How valuable is the concept of resilience in understanding how paramedics 'survive' their work?

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Abstract

This study was prompted by the reflective essays submitted by paramedics in which they recounted traumatic experiences from work which seemed unprocessed. I subsequently became interested in how paramedics maintained their resilience and 'survived' their work as measured by for example, job satisfaction, morale, attrition and mental and physical well-being.

A qualitative research design was adopted which used a psycho-social interview technique called 'free association narrative interviewing' (FANI) as the means of data collection. Data collection included a one hour biographical interview initially and a second follow up 45 minute semi structured interview with seven participants recruited from a trust in England. In all instances data was collected at the university or participant's home and interviews were digitally recorded. The interviews were transcribed and analysed thematically. The study was approved by UWE and NHS ethics committees.

The analysis explored the key findings within the context of contemporary resilience theory drawing on psychological, sociological and psycho-social literature. However the main focus of the work was from a psycho-social perspective which is psycho-dynamically informed and uses psychoanalytic concepts and principles to explore core issues. The themes captured respondents' motivations to become a paramedic, which embraced notions of gender differences and the 'wounded healer'. The hidden toll of the work in relation to health, and the impact of recent performance targets and changes to skill mix which appeared to threaten traditional protective methods of support, emerged as other themes. Support from within the organisation was explored, focusing on the role of management, debriefing, peer support, humour, time out and the culture of

shame and denial within the organisation. Outside support explored the role of friends, family and referral to outside agencies. In dealing with unprocessed encounters, paramedics appeared to use other strategies including emotional detachment, dissociation, displays of anger and inappropriate professional behaviour. Despite limitations to the study, the findings unveil a unique account of how paramedics survive and become resilient.

Table of contents

Title and aim of proposed investigation 10

Background 11

Chapter 1- Literature review 13

1.1 Policy context 13

1.2 Impact of the job on paramedic's health 18

1.3 Identification with the patient 20

1.4 Resilience, what is it? 22

1.5 Resilience and psychological research 27

1.5.1 Resilience and attachment 27

1.5.2 Attachment affects the types of jobs people seek 29

1.5.3 The wounded healer 31

1.5.4 Incidence of Post-traumatic stress disorder in paramedics 33

1.5.5 Psychological research on traits needed for resilience 36

1.5.6 Resilience or recovery 39

1.6 Resilience and sociological research 41

1.6.1 Agency and identity formation 41

1.6.2 The impact of class on resilience 44

1.6.3 Emotion management 45

1.7 Resilience and Psycho-Social research 48

1.7.1 Psycho-social studies 48

1.7.2 A kleinian view of health organisations 51

1.8 Strategies to maintain resilience 57

1.8.1 Potential methods of support – counselling 58

1.8.2 Support from managers 59

1.8.3 Implications for practice 59

1.8.4 Critical incident stress management 61

1.8.5 Conclusion 67

Chapter 2 – Methodology 70

2.1 Theoretical framework of Psycho-social research methods 70

2.2 Methods of Inquiry - Psycho-social method 71

2.3 The dynamics of the research encounter 77

2.4 Criticisms of the psycho-social approach 80

2.5 Access and ethics 83

2.6 The sample 85

2.7 Demographics 85

2.8 Data collection 86

2.9 Analysis 88

2.10 Ethics 90

2.11 Conclusion 90

Chapter 3 – Findings 92

3.1 Overview 92

3.2 Biography – Ann 94

3.3 Biography – Bryony 95

3.4 Biography – Carol 96

3.5 Biography – Dee 97

3.6 Biography – Eve 98

3.7 Biography – Fred 99

3.8 Biography – Greg 100

3.9 Thematic presentation of findings 101

3.10 Theme 1 - Motivations for becoming paramedic 101

1.1 Jobs for the boys 102

1.2 Safety and gender 103

1.3 The wounded healer 105

3.11 Theme 2 – A hidden toll 109

2.1 It's just not a healthy job 109

2.2 Coping with humanising moments and connections 112

3.12 Theme 3 - Pressure of performance targets 114

3.1 Impact on patients 114

3.2 Impact on staff 115

3.13 Theme 4 - Organisational support 123

4.1 Peer support, humour and debriefing 123

4.2 Management support 127

4.3 A culture of shame and denial 129

3.14 Theme 5 - Processing emotions 132

5.1 Anger and projection 132

5.2 Attitudes to 'regulars' and 'timewasters' 134

3.15 Theme 6 - Seeking support 136

6.1 Reflective space 136

6.2 Support from family 137

6.3 Referral to outside agencies 139

6.4 Use of antidepressants and counselling 141

3.16 Theme 7 - Becoming resilient 143

7.1 Learning to detach 143

7.2 Technical versus caring work 147

Chapter 4 - Reflexive account of the interview process 151

4.1 Conclusion 159

Chapter 5 – Discussion 162

5.1 Motivations for becoming a paramedic 163

5.2 Hidden toll of the work 168

5.3 Impact of performance targets 170

5.4 Informal methods of support – storytelling with peers 174

5.5 Informal methods of support – family and friends 175

5.6 Informal methods of support – humour 176

5.7 Informal methods of support – time out 177

5.8 Formal methods of support – management support 178

5.9 Formal methods of support – debriefing 180

5.10 Formal methods of support – referral to outside agencies 181

5.11 Changing cultures 183

5.12 Unprocessed emotions 184

5.13 Strengths of the study 190

5.14 Limitations of the study 191

5.15 Reflection on the methodology and use of FANI 192

5.16 Conclusion 195

5.17 Recommendations for practice 198

References 200

Appendices 244

Appendix A - Outcome of NHS ethics application approval 245

Appendix B - Advert for recruiting participants 246

Appendix C - Information sheet for participants 247

Appendix D - Consent form for participants 251

Appendix E - How to access counselling (information for participants) 252

Appendix F - Second interview questions (all participants) 253

Appendix G –Themes and Quotes for participant A1, A2 259

Appendix H - Themes occurring across all respondents 284

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Title

How valuable is the concept of resilience in understanding how paramedics 'survive' their work?

Aim of the proposed investigation

1. To examine the explanatory capacity of contemporary resilience theory and how it is deployed in health care research, in terms of traditional psychological, sociological and psycho-social approaches.

2. To consider 'survival' (measured for example by, job satisfaction, morale, attrition, mental and physical well-being) of paramedics through the lens of resilience theory.

3. To conduct qualitative research using free association narrative interviews to explore the lives of paramedics in terms of how they 'survive' their work.

4. To consider methods of building resilience into training and supervision for paramedics.

Background

Whilst teaching and leading the module ‘Accelerated learning for professionals’ for the BSc Emergency care for Paramedics. I regularly taught a session called Art, music and storytelling; this is a reflective space in which the paramedics can reflect on critical incidents in their work. For the module, paramedic students wrote a reflective critical incident assignment. I noticed that many of the students used the opportunity to explore difficulties associated with their role, in particular, unresolved feelings following traumatic jobs. They often commented that the module provoked profound emotions, and was often the first time they had accessed a reflective space to explore the emotional impact of their work.

What had been interesting during this module was the desire by paramedics to explore critical incidents which had impacted on them greatly and had not been fully resolved, but had remained a niggling problem in some instances for many years. Critical incidents included amongst others difficult resuscitations, suicides, accident victims, child injuries and accidents, and patients with mental health problems. Some paramedics’ experience of work seemed to be traumatic and stressful and I wanted to understand this more. It was clear from the paramedics’ reflective discussions that some of them seem to ‘survive’ better than others. Survivors had, during their life course experienced ‘ups and downs’ but somehow had stuck with the job. I wanted to explore why this was the case using the notion of resilience as defined within the three major perspectives of, psychological, sociological and psycho-social studies. Chapter one explores the policy context in which paramedics operate which has changed rapidly over recent years. This is followed by a discussion of the impact of the job on paramedics’ health, the role of identification with patients and the use of strategies such as dissociation which

can protect paramedics. This is followed by a discussion on resilience, drawing on psychological, sociological and psycho social perspectives. Lastly an overview of strategies used to maintain resilience will be examined.

Chapter 1 – Literature review

1.1 Policy context.

Ambulance services have undergone transformation over the past ten years in response to a number of government policies. These include '*Reforming Emergency Care'* (Department of health 2001) where the government set out to reform the nations emergency care services over a four year period. The report aimed to modernize the delivery of emergency services as fast, responsive and effective. This included providing a range of services appropriate to patient's needs, in particular a flexible approach to the skill mix and workforce. *'Reforming Emergency Care'* has led to improvements in emergency response times, the deployment of new technology (including satellite navigation systems and better equipment to deal with cardiac patients) and has led to funding increases in frontline ambulance staff and vehicles.

'*Taking Health care to the patient, Transforming NHS Ambulance services'*, (DOH 2005) suggested the need to transform from a service focusing primarily on resuscitation, trauma and acute care towards becoming the mobile health resource for the whole NHS – taking healthcare to the patient in the community. '*Right skill, Right place, Right time'* (DOH 2004) suggested that patients should receive the highest standard of care, by the most appropriately trained person in the most appropriate setting. The aim was to focus paramedics' work within the primary care team, to help provide diagnostic services and support patients with long term conditions. As a result the Emergency Care Practitioner (ECP) was introduced. ECPs were meant to treat on the spot (for example suturing a wound) or refer directly to e.g. hospital, general practitioner, mental health crisis teams or

social services etc. depending on the problem. The aim was to avoid hospital admission.

In the past the emergency services consisted of paramedics and technicians. Technicians were of a lower grade to paramedics and could do similar work, but were unable to administer drugs. Paramedics were supported by technicians and they worked together on ambulances to provide the service. Paramedics and technicians were trained on residential courses within NHS Trusts' training organisations. Recently there has been a move to training paramedics in institutes of higher education at foundation degree level (Williams, 2012). Paramedics are being encouraged to improve practice by moving away from the traditional didactic protocol led style of teaching to a more evidence based approach based on critical thinking.

More recently the ambulance service have introduced a new role to support clinical care, the Emergency Care Assistants (ECAs) who have minimal (5 weeks) training and are unqualified. Their role is to assist with all clinical, practical, social and emotional care and also to help their colleagues, provide and prepare the right equipment and environment, carry out assessments and provide treatment as necessary. They are key to the Department of Health's (2005) vision for a mobile health care service where ambulance services are '*Taking Health Care to the Patient'*. The role is also an enabler to improve the integration of the ambulance service within the modern NHS and to ensure there is equality of job provision at all skill levels. The role also provides an entrance to a career pathway for staff and an opportunity for staff to progress and develop new ways of working (DOH, 2005).

Alongside the introduction of ECPs the rapid response vehicle (RRV) staffed by ECPs or paramedics as lone workers was developed as an alternative to the ambulance. News coverage (Channel 4: 19.12.11) has suggested that trusts are increasing the number of cars in relation to ambulances. This can be problematic at busy times because if ambulances do not respond swiftly to back up the cars patients' transport to hospital can be delayed. This can have devastating consequences for patients, and provides extra stress for the lone responders in RRVs. In some trusts RRVs are staffed not by ECPs, but by lesser qualified technicians and ECAs, which can arguably affect the quality of care.

The changes outlined above have all taken place within a backdrop of performance targets set by the government in which patients are coded as either category A, B or C as follows:

Category A: immediately life threatening. An emergency response will reach 75% of calls within eight minutes.

Category B: serious but not immediately life threatening. An ambulance will arrive within 19 minutes 95% of the time.

Category C: not serious or life-threatening. Performance requirements are set locally. (NHS Choices, 2010).

More recently categories B and C (non-life threatening calls) have been replaced by four categories. Patients in the first two of these will still be attended by the ambulance service in either 20 or 30 minutes depending on their condition. Patients in other non-serious categories may be offered advice over the phone by the ambulance staff or NHS Direct, or be referred to their GP or a walk-in centre,

or be sent an ambulance if this is deemed necessary (London Ambulance service 2012).

What has emerged in recent years has been an explosion of auditing measures by the government to monitor performance targets within the NHS. Alongside this, trusts have merged to become more economically efficient. On 1 July 2006, the number of ambulance trusts covering England was reduced from 31 to 13. Scotland, Wales and Northern Ireland continue to have their own separate ambulance services (DOH, 2005).

The aim of many of the policies outlined above has been to improve services because many 999 calls were not life threatening and because the ambulance service needed to adapt to respond to more long term and complex conditions such as diabetes, cardiac disease, asthma and stroke. Alongside these aims one of the main objectives of recent policies has been a drive to reduce costs and resources. The broader context is also changing, as increasing longevity means people will experience more ill health leading to greater demands on emergency services.

A recent government review *Taking Healthcare to the Patient 2*: *A review of 6 years' progress and recommendations for the future* (DOH, June 2011) identified that, amongst healthcare workers, front-line ambulance service staff consistently reported low satisfaction levels resulting from high levels of bullying and harassment from patients, members of the public and colleagues. Paramedics have daily contact with distressed patients and stressed relatives and may also face conflict with busy colleagues (Beaton 2006).

'*Taking healthcare to the patient 2'* (DOH, 2011) also found that the nature of ambulance work may contribute to feelings of discontent, due to pressure to meet response times and because managers spend much of their time managing resources rather than relating to their staff. Training and appraisals can also be neglected because the service is trying to maximize the amount of time spent on operational work. As a result ambulance crews can feel pressurized, and be made to feel that their clinical skills matter less than how quickly they drive. Ambulance staff were more likely to work additional hours (79% said they had done so) and to work more unsocial hours than most other NHS staff. It is possible that, if their scores were compared with other NHS workers with similar shift patterns, the differences in satisfaction levels might not be so great suggesting that it is the shift work that is the main problem (DOH, 2011).

'*Taking healthcare to the patient 2'* (DOH, 2011) reported that, compared to other healthcare workers ambulance staff felt less valued by colleagues. More than a third of staff reported feeling dissatisfied that their line manager did not seek their opinion before making decisions which affected their work (National Staff Survey from 2006/07 to 2009/10). Similarly, approximately a third of respondents to the National Staff Survey during the same time period commented that they often considered leaving their current employment. Over a third of respondents also felt dissatisfied with the extent to which their organisation valued their work. Despite this ambulance staff turnover is very low and many front-line staff stay in their jobs for many years.

As outlined earlier I have been concerned with how paramedics manage their stress and maintain resilience in their practice. Factors which contribute to stressors in the workplace include the context outlined above as well as the

traumatic nature of the job. Stress can affect individual's sense of self efficacy and self-esteem and in turn impact on attrition rates. This may be further compounded by hierarchical, bureaucratic, and masculinized workplaces. Paramedics are expected to adhere to a strict hegemonic masculinity which severely restricts the expression of emotion (Boyle, 2005, Steen et al, 1997). This includes self-control and stoicism or "The John Wayne syndrome" (Connell, 1995). Steen et al (1997) linked the constant containment of emotion to the 'pressure cooker phenomena' where pressure builds over time. The predominance of a 'male coping culture' has prompted a call to challenge and change the cultural attitudes towards emotion work and emotional expression within paramedic practice (Steen et al, 1997). There has also been a call to apply resilience research to health care education as a means of understanding the effects of stress among staff and finding how to minimize this (McAllister and Mckinnon 2008). This study intends to explore how paramedics 'survive' their work through the lens of resilience theory. The first task is to examine the impact of the job on paramedics'.

