefits of participating in this research?

- There is no known benefit in participation of this research.

What other choices do I have besides participating in this research?

- If you do not want to be in the study, you can opt out of participation in this research.

What if I want to stop participating in this research?

- You can choose to end your participation at any time. There is no penalty or loss of benefits to which you are otherwise entitled if you decide to withdraw your participation. Your decision about participating will not affect your relationship with the researcher(s) or the University of Memphis.

Will it cost me money to take part in this research?

- There are no financial costs associated with participation in this research study

Will I receive any compensation or reward for participating in this research?

- You will be compensated \$20 for taking part in this research

Before you decide to volunteer for this study, please ask any questions that might come to mind. Later, if you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, Joy Hutchinson MA, CTP, NREMT-P at jhtchns1@memphis.edu (supervising faculty member Stephen Zankas, Ph.D.- szankas@memphis.edu). If you have any questions about your rights as a volunteer in this research, contact the Institutional Review Board staff at the University of Memphis at 1-901-678-2705 or email irb@memphis.edu. We will give you a signed copy of this consent to take with you.

STATEMENT OF CONSENT

I have had the opportunity to consider the information in this document. I understand that I can ask additional questions about the study by emailing the researcher at the email address provided above.

Screening Questions

Screening Questionnaire (part 1)

- Are you between the ages of 19-65?
- Do you have at least one year of experience in the United States as an Emergency Medical Technician (EMT)?
- Have you participated in at least three individual counseling sessions?

Demographic Questionnaire (part 2)

- Was your counseling experience mandated by your employer?
- How did you find the counselor that you saw?
- Would/ have you recommend(ed) counseling to peers in your field?
- What is your provider level?
- What is your relationship status?
- What is your racial identity?
- What is your gender identity?
- What is your age?
- How many years of service do you have?
- How long did it take before you accessed mental wellness services?
- Does your organization provide mental health services of any kind?
- Please provide a pseudonym for me to use during the course of this research.
- Please provide your contact email
- What day and time works best for you to meet? Please provide three answers

Prompts for interview

Prompts were not used as questions in the interview. These were expressed in conversation to encourage retelling of the experience. Not all prompts were used in each interview.

Related to Before the counseling session.

1. Can you describe what led you to counseling?

O (If voluntary), how long did it take you to decide to see a counselor?

O (If mandated), have you considered counseling before being mandated? If not, what led you to change your mind? If yes, did you continue once the mandated sessions were completed?

2. What were your expectations of the counseling experience?

3. How did you find the counselor that you saw?

4. What, if any, were the obstacles that prevented you from coming to counseling?

Related during the counseling sessions, “*What were your experiences in counseling?*”

5. In what ways do you feel like your counselor understood you and your needs?

6. What coping strategies, if any, did you learn in counseling that you found useful?

After the counseling sessions,

7. Would/ have you recommend(ed) counseling to peers in your field?

8. How do you feel that mental health is/ should be promoted more within the department that you work(ed) for?

9. What are your thoughts about mental health services and the department you work(ed) for?

COLLECTED DATA AUDIT TRAIL

1. Copy all pre-interview questions to a Word document
2. Copy all answers to questions to the same Word doc, labeling answers by pseudonyms.
3. printed all de-identified transcripts
4. read all transcripts three times
 1. once without highlighting to increase familiarity with the transcript and check for accuracy while listening to the audio
 2. second to highlight meaning units that appeared significant
 3. third to ensure no significant meaning unit was left out
5. Upload all transcripts to Dedoose for storage and labeling
6. Identity meaningful statements
7. Labeling statements with initial codes
8. Basic run-through comparing interviews (short answers to research questions) (e.g.,
Experiences in seeking counseling? Experiences in individual counseling?)
 1. Desperation
 2. Fear/ Stigma
 3. Not knowing where to look
 4. Not understood
 5. Education of culture
9. Have peer spot-check codes to ensure labels matched the meaning or essence of the
quote/meaningful statement
10. Sort codes by question/prompt
11. Sort all codes by the participant

12. Group similar codes together under each prompt
13. Have a peer look at initial groupings and provide feedback on if the labels/codes made sense and if they could understand the groupings
14. Extract all data from code lists that do not have to do with research questions (extra data/future research)