1.2 Impact of the job on paramedic's health

The nature of paramedic work is fast paced, challenging, and requires making on the spot decisions regarding emergency care often under the gaze of the general public (Sterud et al, 2008). Paramedics can be exposed to pain and suffering on a daily basis as they attend road traffic incidents, suicides, assaults and accidents (Regehr et al 2002a). These demands, alongside increasing management pressures to achieve targets and work long hours, place considerable stress on the paramedics (Okada et al, 2005; Dollard et al, 2007; Jenner, 2007; Regehr and Millar, 2007; Nirel et al, 2008). Such stress may be inherent to the paramedic

profession or organisation rather than an individual specific problem (Hancock and Desmond, 2001, Okada et al, 2005, Smith, 2009).

There are many effects of stress on paramedics. Relative to the general working population, ambulance workers experience elevated rates of standardised mortality and early retirement for medical reasons, as well as more frequent accidental injuries and musculoskeletal symptoms (Sterud et al, 2006). Compared to the general population, health professionals experience a disproportionately high rate of stress related illnesses including coronary disease, substance abuse and suicide (Wieclaw et al, 2006). The cost of stress can also be detected in lifestyle diseases such as myocardial infarction, stroke and hypertension (Lewis, 1994, Shelton and Kelly, 1995). Continued exposure to death and trauma can precipitate psychological problems such as post-traumatic stress symptoms and depression among health care staff (Bryant and Harvey, 1996, Marmar et al, 1999, McFarlane, 1988, Regehr, Hill and Glancy, 2000 cited in Regehr et al 2002a, Sterud et al 2006). The personal costs of stress can be high affecting financial, social and family life (Regehr, 2005) including personal motivation and commitment to work (Jenner, 2007). In addition to the cost of these symptoms to individuals, the conditions that contribute to stress affect sickness rates which are reported to be at high levels (NHS Information Centre 2010). The stressful nature of the job may also make recruitment and retention more difficult, and may affect patient outcomes (Maunder et al, 2011).

1.3 Identification with the patient

It is often assumed that events resulting in mass casualties cause the most stress. However identification with the patient seems to be a strong predictor of traumatic stress reactions amongst health care staff (Dyregrov, 2002; Dyregrov and Mitchell, 1992; Jonssen et al, 2003). Identification seems to be strongest when children are involved, (Ursano et al, 1999, Lundin, 1992).

Regehr et al (2002) found that it is frequently a smaller, less overt event that triggers an emotional response. Often it is related to situations where the worker has formed some sort of empathy or emotional connection with the patient. This could be because the patient reminds him or her of a member of their own family e.g. same age as their mother, or they have a child of a similar age; or they have spent time getting to know the patient as is often the case when dealing with children. Regehr et al (2002) reports that certain characteristics e.g. the helplessness and innocence of a child, the loss of a family member, or the despair of a suicidal person enables the paramedic to develop an emotional connection and therefore experience emotional empathy. It is this connection that leads to increased symptoms of distress following the event. In other words this sense of connection means the paramedics are not able to perform the strategy of emotional distancing that usually protects them. Regher et al (2002) argues that strategies that emotionally distance paramedics from their patients resulted in paramedics experiencing fewer symptoms and having less need to engage with social support mechanisms.

Much of the previous work on the impact of psychological trauma for emergency service workers has been focused on critical incident stress rather than daily

occupational stressors (Alexander and Klein, 2001; Regehr et al, 2002b; Bounds, 2006). Critical incidents are defined as events which may overwhelm individuals rendering them unable to cope with the experience (Mitchel and Bray, 1990; Flannery, 1999; Hammond and Brooks; Harris et al, 2002, Ward el al, 2006). Critical incidents may cause paramedics to experience unusually strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later (Mitchell 1983). These emotional reactions can include self-doubt, sadness, anger, frustration at not being able to help and intense feelings of compassion or loss (Halpern et al, 2009)

However Jenner (2007) argues that, following such incidents paramedics do not always suffer from post-traumatic stress symptoms and very few ambulance staff access formal stress management support (Rose, 2001). Jenner's (2007) work raises important questions that have not previously been researched for instance how do paramedics actually cope with stress? and what do they do on a daily basis to mediate the effects of their work? To date very few studies have explored the specifics of occupational related stress (Lau et al, 2006) and even fewer from the paramedic profession's perspective (Bounds, 2006).

Identifying the specific determinants of paramedics' resilience or vulnerability to critical incidents and daily occupational stress may lead to better individual health and in turn enhance patient care (Maunder et al, 2011). This study is concerned to explore the notion of resilience towards stress from a range of perspectives; psychological, sociological and psycho-social. However before exploring this fully it is useful to define what is meant by resilience, drawing on recent literature.

1.4 Resilience what is it?

The prevailing psychological research paradigm around resilience within the health sector tends to be problem oriented (McAllister, 2007; Robinson and Sirard, 2005) and focuses on reductionist approaches to understanding causative mechanisms of risk and protective factors for workers. This draws on the developmental literature, in which resilience is typically discussed in terms of protective factors that foster positive outcomes and healthy personality traits amongst children exposed to adverse life circumstances (Gameszy, 1991, Luthar, et al, 2000, Masten, 2001, Rutter, 1999, Werner, 1995). The notion of resilience being an individual or community trait has been superseded by resilience research led by Luthar et al, (2000). This research purports to provide a framework for an in depth analysis of the subjectivity and agency of practitioners, which is viewed as a dynamic process in which internal and external factors interact in different ways over time. Practitioners' strengths and vulnerabilities emerge during their life course in response to changing circumstances, situation's and experiences. Resilience can rarely, if ever, be regarded as an intrinsic property of individuals; rather it is an emergent property of a hierarchically organized set of protective systems that cumulatively buffer the effects of adversity for the individual (Roisman et al, 2002). A focus on adaptive functioning can lead to the unhelpful assumption that capability and resilience are personality traits, and that everyone can be resilient if they only try hard enough. Such a dispositional approach can lead to a potentially damaging misunderstanding, blaming the victim of adverse circumstances, instead of examining the factors and processes that enable individuals to beat the odds, or thinking about measures to change the odds by removing obstacles and creating opportunities (Bartley and Schoon, 2008).

The concept of resilience has been developed into a theoretical framework known as the resilience construct (Luthar et al, 2000; Ungar, 2004). The resilience construct examines how many individuals, are able to draw upon a range of resources which assist them in dealing with negative experiences and situations and enable them to 'bounce back' from adversity (McMurray et al, 2008). Ungar (2004) suggests that discussions about resilience should take into account the internal psychological traits or properties of the individual, but also external social factors e.g. gender, ethnicity, and socioeconomic status. Ungar (2004) argues for an approach that does not merely define resilience but seeks to understand the meanings of resilience that individuals bring to their lives through listening to them telling their own life stories. This approach underpins the methodology used in this research project.

Rather than focusing on traits recent research on resilience has focused on an 'assets model' approach, which explores factors leading to wellbeing and salutogenesis (Fleischer et al, 2006), as opposed to illness and deficiencies. This approach seeks to examine the underlying social and psychological processes by which resilience may be achieved. One of the major outcomes of developing resilience is the development of capabilities or capacities (French, 1999). The notion of capability, introduced by Sen (1985) includes the freedom to achieve various lifestyles, depending on the opportunities and choices available to people. Lifestyle choices can be increased by changes in the social or physical environment.

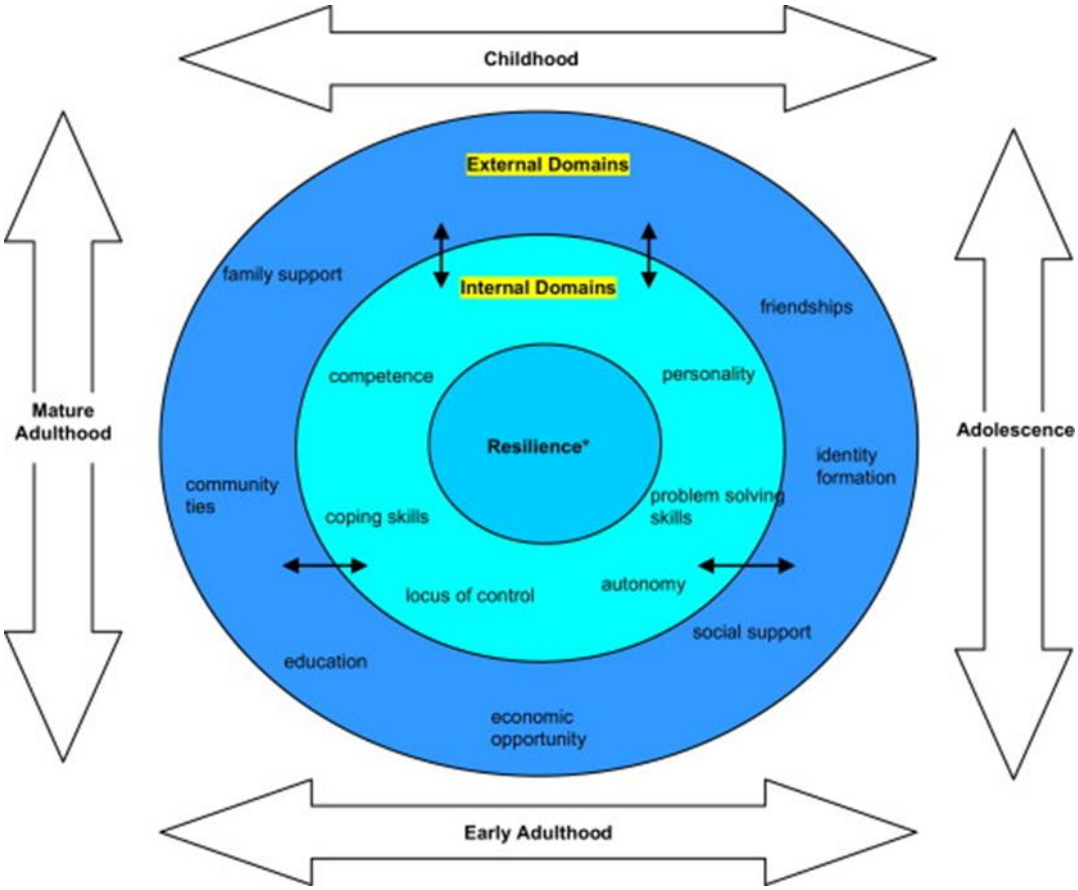
A systematic search and critical review of the various studies on resilience revealed a division within the literature which adopted either a psychological or a sociological definition of resilience, instead of recognising the potential benefits of

integrating both definitions (Ward et al, 2011). For this study Ward et al's, (2010,pg 10) definition will be used in that "Resilience is the interaction between the internal properties of the individual and the set of external conditions that allow individual adaptation, or resistance to different forms of adversity at different points in the life course". Here resilience is not viewed as an inborn trait, nor is it stable or static through one's life. Rather resilience can be developed or eroded unpredictably. Ward et al (2011) suggests it is a set of tools and strategies that a person builds up through facing difficulties which may be useful for future situations. For paramedics, strategies may include emotional distancing, dissociation and humour alongside support from peers, family and friends. A leading cause of the propensity to dissociation is previous experience with severe trauma especially childhood abuse (Saunders and Giolas, 1991). Recent research by Maunder (2012) suggests that the rate of clinically relevant symptoms in paramedics (high burnout, depressive symptoms and multiple physical symptoms) is greater by approximately 60% in paramedics who report previous child abuse or neglect. The recent literature on resilience has less to say about how resilience is influenced via biography and how the internal (psychological) or external (sociological) forms of resilience interact or influence each other over time (Ungar, 2004).

Loosely using Ward et al's (2011) model (figure 1) resilience can be explored through three perspectives namely psychological, sociological and psycho-social studies. Psychology explores the internal factors of Wards et al's (2011), model focusing on attachment and the impact of childhood abuse and neglect, and the paramedic role in relation to reparation. Psychology also explores the incidence of PTSD in paramedics and literature around the traits perspective.

Sociological analyses explores external domains such as agency and identity formation, and the impact of social class and emotion management through the work of Bourdieu (1999) and Giddens (1991) amongst other authors. However psychological and sociological perspectives provide partial and incomplete analyses whilst psycho-social studies can provide a deeper insight into the influence of biography and how the internal (psychological) and external (sociological) forms of resilience interact or influence each other over time. The focus of this research will therefore be from a psycho-social perspective. In addition the text will explore recognised strategies to maintain resilience, including emotional distancing and dissociation, use of antidepressants and counseling, management support and critical incident stress management interventions.

Figure 1 - A psychosocial model of resilience



Ward et al (2011**pg 1142**)

Reprinted from Social Science & Medicine, Vol. 72/7, Ward, P. R., Muller, R., Tsourtos, G., Hersh, D., Lawn, S., Winefield, A. H., Coveney, J. Additive and subtractive resilience strategies as enablers of biographical reinvention: A qualitative study of ex-smokers and never-smokers, 1140-1148, Copyright (2011), with permission from Elsevier.

1.5 Resilience and Psychological research

1.5.1 Resilience and attachment

Resilience appears to be firmly based upon the principles of *attachment theory* which is a theory of psychosocial development based on the work of Lorenz, Harlow and Bowlby in the 1940s. This theory suggests that social relationships in adulthood are highly influenced by childhood attachments. Attachment theory has also explored how individuals cope with stress. The quality of the early parental relationship has been found to affect neural development, which influences social relationships and emotion regulation (Tsuang et al 2004, Schore, 1999) This early attachment experience becomes represented cognitively in the brain as the 'internal working model' (Kraemer, 1992). Kraemer calls the internal working model of attachment the 'caregiver icon' and describes it as being 'engaged' psychologically when the individual is either in need of care or has to provide it. This has important implications for the work of any health care professional as they bring their own internal working model to their work.

Adshead (2010) suggests that 60% of people in a normal population will have secure attachment behaviour patterns originating from active, sensitive, consistent parenting. Children without secure parenting patterns develop behaviours that fall into three subgroups: *insecure avoidant*, which arises from rejecting or non-attendant parenting where children learn it is better not to attach to anything, thus minimising their attachment needs and keeping to themselves. *Insecure ambivalent* where parents have been unreliable sometimes responsive and sometimes not, and where use of threats of abandonments have been used to control the child. These children tend to be anxious about separations and cling to

their attachment figures. *Insecure disorganised* in which there is no clear pattern of child interaction, so the child resorts to dissociation and self-soothing to manage their anxiety, which may later result in control and coercion of others (Holmes 2010, Ainsworth, Bell and Stayton 1971, Main and Solomon, 1986).

Braun (2011) argues that the anger, resentment and longings associated with insecure attachments have to be 'split off'. The result of splitting, reducing or hiding these aspects of self can be what Winnicott (1960, 1965) calls a 'false self'. Attachment therefore affects the development of our personality and personal internal working models namely the model in our mind of the attachment relationships we had as children. Children move from expressing attachment needs behaviourally to representing them psychologically (Bretherton and Munholland, 2008). Longitudinal studies have found that childhood attachment models tend to persist into adulthood, especially in insecure children, who tend to become adults with insecure attachment representations (Grossman et al, 2005). Such studies make it clear that insecurity of attachment is not in itself a pathology, but represents a vulnerability. Insecure children are at increased risk of suffering psychological distress in adulthood compared with secure children, probably because their attachment environment affects the expression of genetically based personality traits (Scott et al, 2009).

However Roman et al's (2008) study of forty four women who had considered themselves successful despite childhood maltreatment found the following factors to be important in achieving resilience. Women reported a process of becoming resolute, or a 'steely will' for decentering abuse and achieving success in work and relationships. This was combined with an 'I'll show them attitude' where they resolved to display opposite behaviours to those personally experienced, 'I will be

the mother I did not have'. The role of key others was also important 'no matter what relationship' for instance husbands, partners, therapists and teachers who appeared solid, helped with self-esteem and who they knew would always be there for them. These positive relationships seemed to mitigate or even transform the destructive effects of earlier abuse. Also people who 'saw something in them' be it short or long term, seemed to help them overcome difficulty. Roman et al (2008) uses the concept of 'earned secure' to explain how the working model of self can change through experiences beyond the early years. Bartley (2010) drawing on the Whitehall 11 study, found that attachment style was a source of resilience in people's careers. Those with a secure attachment style could progress to the higher grades with more pay and status. However people with higher education levels could also get to the top of their careers regardless of attachment style. Additionally Bartley (2010) identified that attachment style did not protect people if they suffered high job strain or lost their jobs. Given the high job strain paramedics face I wondered what the job may offer to people who have either suffered childhood abuse or neglect and whether their career choice acted as a form of 'working through' earlier events.

1.5.2 Attachment affects the types of jobs people seek

Melanie Klein introduced the term reparation in 1929 to explain the child's endeavours to heal the parental image, that they feel has been damaged by aggressive attacks. Klein also connected reparation to creativity on a general level (Olsen, 2004). Levine (2009), drawing on the work of Fairbairn, Klein, Winnicott and Bion, explored why we work and the purpose it serves. This includes internal factors, (greed, guilt, self-development), that shape the meaning of work and work settings. Levine's central idea is that work occurs when an 'idea'

is instantiated in contrast to ‘play’, where experiences are shared. Work involves the capacity to contain or restrict impulses that would interfere with producing an ‘idea’. Levine argues that the reasons people engage in work are that it allows the self to be creative, mature, acknowledged, able to hold its good objects and more importantly not to be overtaken by bad objects into an external reality. The expression of self in work is the prime driving force. Levine argues there are two kinds of work first what he/she believes work really is or should be (the realisation of the potential embedded in the idea) and second that work attempts to repair ‘fantasied damage done to the good object’ (Klein’s idea of reparation). Work is about finding and expressing the true self. However, work can also become defensive, reparation rather than creative, a ‘role play’ rather than a role taken up. The struggle is to gain and express the internal ‘good’ through work. Despite criticisms aimed at Levine (2009) for focusing on a self-constructed individual rather than a person located and created by a broader social construct (Long, 2010). Levine does offer some insight into why some people unconsciously choose certain professions such as paramedic work , and how they can act out their earlier life within the job, thus forming a ‘role play’ rather than a role. Further insight into this can be gleaned from the notion of the ‘wounded healer’ which will be examined next.

1.5.3 The wounded healer

Guggenbuhl-Craig (1998) argues from a Jungian perspective that doctors can embody the archetype of the wounded healer. This could also be applied to paramedics. Within the doctor there is not only a healer but also a patient. Because the ego is poorly equipped to cope with such ambiguities, it seeks clarity and insists on splitting the poles of the archetypes. This is achieved by one part being repressed into the unconscious. When this occurs the repressed aspect can be projected externally. The doctor can project his or her inner wounds onto the patient and then view themselves as strong, well and invulnerable to illness. The patient can project their inner healer onto the health care professional, assuming a passive role and expecting the doctor to heal him or herself without any active involvement on his or her part. This results in patients being seen as sick, weak and ill. The doctor is unable to identify with their own wounds (the patient within) and so cannot activate the healer within his or her patients. This is the classic example of the patient who is sick and helpless and the doctor who is well and powerful.

Guggenuhl –Craig (1998) argues that once the physician has split the patient healer archetype s/he experiences no relief from the patient's sickness and wounds. Yet the sickness also belongs to the doctor, and so the split archetype attempts to reunite. It is this need for reunification that explains why many doctors choose their profession in the first place. The reunification takes place as the doctor relates to the patient as an object, unable to see his or her own wounds and vulnerabilities to illness. The doctor objectifies illness and projects it onto the patient. He thinks of himself more highly than he is and in the process becomes more distant to his weaknesses, he becomes more powerful through his failure

psychologically rather than through strength. When the doctor begins to experience his wounded self this unites him with the patient, in some sense this links to the notion of having more empathy with patients because the doctor has also experienced what they go through. When they become more aware of their own weaknesses they are able to be more empathetic to patients. This work has implications for how paramedics see their patients (as timewasters, deserving or non-deserving) and whether they can relate to them with kindness and compassion. If attachment is disrupted due to childhood abuse and the role of paramedic is used as a form of reparation, these paramedics are 60% more at risk of PTSD, depression and anxiety as indicated earlier by (Maunder et al 2011). Given this it is useful to explore PTSD further.

1.5.4 Incidence of Post-traumatic stress disorder in paramedics

Resilience can be usefully measured through the amount of Post-traumatic stress disorder suffered. Post-traumatic stress disorder (PTSD) is a response to an acute traumatic event or series of events. Paramedics are one group of professionals exposed to acute traumatic events on a regular basis. High stress situations include multiple casualty incidents and deaths of children in particular. PTSD is a severe anxiety disorder characterised by flashbacks, nightmares, increased arousal causing sleep problems, anger and hyervigilance (*DSM-IV*, 1994). Preventing PTSD is of importance to employees and employers in maintaining an effective workforce and in providing services (Alexandra et al 2007).

Sterud et al (2006) in their systematic review of health status in the U.K ambulance service reviewed 49 studies and found that ambulance workers had a higher standardised mortality rate, higher level of fatal injuries and a higher rate of standardised early retirement on medical grounds than the general working population. Ambulance workers also had more musculoskeletal problems than the general population. In terms of mental health problems, the prevalence of post-traumatic stress symptoms was greater than 20% in five of seven studies, and high prevalence rates for anxiety and general psychopathology were reported in four of five studies. However Sterud et al (2006) conclude that it is unclear whether ambulance personnel suffer from more mental health problems than the general working population.

Similar findings were outlined by O'Keefe and Mason (2010) who reviewed a series of studies on PTSD among ambulance staff. These included Bennett et al's

(2004) survey of the prevalence of PTSD using the Impact of Event Scale (IES). It found that in two thirds of the sample of 617 questionnaires distributed, intrusive work-related memories were reported. Furthermore 22% of the sample reported scores indicative of PTSD, with men having a higher prevalence than women. However this needs to be treated with caution due to small numbers of women in the survey. Alexander and Klein (2001) also found high levels of PTSD in ambulance staff with 90% of the sample reporting a particularly disturbing incident in the previous six months. Jonsson et al, (2003) similarly found that emergency workers were at risk of developing PTSD in the course of their everyday work, even if they were not exposed to major disasters. Their analysis suggests that there was a risk of underreporting of PTSD due to avoidance behaviour and fear of exposure. Van der Ploeg and Kleber's (2003) longitudinal questionnaire found 12% PTSD symptoms at time one and 13% symptoms at time two. Additionally social aspects of the work environment, including poor supervisor contact, poor communication and poor colleague support were predictive of PTSD symptoms. Regehr (2002a) reported that personality style predicted which staff were most likely to leave after exposure to a critical incident.

In contrast, Berger et al (2007) identified rates of PTSD to be as low as 5.6% but concluded that this was because the sample included physicians (28%) and a high proportion of paramedics who were ex-military. O'Keefe and Mason (2010) in their review of the above studies suggest that despite the problem of underreporting as cited in Jonssons et al (2003) it may be possible that responders were also over reporting. Many of the measures used to quantify PTSD symptoms were not diagnostic (such as the IES) and therefore the conclusions should be regarded

with caution. They suggested that further research needed to take account of the disability that PTSD causes, the time course of symptoms in relation to critical events, organisational factors that may exacerbate PTSD symptoms including poor supervisor contact, poor communication and poor colleague support, as cited by Van der Ploeg, et al (2003), alongside individual factors such as personality style and coping mechanisms, (Sterud et al 2006). Okeefe and Mason (2010) conclude that the relevant impact of work related and individual factors in explaining variance in PTSD between ambulance workers is not known. Maunders et al's (2012) study of paramedics found that 38.4% reported childhood physical, sexual or emotional abuse. Female paramedics reported significantly more abuse and neglect than a comparison group of 159 female hospital based healthcare workers. Maunders et al (2012) concluded that childhood abuse may be more common in paramedics than in other health care workers, at least in women and that childhood abuse and neglect is associated with 60% more acute stress responses to critical incidents. However the research needs to be treated with caution and may not be generalizable due to its low response rate, only 232 (36.5%) responded out of a sample of 635. However given the relationship between PTSD and paramedics, it is useful to explore the contribution of psychological research on the 'traits' that may serve to protect people.

1.5.5 Psychological research on traits needed for resilience

Resilience has been described as an ability to overcome difficult circumstances in one's life (Marsh 1996). There has been much psychological research into the personality and dispositional characteristics of resilient individuals. Research in this field tends to focus on 'innate' individual characteristics which render people 'at risk' or are 'protective'. For example protective characteristics for paramedics have been claimed to be extroversion, openness, agreeableness, conscientiousness and coping styles (Shakespeare-Finch et al 2005). Other research suggests protective strategies include the ability to build positive professional relationships, optimism, emotional insight, self-care, having life meaning and the ability to be reflective (Jackson et al, 2007).

Other psychological 'traits' include hardiness, self enhancement, positive emotion and humour. The personality trait of hardiness (Kobasa et al, 1982) helps to buffer exposure to extreme stress. Hardiness consists of three dimensions: being committed to finding meaningful purpose in life, the belief that one can influence one's surroundings and the outcome of events, and the belief that one can learn and grow from positive and negative experiences. Armed with this set of beliefs hardy individuals have been found to appraise potentially stressful situations as less threatening, thus minimizing the experience of distress. Hardy individuals are also more confident and better able to use active coping and social support, therefore helping them deal with the distress they experience (Florian et al, 1995).

The trait of self enhancement has been associated with benefits such as high self-esteem, but this comes with costs as self-enhancers score high on measures of narcissism and tend to evoke negative impression in others (Paulhus, 1998).

Repressive copers (Weinberger et al, 1979) are people who avoid unpleasant thoughts, emotions and memories (Weinberger, 1990). In contrast to hardiness and self enhancement which operate primarily at the level of cognitive processes, repressive coping appears to operate primarily through emotion focused mechanisms such as emotional dissociation. Emotional dissociation is generally viewed as maladaptive and may be associated with long term health costs (Bonnano and Singer, 1990). Research on grief reactions and responses to childhood sexual abuse also showed such tendencies to foster adaptation to extreme adversity (Bonnano and Field, 2001, Bonnano, et al, 1995, Bonnano, et al 2003).

One of the way 'repressors' and others showing resilience appear to cope well is through positive emotion and laughter (Bonnano, 2003; Bonnano and Keltner 1997). In the past this has been viewed as a defence mechanism or a form of denial (Bowlby, 1980). Yet research suggests that positive emotions can help reduce levels of distress following aversive events both by 'quieting' or undoing negative emotion (Fredrickson and Levenson, 1998; Bonnano and Keltner 1997) and by "increasing continued contact and support from important people in the persons environment" (Bonnano and Keltner, 1997 pg 134). These findings have also been found in relation to bereavement (Bonnano and Keltner, 1997) and adult survivors of childhood sexual abuse (Colak, et al, 2003).

Recently psychological research suggests that stress may not in itself contribute to vulnerability but may also be a resilience factor. Evidence in this field has indicated that individuals can not only survive, but may also thrive after extreme stress, a concept described as 'post traumatic growth' (Linley and Joseph 2004, Tedeschi and Calhoun, 2004). This term has equally been applied to survivors of

the holocaust or cancer survivors, people living with Aids, people who are ageing and survivors of the September 11th attacks, (McAllister and McKinnon 2008). It has been claimed that resilient individuals possess personal attributes such as pro social behavior, an internal locus of control, empathy, positive self-image, optimism and the ability to manage and organize the self (Friborg et al, 2003). These unique protective resources enable them to develop supportive relationships with family members and friends that are useful in stressful times (Friborg et al, 2003). Research further suggests resilience in adults involves the importance of a feeling of connectedness to their family and physical and social environment. Resilience has also been linked to inner wisdom or a supportive mindset that reinforces a way of living that is conducive to an individual's values (Denz-Penhey and Murdoch 2008, Siebert 2005). These characteristics enable the development of coping mechanisms that support people through adversity. Resilience can also be contextual and dynamic with variations dependent on different life transitions (Tusaie and Dyer 2004). Resources may be available in some contexts and not others. For example social support may not be available in crises associated with stigma or shame, thus requiring a different quality of coping (Deveson 2003). Psychological research into resilience has moved beyond individual characteristics, with the ecological model suggesting the importance of an inter-relationship between family, school, peers, neighbours' and wider society, which enables the development of resilience for both self and others.

Resilience can also be seen as having agency in terms of mentalisation or as 'emotion focused' but also 'problem focused' (Lazurus and Folkman, 1984) which refers to agency directed towards the external world rather than the self. Both forms of agency strengthen resources but may also present difficulties and

problems. For example a paramedic may use dissociation to cope with witnessing the traumatic events of a road traffic accident but at the same time this may result in an approach to patients which can be seen as harsh or callous. Similarly the reason for choosing the job of paramedic may contribute to acting out inner defenses in which work becomes a 'role play' rather than a role primarily serving the needs of the patient.

1.5.6 Resilience or recovery

A key feature of resilience towards traumatic occurrences at work is the distinction between resilience and the process of recovery. The term 'recovery' connotes a trajectory in which normal functioning temporarily gives way to symptoms of depression or PTSD, usually for a period of at least several months and then gradually falls to pre event levels. Full recovery may take longer e.g. several years. By contrast, resilience reflects the ability to maintain a stable equilibrium. (Bonnano, 2004). Bonnano (2004) suggests that that resilience is more common than was previously thought and should be examined as a distinct concept to that of 'recovery' which can potentially be reached by a variety of different pathways. Individuals can be operating well at one level of life for example at work but not performing well in other aspects of their life. For example suffering psychological reactions, emotional distress and problems with social and personal relationships.

There are multiple pathways to resilience which can be mediated throughout the lifespan (Luthur, Doernberger and Zigler, 1993, Rutter, 1987). Rather than resilience being the premise of 'rare' individuals with 'exceptional emotional strength', it may be useful to explore the mechanisms through which resilience is mediated. These can include coping mechanisms such as dissociation, positive

emotion and humour, support from peers, managers and family. These need to be examined within the changing context of the paramedic's biography as suggested by the psycho-social methods of inquiry. By examining the processes involved it is possible to begin to understand the range of capabilities drawn upon at different moments in time. However before exploring the contribution of psycho-social studies it is useful to explore the sociological literature to examine the external domains such as agency and identity formation, the impact of social class and emotion management.

1.6 Resilience and sociological research

1.6.1 Agency and identity formation

As previously discussed thinking about resilience from a trait perspective seems unsatisfactory. It is useful to consider sociological theories that examine a version of agency that takes into account the internal world of the individual and their social context, and consider how this may impact on potential resilience. Such theories include Bourdieu's (1973) notion of 'habitus' which like Giddens' (1991) 'reflexive identity', attempts to theorise how the social context of people's lives becomes 'internalised' and impacts on their identity formation and capacity to change. Bourdieu offers a useful analysis of social structuration using concepts such as 'habitus' (McNay 1999). Bourdieu argues that the social world is divided into what he calls 'fields', within which social actors attempt to occupy the dominant positions (e.g. the arts, education, politics, law and the economy). One of their tools is 'habitus', or a 'feel for the game', which includes opinions, taste, tone of voice, body movements and mannerisms. Social agents therefore acknowledge, legitimate and reproduce forms of domination (including prejudices). Objective social structures are incorporated into the subjective, mental experience of agents. Bourdieu claims that large scale social inequalities are established due to a subtle inculcation of power relations upon the bodies and dispositions of people. He terms this 'symbolic violence' or a form of domination which is exercised upon people with their complicity. Bourdieu's term 'doxa' refers to deep rooted unconscious beliefs and values which inform an agent's actions and thoughts within a particular field. For example working class children may see the educational success of middle class children as due to hard work or natural ability rather than class based inequality. The habitus is a generative structure that can

reinforce and also modify the unequal structure (McNay 1999). Habitus is the whole of what one is: history, taste, accent, attitudes, behaviour, one's culture, gender and class and how this is expressed in movement, idiom and choices. It is both how social structures such as class and culture become inscribed within individuals and how they then unconsciously express these things e.g. identity and ability (Skeggs, 2001). One's habitus as a way of being is transferred to all new situations and is quite enduring. In other words habitus is difficult to change except in circumstances of prolonged historical change or as a result of extraordinary circumstances. Bourdieu presents habitus as the patterns and resources for being in the world, the elements of how we can be, including how we think about being. Habitus is profoundly socially hierarchical and carries the distinctive lines of class, race, gender and sexuality within it. Most importantly, not all habituses are of equal worth (Lawlor , 2008). Using Bourdieu's concept of habitus it is reasonable to argue that paramedics come from a particular 'paramedic habitus' based on class and gender. This has implications for how resilience manifests in these groups and ways of being in the world which in turn affect how they cope in work environments such as prizing masculinity, use of humour, shame about expressing emotion, an emphasis on being able to 'cut it', feeling weak if they express emotion etc. If this is their habitus, and as Bourdieu suggests, it is inscribed, and unable to be revised then this has implications for developing resilience. Indeed Bourdieu's analysis seems somewhat contradictory given his humble beginnings and rise to enormous academic success which suggests he would have required a high level of mastery and life planning re skilling and personal agency. Blackshaw (2005) cites Bauman who suggests the concept of habitus is limited replacing it with '*habitats'* which can 'unbind time' and the impact of the past. He suggests

people are able to transform themselves via palimpsest identities in which they constantly rewrite their identities. He suggests the continual struggle for self-creation and transcendence is racked with ambivalence as by making new identities people believe they can remodel their histories but often find their new identities are no better than the old. His view of new identities encompass aspects of people's lives which include new jobs, a new trendy image, 'the lads night out', the holiday maker, the exciting new lover (Blackshaw, 2005)

Giddens' suggests a more useful means of understanding such transitions. Giddens' (1991) more phenomenological work is helpful in understanding 'resilience' through his notion of reflexive identity and fateful moments in considering who 'sinks' or 'swims'. Reflexive identity encompasses notions around biography, resourcefulness and supportive resources. Fateful moments suggests that individuals make sense of their lives through narratives of single life-changing incidents which present individuals with a set of crossroads which may be destructive or potentially empowering, essentially 'make or break' times (Henderson et al, 2007, Sharpe, 1994, Thomson and Holland, 2004).

Giddens (1991) argues that late modern identity includes a considerable degree of personal power and the capacity to bring about change in one's life including relationships, attitudes and lifestyles. For Giddens our identity is not hemmed in by families, cultures and traditions, as suggested by Bourdieu, but is something we negotiate and choose, through constant reflexivity, revisions and reskilling. In relation to the body and self we make life plans and adjust them to achieve mastery and empowerment and potential self-actualisation (Maslow 1943). Giddens makes the point that in contemporary times due to the media, globalism and networks of connection, we have multiple choices available. We are able to

rationally think through our choices and how to achieve our desired outcomes, without too many limitations. Giddens suggests our identities are fluid and flexible, redesigned for preference or convenience, which brings with it a sense of 'ontological insecurity'. He suggests that alongside the motivational aspect of our identity we can also experience shame, when we feel insufficient or not able to sustain the desired narrative and experience and fear inadequacy in the eyes of esteemed others. This will inevitably hamper our power to bring about change.

Giddens' overview appears to be more useful when exploring upper middle class white males in wealthier regions of the West. From my own anecdotal experience paramedics tend to be situated within a 'macho' working class culture. Paramedics are expected to adhere to a strict hegemonic masculinity which severely restricts the expression of emotion (Boyle, 2005, Steen et al, 1997). The extent to which that culture can be challenged and changed will impact on their identity and opportunities to develop resilience.

1.6.2 The impact of class on resilience

The concept of social suffering is also useful to explain the lived experience of paramedics who inhabit social structures of oppression such as class, poverty and oppression etc. and the pain that may arise from this This concept illustrates how social misery accompanies processes of exclusion and oppression that arise from social divisions within democratic societies. This refers to people's lived experience of domination and repression and the feelings of humiliation, shame, despair and resentment that may accompany the experience of poverty, class and race (Bourdieu 1999). Hoggett (2009) goes on to extend Bourdieu's (1999) concept of social suffering and suggests that there are two primary sources of this

suffering – hurt and shame. Hurt refers to the psychological consequences of feeling inferior and stigmatised whereas Reay (2005) draws attention to the presence of shame and disrespect which can permeate class and social divisions. The notion of 'hidden injuries' of class also explains the humiliation, anger, despair and resentment that may accompany poverty, class, gender or race (Sennett and Cobb 1993). These concepts have implications for the ability of paramedics to develop Giddens' notion of reflexive identity and achieve mastery, reskilling and the development of life plans or in other words, the resources needed for resilience. It is interesting that the DOH (2011) review found that despite poor satisfaction rates indicated in staff satisfaction surveys, ambulance staff turnover remains very low and many front-line staff stay in their jobs for many years. One reason for this could be the limitations placed upon ambulance staff due to their working class status. Many paramedics start off with low self-esteem and self-belief, but once they begin to develop and gain academic success, some begin to see education as a way to progress to alternative careers or career development.

1.6.3 Emotion management

There seems to be a link between paramedics managing intense situations and the need to be 'emotionally tough' to hide or manage emotions (Lowery and Stokes 2005). Humour is widely used by emergency personnel when dealing with the emotional aspects associated with witnessing sudden death (Scott 2007). Lively (2002) argues that good emotion management is critical to both the care given to patients and to the effectiveness of teams and co-worker relations. The training of paramedics focuses on cognitive skills and technical proficiency (Smith, 1992, Woodward 1997). Bolton (2000) argues that if the provider-patient relationship is commodified due to economic rationalisation this can result in

healthcare professionals only engaging in instrumental caring (a scripted approach focusing on specific actions) as opposed to expressive caring (which emphasises the unique identity and specific needs of the individual being cared for). Emotional skills such as empathy are less actively taught or valued in health care work. This disengagement leads to what Hochschild (1983) calls ‘emotional labour’ which includes display rules such as surface acting (where outward emotional expression is inconsistent with feelings within) or deep acting (in which emotions felt are actively changed to fit situational or socialisation norms).

Boyle (2005) found that emotional labour was seen as part of the job involving suppression of negative emotions such as disgust, the adoption of a ‘somber demeaner’ when dealing with intoxicated or adolescent patients, using humour to cajole anxious or irate patients. Additionally Boyle (2005) found that paramedics highlighted the importance of distancing themselves emotionally or dissociating from patients using a task based approach combined with seeing the patient as a thing or an object or as one respondent described ‘a piece of meat’. Boyle (2005) uses Goffmans ‘front stage’, ‘back stage’ and ’off stage’ regions to explore the support available to paramedics. Back stage includes the base stations where paramedics tell ‘war stories’ use black humour and engage in critical incident debriefing with a trusted partner (Filstead 2010). However Boyle (2005) and Steen (1997) are concerned that the traditional masculine culture in the ambulance service limits the expression of emotion in the back stage regions, the outcome of which is an over reliance on ‘off stage ‘ support from a spouse (Boyle, 2005).

Gosserand and Diefendorff (2005) argue that the extent to which employees engage in emotional labour varies according to the commitment to the display

rules under consideration which is linked to the socialisation and cultural norms of the working environment. If the culture of the paramedics' working environment is dependent on humour as a means of defence against stress, alongside a macho culture which operates through a fear of stigma and weakness, then disengagement from interactional episodes with others could be a central indicator of increasing burnout (Halpern 2001).

However sociological and psychological perspectives can only present a partial picture, mainly because of the split between the 'individual' (within psychology) and 'society' (within sociology) which is unhelpful and incomplete. Despite Bourdieu's and Giddens' efforts to incorporate the social into the 'internal' this is presented via a mainly rational discourse. Psychological and sociological, rationalist approaches to understanding human nature is increasingly being challenged (Clarke and Hoggett, 2009). Within the social sciences the turn to '*Affect*' has started to give equal interest in the role of emotion and affect for informing the life of the individual within the society. Psycho-social studies can further our understanding of resilience because it attends to this split. This will be outlined as follows.

1.7 Resilience and Psycho-Social research

1.7.1 Psycho-Social studies

This approach attempts to go beneath the surface using a recently developed research methodology that is psycho-dynamically informed. Psycho-social studies is a new emerging discipline which uses psychoanalytic concepts and principles to explore core issues within social sciences. Clarke (2008) argues that together sociology and psychoanalysis provide a deeper understanding of the social world. Clarke (2008) argues that psychoanalysis can complement sociological analysis in three ways. First it addresses the affective component of human relations, we are not just rational beings but have feelings and emotions that are not obvious and can be largely unconscious. Secondly the way that we relate to others (individuals and groups) is not purely a rational phenomenon and can also include unconscious perceptions, desires and wishes for example, the often eruptive nature of ethnic hatred. Third, the complex inter-relationship between socio-structural and psychological factors in which the psychological can play a part in structuring the social and the social structures can impact on the psychological. The most important element of psycho-social research is that there is no duality, neither social nor psychic but an inseparable relationship (Clarke 2008).

Clarke (2008) argues that the most important thing about psycho-social studies is the emphasis on empirical research in which the emotional life of the researched and researcher are explored. This is a relatively new field of academic enquiry which challenges masculine notions of rationality structured in positivism and the social sciences in general. It challenges the idea that the researcher is the font of all knowledge and instead the emphasis is on co construction of the data and

research environment. Psycho-social research has been used to investigate crime (Hollway and Jefferson's 2000), young masculinities (Froshs et al, 2002), adolescent female identity (Walkerdine et al, 2001) and the personal identifications of welfare workers *(*Hoggett 2006).

Psycho-social studies aims to explore the relationship between individual biographies and social processes and is concerned with the mechanisms in which the 'social' can become internalised. The psycho-social perspective attempts to 'get beneath the surface' to understand how internal anxieties are played out through defense mechanisms which operate within a social context. One of the first studies on disengagement by health care professionals was conducted by Menzies-Lyth (1959) who in her seminal study argued that nurses operated 'defense mechanisms' to shield them from the anxiety and stress that accompanied working with ill and dying patients. It could be reasonably argued that paramedics adopt similar defense mechanisms which include distancing; detachment and denial, splitting and projection of feelings. Where professionals receive little support in processing these anxieties, 'social defenses' which are organized but unconscious 'coping mechanisms' can become part of the team or organisational culture. They can also have a negative effect on patient / paramedic relations and working life itself.

Frost and Hoggett (2008) argue that the 'hurt' that cannot be thought about can at times be embodied, enacted or projected. They present the concept 'double suffering' to explain how the inner worlds of psychic suffering and outer world of social structural oppression can inhabit people and can influence them and their form of agency. Particularly in relation to 'othering', so that what cannot be borne in oneself is projected onto others, in the form of for example racism or

homophobia. Frost and Hoggett (2008) argue that coping strategies are also mechanisms of defense; suffering can be dealt with by splitting, projection, denigration and idealisation. Layton (2008) argues that the 'normative unconscious processes' which develop 'identity', in the case of paramedics a traditional masculine one, may also bring about symptoms such as stress related illness.

Hoggett (2008) argues that welfare professionals (and one could add paramedics) work with rage, pain and despair on a daily basis. He suggests adding psychoanalytic insights to Bordieu's concept of social suffering. He argues that suffering which has not been worked through can then be embodied (resulting in illness, as suggested in the effects of stress earlier), enacted (through the masculine notion of 'hardness', e.g. paramedics macho culture) or projected (onto others e.g. the way in which paramedics can project their own feelings of vulnerability onto weak and vulnerable clients such as those with addictions or mental health problems or the 'undeserving'). Hoggett (2008) suggests that this perspective presents a fuller understanding of the 'double suffering' that results from the effects of people's lived experience of powerlessness, poverty and class backgrounds, and how their sense of grievance can not only be turned on themselves but also onto others.

Psycho-social studies draw on psychoanalytical psychology, in particular the work of Bion (1962) and Klein (1946). Kleinian concepts such as transference, counter transference, projection, projective identification and containment, will be used to analyse the lived experience of paramedics. These concepts (discussed later in the methods chapter) can help to explore how paramedics maintain resilience during their work as they enable a deeper understanding of the 'inner dynamic'

which may be operating within individuals and groups. Psycho-social studies also enable us to understand how the internal and external factors interlink as discussed in the following section of the thesis.

1.7.2 A Kleinian view of health organisations

Kleins (1952) concept of the paranoid schizoid-depressive position is a useful concept for understanding organisational defenses and the role of reparation. Klein (1952) suggested a fundamental tension within human personalities between the paranoid schizoid level and depressive level. The paranoid schizoid level is associated with deeply held anxieties about dependency on others and issues of survival, life and death. In this position we are unable to treat the other as a whole person, consideration for others is cut off, people can be split into simple categories (good or bad), similar to cartoon characters ‘devils’ or ‘angels’, we blame others and see them unrealistically for instance as vital to our survival or as threatening it in some way. With reduced anxieties (associated with increased containment) we can achieve the depressive position and have concern for others and experience them empathically. The fear of others becomes less powerful and more realistic. People can move from one position to the other as their anxieties are raised or lowered by the interchange between internal states in individuals and external ones in the team/organization. Sievers (1999) attempts to use Kleinian concepts as a metaphoric frame for the organisations in which we reside which helps us to understand the impact of the organisation that the paramedic resides in.

Klein (1952) argued that the early development of the infant takes a paranoid schizoid position in which the leading anxiety is that the persecutory object or objects will get inside the ego and overwhelm the ideal object and the self. Denial projections and introjections act as defences of this phase. Alongside this the splitting into good and bad objects enforces an idealisation of the ideal object. During the course of normal development these psychotic persecutory anxieties, retaliation and revenge are worked through and integrated with feelings of love, care, guilt and the desire for reconciliation characterised by Klein's depressive position. (Segal, 1972, Hinshelwood, 1991, Sievers, 1999)

"In the depressive position the object is loved despite its bad parts, whereas in the paranoid- schizoid position awareness of the bad parts changes the good object abruptly into a persecutor….." (Hinshelwood, 1991. P41)

However the early anxieties always remain part of the psyche. In the unconscious mind they are the predominant medium through which the adult can experience the outer world. The implications for organisations are that "psychotic tendencies are in danger of breaking through from moment to moment" (Young, 1994, pg 156). Reaching the depressive position does not mean wholly overcoming the paranoid schizoid one. The two positions remain ever present for the adult. The paranoid defense against depressive anxieties is an everyday experience for the adult (despite being held via certain objective or subjective conditions). In a sense one could see that the organisations paramedics occupy can be triggers for unleashing such defenses.

If adults have not worked through the paranoid schizoid position the depressive position is impeded. This failure may lead to a reinforcement of persecutory fears.

If the ‘healthy’ and ‘sick’ parts of the personality are not integrated the sick parts can be projected into the outer world. At its severe level this can lead to severe psychosis. Or it may result in a narcissistic personality structure organised around omnipotent defensive mechanisms under the predominance of the death instinct. Pathological organisations are characterized by a liaison of fragments under this structure which is itself a result of failed splitting. Pathological organisations are attempts to bind together some of the threats of destructiveness e.g. it defends against feelings of mourning and guilt. The healthy parts collude with the destructive purposes and are perversely used to masquerade as health (Hinshelwood, 1991,Sievers, 1999).

Sievers (1999), attempts to use Kleinian concepts as a metaphoric frame for the organisations in which we reside. Despite entering into the broader epistemological argument as to whether one can transfer individual psychoanalytical concepts into the context of broader organisations, pragmatically he suggests it can give us insights into the world of the organisation. Similarly to the way severely psychotic patients can appear normal, social and profit organisations often seem to cover their internal anxiety with a normal appearance. Such organisations are stuck in an attempt to defend against the threat of markets and competitors through a tendency to dominant and control organisations with a high degree of aggression, sadism and destructiveness. The organisation is caught in the behaviour characterised by the paranoid–schizoid position. In the face of the on-going development of these organisations in terms of growth, profit margins etc. there seems to be no capacity for the depressive position with its concern for good objects and its desire for love, mourning and reparation. The external world becomes shaped by psychotic tendencies and defensive

mechanisms. Lawrence (1995) extends this by suggesting that the recent radical changes in the NHS have placed it under enormous pressure to operate under capitalist principles which have resulted into management systems that have become ‘totalitarian states of mind’. The fantasy, that tighter management control, will banish anxiety has resulted in speeding up the throughput of patients, cutting costs and employees. The more this continues the organisation becomes identified with the surgeon who has no choice whether to amputate to save the life of the patient. Similarly management feel they have no choice but to cut the costs to save the organisation per se. Lawrence (1995) suggests such a culture diminishes the capacity for thinking and feeling so role holders become less able to reflect on the nature, quality and methods used in the primary task of the institutions. With a focus on commercial interests this leads to a frame of mind which can only encompass the short and immediate terms. Managers become trapped in the inner life of the institution and larger issues such as caring and humane ways of managing ill patients can become irrelevant. The health care system serves as a social defence against death (Menzies-Lyth, 1960). The more the role holders introject the wishes of the people that they can avoid death, the more expensive health care becomes. Life expectancy has risen over the years with the development of more drugs, technology and surgical procedures. As a result the health system has become a pot into which money can forever be poured. Yet a small proportion is spent on the caring and humane aspects of illness compared with large grants awarded to sexy areas such as cardiac disease etc. The notion of “management” was thought to be the solution. This is mainly because caring and humane ways of treating patients cannot be measured and objectified.

The management of the health system becomes the unconscious object of projections about death from the medical and nursing staff, the patients, relatives and surrounding community. But because these projections mirror the psychotic state of the role holders and their split off anxieties about illness, suffering, despair and annihilation, they cannot be contained by the management who deny these anxieties in themselves. Through splitting (a predominant strategy of the paranoid schizoid state) they identify with the idealised commercial management which is seen as the only solution for both their individual and organisation survival. As a result management tends to go into over control and creates a climate in which initiative is frowned upon. (Lawrence, 1995, 1997, Sievers, 1999).

Lipsky (1980) argued that public professionals of the late twentieth century could not fulfil their responsibilities because of the caseloads they carried. Much of the work on stress and the public sector shows that impossible workloads and experienced powerlessness are the main source of stress, rather than money (Bogg and Cooper, 1995; Cooper and Kelly, 1993). Long (2008) in her book '*The perverse organisation and its deadly sins*', suggests that organisations contain within them perverse social relations which are conducted against the run of human values, they are perverse because they are indulged for their own sake. She argues that the drive for commercial success brings about specifically perverse potentials in human beings who 'enjoy' destructiveness for its own sake. She suggests that organisations need to attend to the 'split' between individual (as person and citizen) and organisation (with people in corporate roles), in other words the instrumentality by which individuals are reduced in a working organisation which contrasts and in fact opposes the person's own needs and

initiatives. Long's ideas have implications for understanding the relationships between the paramedics and the 'organisation' they work for.

This can be further understood by Hinshelwood (2009) who argues that the organisation is reflected back as an entity in the memories and intentions in the minds of those occupying it. It is 'their' organisation and becomes an 'internal object' in the psychoanalytic sense. Like all internal objects the organisation is seen as having human properties as if it were a person in its own right with a 'personality' or atmosphere. Hinshelwood (2009) suggests that there is an irony that individuals in twenty first century organisations seem to be reduced to depersonalised, instrumental roles while the organisation itself attracts the notions of the evil sinful person. If our organisations are tending towards corrupt practices perhaps the thing that brings out this perversity in working people is the increasing pressure and anxiety in business life about survival thus spurring people to work harder, do better and achieve more for less. He suggests this survival anxiety can become a panic and perverse sadism is released in the urge to survive.

Lasch (1978) argues that western style democracies have given rise to narcissistic cultures that are unable to take on board death, ageing, physical dependency and incapacity. Menzies-Lyth's (1960) work illustrates clearly how nurses operated defence systems such as depersonalisation, splitting, and denial of responsibility to protect them from the pain of working with distressed people. Further work by Obholzer and Roberts (1994) from the Tavistock tradition has found that such defences are built into the systematic formal routines of organisations. These are often defences against seeing and facing suffering. Hoggett (2009) argues that depersonalisation is a defence against feeling. Also defences against thinking include hyperactivity, frontline workers have unmanageable caseloads. Hoggett

(2009 pg165) argues that ‘working life has a manic edge of busyness about it but it is precisely this busyness that protects workers from thinking about what they are doing as a social worker once told him “ getting high on getting by”, but because it is unsustainable it often leads to stress and burnout’ . These concepts are useful as they situate the paramedic within the NHS organisational structures that can impede healthy forms of resilience.

1.8 Strategies to maintain resilience

Resilience can be maintained in varied ways such as emotional distancing and dissociation. Dissociation is a method of coping with adverse events (Cardeña 1994, Holmes et al, 2005). Yet caution is necessary in the definition of dissociation, the term should only be applied to a qualitative disconnection to the self. There is a need to distinguish between the processes of dissociation and the symptoms that result from these processes. Brown (2006, 2011) suggests there is a need to qualify the type of ‘dissociative detachment’ or ‘dissociative compartmentalisation’, rather than identifying one phenomenon as dissociation and another as not.

Detachment includes a sense of separation from everyday experience. This includes emotional numbing, depersonalisation, out of body phenomena, derealisation and a sense of being an outside observer of one’s body, feeling disconnected, unreal or dreamlike, (Holmes et al, 2005, Brown 2006). Such experiences can follow traumatic events and have been termed peri-traumatic dissociation (Marmar et al, 1998; for a critique, see Van der Hart and Nijenhuis, 2008). Mild and transient detachment experiences can follow stress and fatigue,

(Brown 2006). These symptoms can be arranged on a continuum from mild symptoms to severe depersonalisation disorder.

Compartmentalisation of experiences can also be used to describe dissociation. This means that actions, emotions and cognitions although functioning normally cannot be linked together. So the person experiences them separately. Such experiences are ‘unbridgeable’. This separation cannot be overcome by force of will. However in principle they are reversible, yet they operate as separate categories. (Holmes, 2005, Brown, 2006, Spiegel and Cardeña 1991)

If emotional distancing is used as a strategy via ‘dissociative detachment’ or ‘dissociative compartmentalisation’ to maintain defences against trauma, there is a contradiction as social support is just what is required when trauma symptoms develop. Regehr et al (2002) suggests the social supports, strategies and symptoms appear to interact with each other in a reciprocal way.

1.8.1 Potential methods of support – Counselling

Resilience could be maintained through more formal methods of support for example counselling. Jonsson and Segeston (2004) explore the theoretical model of the ‘container’ (Bion, 1962, Crafoord, 1991) to explore PTSD in ambulance staff. They argue that seeking support through others can be highly beneficial in managing PTSD (McCarroll et al, 1993, Dyregrov, 2002, Jonsson and Segeston, 2003). The exchange of thoughts and dialogue enables the paramedic to modify or transform the inability to cultivate the unbearable experience (Bion, 1962, Crafoord, 1991). From this perspective the paramedic handles intolerable affects by dissolving them and projecting them into the corresponding person. The corresponding person then contains them and detoxicates them so they can be

reinternalised by the paramedic. Jonsson and Segeston (2004) make the point that a lack of support can be one of the explanations for the existence of post-traumatic stress disorder. They argue that longitudinal research is needed to explore whether the container function is useful to enable paramedics to cope following stressful encounters.

1.8.2 Support from Managers

Managers can dramatically affect the way one feels about work and oneself (House 1981). The social setting of work can be both supportive and a source of stress. Poor management support, communication and lack of feedback can contribute substantially to feelings of stress (Cartwright and Cooper, 1994). The supervisor-subordinate relationship is cited as one of the most common sources of stress (Landeweerd and Boumans, 1994; Tepper 2000).

1.8.3 Implications for practice

Resilience frameworks to assist employees within organisations have been developed (Walsh 2003). Strategies suggested by Jackson et al (2007) for building resilience in nurses which could also be applied to the paramedic context include the following: building positive professional relationships through networks and mentoring, maintaining positivity through laughter, optimism and positive emotions, developing emotional insight to understand one's own risk and protective factors for example, many health care professionals neglect self-care which is an important factor in resilience. Also using life balance and spirituality to give meaning and coherence to one's life and using reflection to assist in understanding and transcending adversity. In particular the authors argue for the need to teach and encourage health care professionals to identify their own risk

and protective factors, share experience of resilience and vulnerability so that they learn from each other, praise success of peer's achievements and promote feelings of pride and self-esteem. All these strategies help to build resilience.

Halpern's (2008) qualitative study of interventions for paramedics following stressful incidents suggested that support could be provided first, through supervisor support acknowledging difficult jobs, listening and valuing their work. Second, a time out period off road, spending time with peers to enable them to debrief informally was also useful. Barriers to supervisor support included not recognizing incidents as stressful, fear of stigma or appearing weak, and difficulty and fear of managing one's own and others' emotional state. Halpern (2008) found that barriers to timeout periods included time pressures and fear of lack of confidentiality. One frequent recommendation was the introduction of morbidity and mortality rounds that are used in medical settings, which is a non-judgmental format for feedback on difficult cases which can provide support and reassurance. Other suggestions were the need for education around stigma in the workplace and improving supervisors' capacity to reach out and connect with their staff. Most paramedics preferred that the intervention be optional whilst others suggested serious incidents be followed up by supervisors, mental health staff or mandatory debriefing. At present there is very little provision in the ambulance service for debriefing after traumatic incidents. Robinson (2002) found that only 37% of her sample used talking to debrief the incidents. Critical incident stress management (CISM) and psychological debriefing have recently been abandoned as a result of the NICE guidelines although this has recently been challenged by Regel (2007).

1.8.4 Critical incident stress management

Regel (2007) discusses the controversy over the provision of Critical incident stress management (CISM) over the past decade. The basic conceptual framework was drawn from crisis intervention theories (Lindemann, 1944, Caplan 1964). In its current form it comprises of many elements including pre crisis education, assessment, defusing, critical incident stress debriefing (CISD) and identifying the need for specialist psychological support if necessary (Mitchell, 1983, 1988a, 1988b, Everly and Mitchell, 2000). Regel (2007) argues that the controversy arose because attention was focused on one element of CISM namely CISD or psychological debriefing (PD) a term coined by Dyregrov (1989). PD became the focus of attention for research because it was erroneously perceived that this particular aspect of the model would prevent the development of post-traumatic stress disorder (PTSD) per se and was a stand-alone process. Regal (2007), describes PD as a structured form of group crisis intervention facilitated through a series of seven stages. Dyregrov (1989pg25) defined PD as '…a group meeting arranged for the purpose of integrating profound personal experiences both on the cognitive, emotional and group level, and thus preventing the development of adverse reactions'. Regal (2007) describes the seven stages as follows: introduction, fact phase, thought phase, reaction phase, symptom phase, teaching phase and re-entry phase.

Regal (2007) suggests that PD usually takes 1.5 to 3hrs to facilitate and is usually held 72 hours to 14 days post incident. The aim of PD is to provide education about normal and pathological reactions to traumatic events, indicate further sources of help and support and to begin to facilitate the process of coming to terms with the traumatic incident. It was designed to facilitate early help seeking,

normal recovery and personal growth. Regal (2007) argues that PD was never intended to substitute counselling, psychotherapy or act as a stand-alone 'psychological' treatment. Unfortunately PD as reviewed by the Cochrane Reviews (Rose et al 2002) has been consistently and misleadingly viewed as a form of counselling or psychotherapy. PD is based on crisis intervention theory and is psycho-educational in purpose rather than concerned with re-configuration of the personality or altering personal defences as in the case with counselling or psychotherapy. Consequently Regal (2007) argues that this is an extremely important distinction because the misconception within the academic press and media that PD is a treatment has influenced the development of policy within occupational health and the research around it. The studies reviewed by Cochrane (Rose et al 2002) consisted of two randomised controlled trials of single sessions with individuals who had suffered burns trauma (Bisson et al 1997) and road traffic accidents (Hobbs et al 1996). In particular the NICE clinical guidelines (2005) are based on research by Bisson and Deahl (1994) which cites a lack of uniformity in the application of PD. Regal (2007) acknowledges that there are methodological shortcomings in the NICE guidelines and the Cochrane reviews. In the study on burn trauma (Bisson et al 1997) the subjects all had factors which were predictive of poor psychological outcome i.e. high levels of threat to life, previous morbidity and psychological treatment. The authors described PD as involving 'intense imagined exposure to a traumatic incident' which involved the patient reliving the traumatic experience as if it were occurring again, this is a demanding and anxiety provoking procedure which should only be done within the confines of a therapeutic relationship after careful assessment. Regal (2007) makes the point clearly that PD does not include imagined exposure. The study involving road

traffic accidents (Hobbs et al 1996) also had limitations, after the first 10 subjects, interventions were undertaken by the researcher thus compromising the research. The deterioration in the debriefed group although statistically significant, was so slight as to be clinically irrelevant. The debriefed groups had more severe injuries in both studies. The NICE guidelines are based on these randomised controlled trials (RCT's) and Regal (2007) argues that the Cochrane review explicitly excluded 19 studies because of 'methodological shortcomings' principally concerning methods' of randomisation. These included RCTs of group debriefing in naturalistic settings for which PD was intended. In attempting to satisfy the rigorous methodological criteria demanded of Level 1 evidence many RCTs become detached from clinical reality, losing validity and rendering the findings clinically meaningless. Regal (2007) argues that Level 1 RCTs are not the sine qua non of evidence based medicine. PD challenges the hegemony of RCTs, lending credibility to observational studies and more qualitative orientated research. The Cochrane review also acknowledged that there was a lack of training for those facilitating PD as it is defined above. All the studies chosen for review by Cochrane and the NICE guidelines that conclude that PD is of no value in preventing PTSD were unrelated to subjects from the emergency services using PD. Instead the studies included subjects who were medically ill or suffering with obstetric complications. The main outcome measure the studies assessed were symptoms of PTSD. None of the studies cited assessed the impact of the intervention on other outcomes such as either substance misuse or effects on occupational or social functioning. Regal (2007) argues that studies that measured a broader range of outcomes demonstrated a positive debriefing effect (Deahl et al 2000, Richards, 2001, Dyregrov and Gjestad, 2003 and Solomon et al

2005). Finally Regal (2007) urges caution in the conclusions of the Cochrane report as many of the studies were not concerned with CISM or PD as technically defined by workers in that field. It is often suggested that PD is of little benefit for PTSD sufferers but Regal makes the point that CISM or PD was never intended for PTSD sufferers, as it is an intervention strategy only intended for the first 2 weeks post incident. Whereas it is necessary to take into account that PTSD can only be diagnosed one month after exposure.

Regal (2007) proposes that whether or not PD reduces long term morbidity needs to be properly investigated but he argues that individuals do find it helpful at the time as a form of psycho-educational support. Regal (2007) reports that PD is currently utilised by the many major international humanitarian aid agencies such as the International Federation of the Red Cross and Red Crescent Societies and the United Nations High Commissioner for Refugees, along with many other law enforcement agencies and emergency service providers in Europe, Scandinavia, the US and Australia. Regal (2007) proposes that the current evidence suggests that many organisations in the UK and abroad continue to utilise CISM and PD including London's metropolitan police and many other police forces in the UK who have utilised PD in a model adapted by Mitchell known as the 3 stage model comprising of 'facts, feelings and future'. The current trend is to train support teams in Dyregrov's approach (Dyregrov, 1989, 1997, 2003). In view of the past controversy and the NICE guidelines there has been a shift for some organisations to develop a new CISM model. An example is critical incident processing (Galliano, 2002), which contains all the elements recommended by Everly and Mitchell (2000) and is effectively the same. Similarly Trauma risk management (TriM), a model favoured by the Royal Marines (Jones and Roberts, 1998, Jones

et al 2003) also contains all the CISM elements and makes use of the 3 stage model of PD. These models purport to offer different trauma support seem to be practising CISM and PD under different acronyms. While TriM can be seen to be very effective in the military context it remains to be seen whether it can be transferred to other contexts such as the ambulance service. Jones et al (2003) suggests that the focus by TriM on risk assessment avoids excessive exploration of emotions or enforced catharsis which was never the intention of PD in keeping with the findings of the Cochrane review. Worsening of symptoms and reactions may be due to the inappropriateness of the application of the model and lack of training in PD which may account for the negative outcomes. Regal (2007pg 414) makes the point that evaluations of PD are inaccurate as 'it is akin to assessing a surgical technique as having a poor outcome, but only researching its effectiveness after it has been used in inappropriate circumstances, with the wrong instruments, untrained practitioners and with the wrong patients'.

Regal (2007) also argues that another criticism aimed at PD is that it is compulsory. The majority of organisations that offer PD provision do so on a voluntary basis, this included the fire and rescue services, health and social care providers and the police. CISM services are offered by occupational health departments and provided by teams of trained peer supporters, which in many cases is a combination of welfare and operational personnel. In 2002 the British Psychological Society (BPS) Professional Practice Board Working party (2002) produced a report on PD. They looked at existing studies and found them to be seriously flawed leading to a working party to develop new research methods suited to complex situations where PD was employed. They also concluded that PD needed to be undertaken by competent practitioners with adequate

supervision and support. They viewed it as a community support and cohesion strategy rather than a treatment intervention to prevent PTSD.

Regal (2007) suggests that calls for the cessation of PD in the emergency services are premature. It has an important psycho-educational role and facilitates identification of individuals experiencing acute stress reactions (who are at greater risk of developing longer term disorders, (Brewin et al 2000). Regal (2007) clearly makes the point that PD was never meant to be a stand-alone intervention but part of a comprehensive stress management package that enables individuals and groups to receive assessment of their needs, practical support and early detection and follow up and prompt treatment of conditions such as PTSD. Inevitably abandoning CISM and components such as PD sends out a dangerous message that doing nothing for individuals and groups following traumatic events is acceptable, leaving employers neglecting an important duty of care (Wheat and Regal, 2003, Regal, 2007).

1.8.5 Conclusion

To conclude much of the previous work on the impact of psychological trauma for emergency service workers has been focused on critical incident stress rather than daily occupational stressors (Alexander and Klein, 2001; Regehr et al, 2002b; Bounds, 2006). To date very few studies have explored the specifics of occupational related stress (Lau et al, 2006) and even fewer from the paramedic profession's perspective (Bounds, 2006). The literature review explored the policy context in which paramedics occupy with particular reference to the constraint of performance targets and changes to working practices and relationships. These demands, alongside increasing management pressures to achieve targets and work long hours, place considerable stress on the paramedics (Okada et al, 2005; Dollard et al, 2007; Jenner, 2007; Regehr and Millar, 2007; Nirel et al, 2008).

The literature review also explored the impact of the role on a paramedic's health and concluded that they experience a range of adverse physical and mental changes (Sterud et al, 2006). Identification with some patients appears to be a strong predictor of traumatic stress reactions amongst health care staff, particularly if children are involved (Dyregrov, 2002; Dyregrov and Mitchell, 1992; Jonssen et al, 2003, Ursano et al, 1999). Additionally identification with patients can lead to increased symptoms of distress and an inability to adopt 'emotional distancing' to protect themselves (Regher et al 2002).

The appraisal of the literature revealed that paramedics work in a culture in which they are expected to adhere to a strict hegemonic masculine environment which may restrict expressions of emotion (Boyle, 2005, Steen et al, 1997). Strategies to maintain resilience included emotional distancing and dissociation, use of

antidepressants and counselling, management support and critical incident stress management interventions.

The concept of resilience was explored using the theoretical framework known as the resilience construct (Luthar et al, 2000; Ungar, 2004). The resilience construct examines how many individuals, are able to draw upon a range of resources which assist them in dealing with negative experiences and situations and enable them to 'bounce back' from adversity (McMurray et al, 2008). Ungar (2004) suggests that discussions about resilience should take into account the internal psychological traits or properties of the individual, but also external social factors e.g. gender, ethnicity, and socioeconomic status. Ungar (2004) argues for an approach that does not merely define resilience but seeks to understand the meanings of resilience that individuals bring to their lives through listening to them telling their own life stories. This approach underpinned the methodology used in this research project. As a result of this it was decided to explore resilience using Ward et al's (2011) model (figure 1). Resilience was explored through three perspectives namely psychological, sociological and psycho-social studies. Psychology explored the internal factors of Wards et al's (2011), model focusing on attachment and the impact of childhood abuse and neglect, and the paramedic role in relation to reparation. Psychological perspectives explored the incidence of PTSD in paramedics and literature around the traits perspective. Sociological analyses explored external domains such as agency and identity formation, and the impact of social class and emotion management through the work of Bourdieu (1999) and Gidden's (1991) amongst other authors. However psychological and sociological perspectives provided a partial and incomplete analyses whilst psycho-social studies can provide a deeper insight into the influence of biography

and how the internal (psychological) and external (sociological) forms of resilience interact or influence each other over time. The focus of this research will therefore be from a psycho-social perspective. The methodology draws on the psycho-social research methods which incorporate a biographical narrative to explore the outer dimension of Wards model notably the Free association narrative interview method (FANI).

In order to understand resilience from a practising paramedic's perspective, contribute to the body of knowledge in this field and achieve the aims of the study, a psychosocial design which draws on the methods of biographic narrative and free association narrative interviews seems both innovative and appropriate. This will be discussed in the next chapter. While this literature review has set the backdrop for the thesis, it is anticipated that the data from the study in combination will help shape the discussion and recommendations for the future.

Chapter 2 – Methodology

2.1 Theoretical framework of Psycho-Social research methods

Psycho-social research methods have emerged over the previous ten years. In contrast to the view, that, 'one reality exists independently of the researchers conscious mental activity' (Hunt, 1989$_{p17}$). Hunt (1989) suggested that subjectivity and self-understanding are crucial to ethnographic work. Psycho-social methods are informed by psychoanalytic processes as a tool for understanding society. The theoretical framework of psycho-social research has two key premises. First, that the unconscious plays a role in the construction of our reality and the way in which we perceive others and second that the unconscious plays a significant part in both the generation of research data and the construction of the research environment. Hunt (1989) suggests ways in which unconscious forces may affect research. First the choice of the research subject and setting may reflect an "inner dynamic". In my case it was a deep interest in why health care professionals appear to become emotionally disengaged with patients based on my own early experiences as a nurse. Once the research is underway unconscious forces mediate encounters between participant and researchers, transference (researchers and participants unconscious reactions) and counter transference (researcher's unconscious reactions to the participants' transference). This addition of the psychoanalytical perspective to research serves to address the deficiency that structural explanation lacks, as structural analysis may explain the 'how' but not the 'why'. It attempts to understand the unique ways individuals 'live' in social formations. This enables a deeper understanding of social formations and restores the focus on conscious and unconscious agency that is often lost in discourse (Clarke and Hoggett, 2009).

My interest in psychosocial research grew out of completing MSc modules taught by staff from the Centre for Psycho-Social Studies at UWE. These included 'Researching Beneath the Surface', 'Affect Emotion and Society' and 'Psychoanalytic Concepts and Theories'. I was also invited to participate in support days for PhD students using psycho-social methods. I recognise that as a lone doctorate researcher I may not have the tools of analysis available to researchers dealing with larger data sets. This would include researchers with psychoanalytic backgrounds reflecting in small groups on data in order to enable the unconscious to emerge. My data was discussed with one of my supervisors who is a qualified psychotherapist. I feel this is a disadvantage to a lone researcher as the richness of analysis may not come through as much as if there were more people spending time exploring and reflecting on the data. Despite this I wanted to expand my understanding of research methods and move away from more traditional methods of ethnographic enquiry. I recognise that what I present may not be 'truly' psycho-social as much of the interpretation is my own (with input from my supervision team). However I believe the richness and depth is more evident than in previous qualitative work I did for my MA Sociology.

2.2 Methods of Inquiry – Psycho-Social method

A Free Association Narrative Interviewing (FANI) approach was adopted as it is designed to fit with psycho-social approaches of research. Psycho-social approaches to biographical narrative interviews have been emerging over the last decade (Hollway and Jefferson, 2000, Wengraf, 2001, Chamberlayne, 2005, Wengraf and Chamberlayne ,2006). One of the major contributions to biographical interviewing has been made by Wengraf and Chamberlayne (2006) in their biographic narrative – interpretive method (BNIM) which gives priorities to

eliciting narratives in an uninterrupted way. Chamberlayne (2005) makes the distinction between the 'told story' and the 'lived life' suggesting that the 'real author' exists beyond what is presented in the interviews.

Hollway (2007) claims that traditional qualitative approaches tend to be descriptive instead of explanatory, with research subjects tending to be seen as products of their social circumstances which neglect psychological dynamics. Interview methods assume that factual answers can be obtained and statements are 'cherry picked' from transcripts, which then stand as evidence. Hollway (2007) argues that this is a positivistic carry over from quantitative methods, in which statements are broken down and treated as separate from their context. There is also the notion that the interviewer is neutral. This is challenged by Hollway (2007) who makes the point that within the relationship of researcher and respondent, fantasies and desires imported from other relationships make up the transference, countertransference matrix which can be used as a source of evidence.

FANI draws on the work of Hollway and Jefferson (2000) who advocate that using a psycho-social approach perspective in research encourages a conceptualization of both researcher and respondent as co-producers of meanings. The method uses a combination of biographical interviews followed by semi structured interviews. The three key principles involved in FANI include first the need to elicit a story. The researcher does this via the second principle of the use of open questions e.g. 'tell me the story of your life' is often all that is needed. The third principle includes the researcher not intervening which allows the respondents to order the telling of that story without interruption. These principles and the reasons underlying them are discussed as follows:

The need for the story to unfold via the use of open questions is important to enable free association to take place. There is an emphasis in Hollway and Jefferson's work on the unconscious dynamics between the researcher and respondent. Free association is a Freudian term used in psychoanalytic therapy in which a patient (who lies on a couch) is asked to say the first thing that comes to mind for analysis purposes. Free association narrative interviewing uses this technique through the use of open questions. The respondent is asked to tell their life story. It is important that the respondent orders the flow of their storytelling themselves. The researcher should not intervene nor try to control the flow of the storytelling / account / narrative as it is useful to see what emerges when. Any interruption on behalf of the researcher may interrupt the continuity of the flow of the unconscious.

> "The particular story told, the manner and detail of its telling,
>
> the points emphasized, the morals drawn, all represent
>
> choices made by the storyteller. Such choices are revealing,
>
> often more so than the teller suspects".
>
> (Hollway and Jefferson, 2000,p35)

The principle of free association is the innovation in this type of research as the unstructured nature of the encounter enables the researcher to get beneath the surface. This allows the researcher using FANI to consider any unconscious communication such as transference, counter transference and projective identification that may be present in the interview process. One of the limitations of traditional research methods is that by trying to impose a structure on the

narrative via questioning the realisation of a person's real concerns is limited. By allowing the respondent to structure the interview and determine the content and direction of the interview there is more opportunity for uncovering unconscious feelings and motivations. The aim is to get to a deeper understanding. So often in traditional interviewing respondents portray a representation of the self that they wish to portray. Rather free association interviewing attempts to uncover unconscious communication (Hollway and Jefferson, 2000).

Psychoanalytic concepts that inform FANI include denial and projective identification. Hoggett (2001) suggests that many of the life choices that people make are based on the Freudian concept of denial, in which the self is subject to splitting and fragmentation. There are several selves within people, each characterised by different voices and moods, some of whom can be familiar and others less so. Hoggett (2001) proposes that people's ability to be reflexive is often constrained by their ability to face their own fears and anxieties, so therefore get split off. One of the earliest mechanisms of defence of the self, identified by Melanie Klein (1946), is 'projective identification'. This is the way individuals may transfer their thoughts, feelings and emotions onto someone else. Clarke (2002) suggests that straightforward projection is where a person attributes their own affective state to others. For example we may feel angry and perceive others to be angry, even if they are not and the person we project onto is unaware of what we are doing. However projective identification involves expelling the parts of self that a person may dislike into other people, forcing them to feel the other persons emotions. In other words leading the other person to experience the quality in themselves.

Another principle of FANI is the need to avoid asking 'why' questions. Hollway and Jefferson (2000) acknowledge this may seem odd as surely there is a need to gain respondents' own understandings and insights into what has happened to them. However, 'why' questions often lead to clichéd, superficial or socially acceptable answers. If 'why' questions are avoided this prevents the respondent from having to explain, and instead they can be asked how they felt, which can give more meaning to their experience. For example if a respondent was asked 'why did you move jobs?' they may explain the move in terms of finance, opportunity or career progression. However, if asked 'how did you feel about moving jobs?' this will enable them to ascribe more meaning to their experience, including contrary emotions. Thus the answers given will be deeper and personal.

The FANI method involves two interview phases. The first interview aims to 'interrogate critically what was said, to pick up contradictions, inconsistencies, avoidances and changes of emotional tone' (Hollway and Jefferson, 2000 p43). The purpose of the second interview allows the researcher to follow up and 'seek further evidence to test…emergent hunches and provisional hypotheses. It also gives interviewees a chance to reflect' (ibid). To prepare for the second interview careful listening of the first interview is necessary to identify follow up questions for the respondent to expand on. These are intentionally structured according to the order in which they were presented. Hollway and Jefferson (2000) suggest that it is imperative that the researchers undertake interview transcription themselves. This immersion allows researchers to start thinking in a theoretical way about the material that has been transcribed and to note themes and issues. Researchers should be concerned to examine the interview and the text for psychological mechanisms from a psychoanalytic theoretical framework, e.g. transference,

counter transference and projective identification. The methodology of psycho-social research though informed by psychoanalysis differs greatly from clinical therapy in terms of its purpose and technique; the interpretations are not fed back during the interaction itself but are withheld and processed as data later. (Hollway and Jefferson, 2001)

Transference is a phenomenon in psychoanalysis characterised by unconscious redirection of feelings from one person to another. One definition of transference is the inappropriate repetition in the present, of a relationship that was important in a person's childhood (Kapelovitz, 1987). Transference can take place from the participant to the researcher and vice versa and can be described as what either party feels physically and emotionally during the interview. Both researcher and participant are anxious and defended, with porous mental boundaries. They can both project and introject emotions and feelings in the research encounter (Hollway & Jefferson, 2000).

Countertransference is a response that is elicited in the researcher by the participant's unconscious transference communications and projections. It is when the researcher acts on the transference; these could include the feelings and emotions evoked during the interview. Projective identification is where a thought, feeling or emotion that is perceived as either too anxiety provoking or painful is projected onto another who becomes influenced by the projection and begins to behave as though he or she is in fact actually characterized by the projected thoughts or beliefs (Klein's 1946). These concepts can be useful to explore the 'inner dynamics' between the interviewee and interviewer.

Clarke (2008) argues that the interview transcript is just one of several sources of data and that the live recording and the 'here and now' experience of the interview provides important insights into positioning dynamics etc. Hollway and Jefferson (2000p19) add that it is important to allow an 'individual gestalt to emerge to trace an individual's subjectivity: their trajectories, dilemmas, conflicts, turning points, loose ends, repetitions and fixations, resolutions and so on'. This requires staying close to the data rather than searching for categories. As more cases are explored certain themes may begin to emerge which provide the blueprint for cross case analysis. However Clarke (2008) warns that the closure that themed analysis produces needs to be resisted as new cases can add an element of surprise which can add further depth of analysis and understanding. However themed analysis is inevitable in this type of research. For the purpose of developing gestalts from each case study I will be exploring each case study in full before going on to interview further cases in order to enable the surprise element from each case study.

2.3 The dynamics of the research encounter

Psycho-social approaches seek to place at their heart the relationship between the researcher and respondent and what is played out during the interview process. Clarke (2008) argues that the research encounter is full of affect, anxiety, fear, boredom, excitement, depression. These may be co-produced or brought into the relationship by one of the two parties. For example as a new researcher I may feel nervous or anxious. In previous work for the module titled 'Researching Beneath the Surface' (which was an optional module undertaken for the Doctorate in Health and Social Care) I interviewed a paramedic using the same FANI method. On reflection I realised I had identified with the person so much that I had

colluded with his ideas and began to identify with him in terms of shared experiences. That experience has enabled me to be more alert to feelings that come up in the interview and use them as data. Hollway and Jefferson (2000) note this clearly in their notion of the 'defended' researcher and 'defended' subject. Bion's (1962) concept of 'containment' is a useful way of exploring how affect is managed in human relations. Containment refers to the ability to hold on to another person's feelings without getting rid them in order to think about what it is that the feeling is communicating. It can also refer to the capacity to contain one's own feelings as well as others.

In this sense it will be imperative during the interview that any feelings and reactions I notice within me are a source of data. Potentially as an interviewer I might become the container of participant's feelings. Clarke (2002) discusses how Bion (1962) develops Klein's idea of projective identification in the terms 'container' and 'contained'. The recipient of the projection acts as a container for feelings such as love, hatred and anxiety. These feelings are then contained. In the therapy scenario these feelings are reprocessed and returned to the projector in a more manageable form (as in an ideal mother infant relationship). However during the interview it may be that unwanted feelings may be projected towards me (projection) or into me (projective identification) and it is these unconscious processes that need to be reflected on to uncover a deeper understanding to what is said. Projective identification is a subtle but powerful way in which a researcher or respondent can be coerced into occupying a particular position in relation to the other.

It is not so much what is said but how things are said, therefore the researcher needs to reflect on their own feelings during the interview. Exploring how the

person made them feel, what may have been projected? Also were there any inconsistencies that needed to be noted e.g. nonverbal cues, silences, facial expressions, tone of voice, laughs etc.? It is important that the researcher spends some time immediately after the interview noting these down. Usually this is via a diary which is completed as soon as possible after the interview.

Clarke (2008) argues that this enables a space for understanding, which goes beyond 'defended' researcher and respondent. Jervis (2008) argues that researchers who pay attention to what is going on inside them physically and emotionally may discover that a respondent has communicated their feelings to them non verbally. Clarke (2008) suggests that respondents can communicate their emotional states by evoking feelings in researchers. Jervis (2008) cites an example of emotions being felt somatically. When interviewing military wives, she noticed that when interviewing she felt sad and was aware of a discomfort in her throat, she started swallowing a lot and noticed the respondent swallowing a lot too, whilst at the same time the respondent was making light of her painful experiences, Jervis wondered later whether the respondent had been swallowing painful feelings that may cause her to 'choke' if they were verbalised. It is important that supervision takes place to understand the experience of the interview. One of my supervisors is a qualified psychotherapist and I discussed the interviews with him to enable reflection on the process and findings.

2.4 Criticisms of the psycho-social approach

The psycho-social method of FANI can be criticised for its focus on psychoanalysis and the notion that the unconscious actually exists. Also the psychoanalytic certainty that it harbours the deep truth of human nature has been questioned. Discursive psychology questions the notion of being 'unconsciously propelled' to act in certain ways and instead suggests the need to seek the identity positions that are constructed by the subject. Psychoanalysis has also been criticised by identity theorists suggesting it is static and is confined to early development rather than identities being transformed through on-going social relations. The FANI method has also been criticised for favouring the 'inner' unconscious world over the 'outer' social world (Frosh and Baraitser 2008, Wetheralls 2003). However Hollway responds to this criticism by suggesting the use of the term 'psychic reality' which is neither, inner or outer but a state of flux like the folding of space in the Moebius strip. Hollway and Jefferson (2013), also explain that a deeper level of understanding 'social' questions can be gleaned by using individual case study research which focuses on the psycho-biographical dimension.

There has been debate over the type of psychoanalysis used Kleinian or Lacanian with psycho-social methods favouring the former. A Kleinian approach seeks to make sense of a person's unconscious life e.g. their investments in certain problematic positions (Hollway and Jefferson, 2005) thus retaining a redemptive element (Stonebridge, 1998). Critics suggest that there is relentless optimism about the claim that the paranoid schizoid position can be topped by a depressive scenario and reparation achieved. Such a stance is perhaps an idealistic presentation of human relations in which envy, violence, greed can be kept at bay

given the destructiveness in the social world (Rustin, 1995, Frosh and Baraitser 2008). Whereas for the Lacanians, the role of psychoanalysis is not to use the unconscious to make narrative sense. Rather, through the repetition of certain signifiers in language the unconscious is seen as an 'intersubjective' space between people which arises to '*disrupt'* sense and the task of psychoanalysis is to examine the building blocks out of which sense is being produced. Within language, the subject tries to represent itself. According to Lacan, the unconscious is structured like language. The narrative sense is always made post hoc by the researcher re reading the subjects discourse to find anchors and signifiers to enable the subject to 'see' what is there rather than the analysis being made by others as in the Kleinian tradition (Frosh and Baraitser 2008). Despite the differences between Kleinian and Lacanian psychoanalysis, Hoggett (2000) suggests that the critical edge of psychoanalysis is being blunted by thinking about psycho-social studies as effectively Kleinian object relational thinking.

Frosh (2010) has questioned whether taking psychoanalysis outside of the clinic into research is appropriate arguing that psychoanalysis can only be applied within its specific frame. Hollway and Jefferson (2013) reply to this criticism by suggesting that similarly to psychoanalysis, a psycho social interview (FANI) enables respondents the unique opportunity to engage in an uninterrupted flow of talk with an attentive listener (the researcher) whose role is to attempt to understand the listener. The roles of the researcher and analyst only diverge when it comes to helping the speaker make sense. They suggest the use of the words 'psycho-dynamically informed' to make clear that terms such as free association, interpretation, transference, counter transference and projective identification and the idea of unconscious processes, are not identical to their use in clinical

psychoanalysis. Hollway and Jefferson (2013) also question the notion that the unconscious is only accessible within the clinical encounter. Rather than exploring Oedipal dramas psycho social researchers are more concerned to explore the kinds of defences of ordinary life, traces of which can be found in all human interactions and practices and are not exclusive to the clinic. The expression of repressed material, (although a bonus), is not the central aim of the use of free association in research interviewing. Hollway and Jefferson (2013) emphasise the notion of the 'relational unconscious' (Layton, 2004), 'intra psychic' and 'co creation'. In which the containing interview enables participants to relax defences and 'think new thoughts' about painful or unbearable experiences previously defended against. This enables integration characteristic of object relations and relational schools.

Psycho-social methods have also been criticised for interpretation and over interpretation. Hollway and Jefferson (2013) reply that as in psychoanalysis 'wild analysis' can be avoided if concepts are congruent e.g. attachment theory can be used if the participant explores his or her childhood and data presented is holistic. Finally the criticism of ethics and power relations have been addressed by Hoggett et al (2010) whose modified version of FANI allowed for 6 interviews over a course of a year alongside small inquiry groups which enabled a democratic approach to data collection when researching development workers. Hollway and Jefferson (2013p157) conclude that although they still maintain that it is impractical and perhaps unethical to use interpretation to feed back to the respondent, they now suggest 'it depends on the many facets of the research situation and the many versions of interpretation'.

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2.5 Access and ethics

In order to safeguard and protect the interests of individuals participating in the study I made contact with the ambulance trust's, research and development officer and explained the research to him over the phone and forwarded a copy of the RD1 to him. He approved the study could take place in the ambulance trust in which he worked (via email). Ethical approval for the research was approved by UWE's ethics committee and the NHS ethics committee via an NRES application which was completed in December 2009. I attended an NHS ethics approval meeting in December 2009 and was asked to provide headings to the information sheet and it was noted that if I used any university laptops then they needed to be password secured should they become lost or stolen. Apart from that there were no serious concerns and I was granted NHS and UWE ethical approval in January 2010. (See appendix A).

I indicated on the NRES application that I intended to interview six to eight participants who were currently employed as paramedics of any grade (technician, paramedic or emergency care practitioner). I was particularly interested in recruiting individuals currently working in the ambulance service and of working age so retired participants were excluded. In order to recruit eligible individuals I contacted the research and development officer for a specific ambulance trust in England, who arranged for me to place an advert (see appendix B) written by me requesting volunteers for the a study on 'paramedics and resilience'. This was organised through the communications team at the Trust who edit a monthly bulletin which was circulated to all trust staff. The advert contained my contact details and individuals expressing an interest in taking part were invited to email.

Individuals who wrote were forwarded a participant information sheet (see appendix C) which outlined the aims of the study and what would be involved by their participation. In addition, an informed consent form was also included (see appendix D).

When emailing this information I suggested participants take some time to read the information sheet, and should they still wish to take part in the study to contact me to arrange a convenient time to meet to discuss the research further and arrange a time when the interviews could be held at a University campus. For those participants that replied I then arranged a half an hour meeting at the university to give them an opportunity to ask questions and arrange a time to conduct the interview. At the beginning of the interview I asked them to sign the consent form to show they had understood the nature of the study and were happy to continue take part having had time to deliberate and ask further questions. The information sheet explained that participant's anonymity would be protected by removing names, and any other identifiable aspects such as place names. It also made participants aware of future publications. After transcription, copies of the files would be kept on the hard drive of my university computer which was password protected. All computer discs of the transcriptions (used in the process of transcription) would also be stored in a locked filing cupboard within my office at the university which is also kept locked. Ultimately all CDs would be destroyed once the research was completed. Any paper transcripts were also to be kept within a locked filing cabinet in my university office. Participants were informed that they could withdraw from the study at any point and I ensured that each participant was emailed a copy of website addresses which showed how to access

private counselling should they need it post interview (see appendix E) I also offered to phone them one week post interview to see how they were feeling.

2.6 The sample

The number of individuals initially indicating an interest to participate in the study included eight women and one man. However, subsequently three of the women and the only male failed to respond to invitations to arrange a date and venue for data collection. Despite promoting the study and inviting volunteers through the staff bulletin those coming forward included five female ex-students who noticed my name in the documentation. Some said they were interested in the topic and some wanted to '*give something back'* as they had enjoyed the 'Accelerating learning for professionals' module enormously. After a short period of time two more males came forward after seeing the bulletin. A total five women and two men based at a regional paramedic trust in England comprised the study sample. They were all qualified and working paramedics.

2.7 Demographics of study sample

Gender	**Age**	**Grade**
5 females	30 – 50	1 ECP 4 paramedics
2 males	30-50	1 ECP 1 paramedic

ECP – Emergency care Practitioner

As the sample was a naturalistic self-selected sample I am aware of the bias this may contain as perhaps only those who were suffering discomfort in their job at the time may have come forward. However despite this it did give me insight into the difficulties they face and how they maintain resilience. Five of the participants were ex-students which I felt was an advantage as they already knew and trusted me, and perhaps were able to be more open. However I also recognise that the sample was not representative and might exclude people with different viewpoints, e.g. those who thought they were resilient.

2.8 Data collection

Once the seven participants had met and agreed to participate in the study I arranged to meet them to conduct the data collection. All interviews took place in a private room booked by me at the university. Two interviews took place at the participants' homes. I ensured my safety was protected by telling a colleague I would contact her once the interview was completed within a given time frame. Participants were made to feel comfortable and coffee or tea was offered and privacy was ensured via the room booking system at the university. In order to conduct the first biographical interview I asked participants to "tell me the story of their life" in accordance with principles involved in FANI which included the use of open questions, allowing the participant to order the flow of their story themselves and to keep interruptions to a minimum. I ensured that consent forms were completed before the interview started and that participants were still happy to go ahead. The interviews came to a natural end after 60 to 90 minutes and I signalled the end down by stating I would turn the digital recorder off. During two of the

interviews participants did became tearful and were offered the opportunity to stop the interview, but they declined and continued. Following the transcription of the first interview, in accordance with the principles in FANI I devised a semi structured questionnaire which picked up on themes that arose from the first interview in the sequential order in which they appeared in the first interview. The tailor made narrative questions for the second interview were based on issues that appeared symptomatic of tension or conflict in the accounts, contradictions, avoidances, hesitations or use of humour. This gave me permission to explore themes that were significant through their absence. For example if no mention was made of a person's childhood or parents. Sometimes the questions enabled the participant to extend, clarify and pick up on the first interview and provide further explanation (see appendices F).

After both the first and second interviews I made notes of my thoughts and feelings about the interview as soon as I was able to (in the car or once home or back in my university office). These hand written notes were kept in a small booklet and used later for data analysis. Most of the first interviews that were conducted were between 60-90 minutes long and the second interviews 45-60 minutes. All interviews were recorded on a digital voice recorder and then transcribed by myself with the help of a transcriber for the second interviews.

2.9 Analysis

I was interested to find out how the paramedics remained resilient in the face of what can be seen as a difficult job to outsiders and what processes enabled paramedics to do their job without 'burning out' or leaving the profession. I analysed the interviews via a case by case approach, treating each one as a separate study and in particular re listening to the CD and noting the participant's tone of voice and feelings which arose within me. I transcribed all the first interviews and used a paid transcriber to transcribe the second interviews. Although I was looking for themes, I was aware that this may compromise the psychosocial research method so initially I aimed to establish a *gestalt* within each case study.

In order to do this I gave each participant a letter A to G to signify their identity. I read the raw data from the first biographical interview (identified by the number 1) and second semi structured interview (identified by the number 2). In the first instance I read and re read the interviews to glean a general meaning of the narrative, alongside listening to the audio versions of interviews when transcribing, in order to gain a 'whole' picture or *gestalt* of each participant. These *gestalts* were later presented as 'one page pen portraits' in the findings section.

However in psycho-social research it is inevitable that to present the data effectively I would need to draw on qualitative thematic analysis so I created a way to search and colour code sections of text that represented ideas put together in clusters. I selected codes (words) which were reflective of key ideas for example words such as 'geezer bird', 'tomboy' and 'one of the lads' led to the sub theme of 1.1 Jobs for the boys. I noticed that men and women spoke differently about safety which led to the sub theme 1.2 'Safety and gender'. Also words such as 'difficult

childhood', 'struggling in early life', 'divorce' and 'parental relationships' led to the sub theme 1.3 'The wounded healer'. The codes or words I selected enabled me to come up with the themes as they appeared to mirror a shared experience with other participants. I analysed the transcripts of each participant in turn and the themes unfolded over time. For each of the participant's transcripts I used different coloured highlighter pens to select the codes and wrote notes in the margins. The selected codes for themes were then copied and pasted into new documents titled 'Themes and quotes for participant A1 and A2, B1 and B2, C1 and C2, D1 and D2, E1 and E2, F1 and F2 and G1 and G2 (See appendix G for an example of this for participant A).

In appendix G, it illustrates the themes unfolding for participant A, written in bold I highlight the themes that represent the quotes such as childhood difficulties, gender, attitudes to women, 8 minute targets, lack of support following traumatic jobs, impact on mental health , forming an attachment affects emotions, debriefing, support from colleagues etc. I then went on to do the same for the other participants and having collated this information I read through these documents and formed a colour coded grid (see appendix H) which enabled me to come up with the final themes and sub themes.

The grid (appendix H) enabled me to identify common themes, for example I identified the theme 'why choose this career' (colour coded green) was evident in the pages cited in the grid for all the respondents. Other themes such as gender (colour coded red), performance targets (colour coded purple), impact on health (colour coded blue), dissociation (colour coded orange) and so on emerged across many of the participants. I wrote down the page numbers for these quotes on the

grid for each participant A-G. This enabled me to find the quotes easily should I wish to include them in the findings section.

Having produced a summary of themes and quotes for each participant (Appendix G) this information alongside earlier notes and my reading of the transcripts enabled me to write a pen portrait for each participant which served as a *gestalt* or substitute 'whole' for the reader who does not have access to the raw data but needed to have a grasp of the person for the findings to be meaningful (Hollway and Jefferson, 2013). The pen portrait consisted of biographical data including significant events and comments made by the participant during the interviews.

2.10 Ethics

The main ethical issue I came across was that some respondents become upset and cried during the interviews. I have offered them the opportunity to access counselling and encouraged them to do this. They have followed this up by seeking support via their GP or occupational health service. They have not seen this as a problem and in many ways they feel the interview has been useful for them to start to explore their emotional life. I ensured that their anonymity was maintained throughout by covering up any personally identifiable aspects.

2.11 Conclusion

This section has described the methods employed to explore the concept of resilience within practising paramedic's lives. The adoption of Free association narrative interviewing (FANI) has been demonstrated to be relevant as it will offer a new and original perspective on resilience among paramedics. FANI is a bold method of generating data which uses biographical narrative interviews to research how paramedics become resilient and 'survive' their work. The three

key principles involved in FANI, namely the need to elicit a story, the use of open questions and non-researcher intervention are the innovation in this type of research as the unstructured nature of the encounter enables the researcher to get 'beneath the surface' and consider unconscious communication via transference, counter transference and projective identification processes that may arise during the interview process. This method enables the consideration of 'survival' i.e. Job satisfaction, morale, attrition, mental and physical well-being to be explored through the context of the paramedic's biography and yet also recognises the psychological dynamics that may exist between researcher and respondent during the interview process. Clarke (2008) argues that the interview transcript is just one of several sources of data and that the live recording and the 'here and now' experience of the interview provides important insights into positioning dynamics etc. Hollway and Jefferson (2000) suggest that it is important to allow an individual gestalt to emerge this requires staying close to the data rather than searching for categories. As more cases are explored certain themes may begin to emerge which provide the blueprint for cross case analysis. Psycho-social approaches seek to place at their heart the relationship between the researcher and respondent and what is played out during the interview process. Potentially as an interviewer I might become the container of participant's feelings. As such the findings section will also include a reflexive account of the interview process which will be presented alongside short biographies of each participant and a themed analysis.

Chapter 3 – Findings

3.1 Overview

What emerged from the interviews was that although some of the participants had experienced mental health problems (e.g. depression and PTSD symptoms), this seemed to be associated with their life course, with depression a recurrent theme throughout their lives. However certain traumatic jobs did seem to make a particular impact causing symptoms of PTSD. Somehow they managed this, in a sense sinking and swimming at the same time. It didn't destroy them; they found ways of accessing support through a variety of different methods including support from family, co-workers and managers, counselling and antidepressants.

On a day to day level the paramedics developed strategies of detachment and distancing in order to cope with difficult scenes or heightened emotion. Also it seemed that the organisation became a container for some of the unprocessed emotions such as feeling unsupported, angry and hurt. Unprocessed emotions were also projected onto patients and staff though labelling and projection. I also found that the very reason people came into the job in the first place was that it 'fitted' with their early life experiences and enabled them to 'work though' earlier life experiences both positively and negatively. Changes to the working structure within the organisation as a result of policy strategies, such as the implementation of performance targets, rapid response vehicles, emergency care assistants and lone working also seemed to impact negatively. The lack of formal debriefing was seen as an obstacle yet they formed other methods of support via their peer groups, which were greatly reduced due to organisational changes to their work structure.

What follows is some of the voices of those I've interviewed to illustrate this in more detail. Initially the findings were presented thematically but this seemed to lose the detail regarding how the biography fitted in with the themes. I then presented the work via case studies but this resulted in repetition of the themes and a long word count. To counter these problems the findings are now presented via a short overview of each of the participant's biography and a thematic presentation of key findings followed by a reflexive account of the interview process.

Short biographies of participants

3.2 Ann

Ann described her home life as unhappy with lots of conflict. Her father was an alcoholic. From age 14 to 16 she had a social worker and was placed on the at risk register due to her father's aggression towards the family. She described how she wanted to do something '*caring*' as a job. Ann describes herself and other paramedics as '*quite boisterous, macho and geezer birds'*. As a child she dressed in overalls and helped out in her dad's garage. Ann joined the ambulance service via patient transport and worked her way up by training as a technician, paramedic and then as an emergency care practitioner (ECP). She gained a degree in emergency care and this inspired her to pursue another degree for an alternative career. During the interview she mentioned how the 'turning point' for her getting a new job with another trust was because she had received no debriefing following a job in which someone had committed suicide by jumping onto a train track. Ann had found the work difficult to cope with at the beginning of her career when attending lots of suicides (hangings). She also described having PTSD symptoms during her career. She talked about her new partner and how she was wary of committing to him because she had suffered domestic violence from her ex-husband who was also an alcoholic. Her new partner seemed to be very healing, he was well educated (unlike her previous partner) and she spoke highly of him. Ann talked about how she felt she couldn't be bothered about her job anymore and didn't feel much excitement about it anymore. She really wanted to be doing her new degree which she had talked about with real passion. However unfortunately she had had to suspend her studies due to financial commitments.

3.3 Bryony

Bryony spoke of having a very close and supportive family yet at the same time she described herself as '*a bit of a miserable child*'. She had experienced a difficult time when she was 14, when her father's business dissolved and they had to move from a lovely big house to a smaller one on a main road. However the family went on to buy and sell houses and she says she was '*spoilt rotten'*. She was convent educated and badly bullied at school by peers and teachers. She described herself as a needy child who didn't fit in and was on her own a lot. She moved schools at 13 years of age and struggled to fit in with the '*popular*' girls. Around the age of 24 a close family member committed suicide at the age of 18. After working in administrative work until the age of 28 she was then made redundant. She took the opportunity to move into care work as she wanted a change and had always been interested in it. She did the technicians' course and then, after five years, she trained to be a paramedic. She described the work as '*hard*'. Bryony enjoyed working in a small rural station as a paramedic but she says it '*lost its station feeling'* when it merged with a larger city station and had to meet eight minute targets all the time'**.** She managed to get into a good team but then had six months off with stress due to a very difficult road traffic accident she attended as a paramedic, which had affected her deeply. After this she had trauma counselling at work and decided to work off road on the telephones. Bryony had suffered from depression on and off for years and linked this back to her school years. During most of the interview she was very tearful and says she coped via antidepressants. At the second interview she explained how the first interview '*had brought it all to the surface'* and she had started unlimited

counselling organised by her GP, which she was finding useful. She had no children, she said that she had tried but it just hadn't happened.

3.4 Carol

Carol is a very experienced paramedic who mainly works alone in a rapid response vehicle. Carol says at the beginning of the interview '*Something happened when I was a baby I don't know what'*. She went on to describe how she had been sexually abused at the age of 12. She had also been raped whilst drunk at a party by her friend's boyfriend at the age of 18. These experiences had affected her choice of boyfriends. She had a baby with a very controlling boyfriend who affected her self-esteem, and she left him following an incident where he was arrested. She describes her grandmother as alcohol dependent. Her mother had various mental health problems. She had a good relationship with her father but sadly he left the family home when she was 22 (she found the letter to her mother saying he was leaving which she read and then put back for her mother to find). Carol decided she wanted to be the opposite of her quietly spoken mother because '*she didn't like what she saw in her'*. She now has no contact with either of her parents. Within this biography there are themes of being let down by her parents, her boyfriends and perhaps life in general. Carol also suffered from PTSD symptoms and she finds the job '*hard*' mainly because of her on-going physical health problems and due to the stressful nature of the work. She wants to work in primary care in order to avoid seeing the traumatic events. At the time of the two interviews she had had no idea that her biography could affect her so much and much later when we met up to discuss the findings she said that the interviews '*had stirred things up*'. As a result she was referred for trauma focused

psychotherapy, which she said '*had really helped'* with the earlier sexual abuse. I was pleased that the interviews had been a catalyst for her seeking therapy and reporting the sexual abuse to the police.

3.5 Dee

Dee's dad left when she was 4, she then had a step dad until she was 12 '*who was a bit of a drinker*' and then another step dad who then became her '*real dad'*. She doesn't have many happy memories of her teenage years, she says she rebelled and got into trouble. She had lots of rows with her second step dad. However she had very happy memories of being with her granddad, who she spent lots of time with, and her uncle, who was a paramedic. She describes her grandmother as '*rather unemotional'*. Dee also described her family as '*hard workers'*. She was also influenced by her mother who had a strong work ethic and returned to study, which encouraged Dee to do the same in order to enter the ambulance service. Dee described how she always wanted to be a paramedic and was very proud when she first got her uniform. She is married with small children and worked part time as a mentor supporting trainee paramedics. She appeared to enjoy her job but at times found it hard. She described working part time as being her '*saviour'*. Also she feels she currently works within a good supportive team, has a good clinical team leader and a good support network at home. Dee had suffered depression on and off throughout her life and she describes how anti-depressants and counselling have helped her. Dee tended to keep out of work politics mainly because she works on the mentor vehicle so she felt she needed to keep up her professional approach for the students. During the interview she came across as very aware of the impact of the work on her and was

interested in using the interviews as a continuing way to analyse her life alongside the use of antidepressants and counselling which she had found very helpful. She came across as the most resilient of all the participants I interviewed.

3.6 Eve

At the age of 10 Eve's parents divorced, it was an unexpected event. She remembers vividly being told and saying '*if I'm really good will he stay*?' She had an excellent relationship with one set of grandparents. Eve decided she wanted to be a paramedic at the age of 11 after watching Casualty on the television. On Christmas day aged 15, her grandfather became very ill and the paramedics came to the house and took him to hospital. Unfortunately her grandfather died 4 months later. She cites this as one of the turning points for joining the ambulance service. Eve joined the ambulance service at the age of 22, qualified as a technician and then went on to train as a paramedic. At the same time she split up with her long term partner, which came out of the blue unexpectedly. Eve genuinely believes she is not a good paramedic because she feels she isn't good at cardiac arrests. Yet this proportion of the job is very small, and in fact she has proved that she can manage them and even take the lead. Eve seems to have a fear of forgetting things and getting things wrong which may harm the patient. She feels she needs to live up to the more experienced paramedics. She feels she is more caring but less confident in the technical aspects of the job. She blames the old style of training for her lack of confidence and thought that if she was doing the new foundation degree in paramedic science she would feel better. She also feels the managers are not trained properly. She also thought that what would help her confidence are lots of updates and training opportunities but has found this difficult

to attend and fund. She was very unhappy at work and wanted to leave to start a new career and when I last met her she had left the service and had taken up alternative employment. She was in a happy long term relationship and was beginning to think about having children in the future.

3.7 Biography Fred

Fred went to a 'posh' private junior school. He felt he was bullied by some of the teachers and failed his 11+, so his parents decided to send him to the local comprehensive school. Fred says he didn't engage with education much whilst in sixth form and further education. At this point in time his parents split up and his dad went to live abroad. At 16 he moved into a friend's house (just down the road from his mum's). He describes this as an exciting time in his life as his friends were in the music industry and the house was epicentre of a new wave of music in the 80s. He did a range of what he describes as 'exciting or edgy jobs' before training as a paramedic and more recently as an emergency care practitioner. He got married shortly after becoming a paramedic and had one child but later split up from his wife. He worked in management in the ambulance service for quite a long time and then trained as an emergency care practitioner and went back to work on the roads.

3.8 Greg

Greg came from what he describes as a happy background despite financial difficulties, but he had academic difficulties in school which were never addressed and were an issue throughout his school life. He also had a difficult teacher he didn't get on with. Greg joined the police service but left after a short time as one of the sergeants was quite aggressive towards him. Greg didn't feel he was suited to that type of work. Greg was an experienced paramedic who had worked in the ambulance service for a long time. He was married with children. He had spent some time in management but it didn't suit him. Greg went on to become a trainer for the ambulance service and completed a degree. He was very keen to be involved in the interviews and later described to me how he had used it as a safe medium to explore a range of very difficult traumatic jobs he had attended which had affected him deeply and which had never been processed. He was very reluctant to attend counselling or seek help from his GP. He spent most of the first interview recounting at length a number of very traumatic jobs he had witnessed describing them in detail.

3.9 Thematic presentation of findings

Seven core themes and 18 sub-themes were generated by data analysis (table 1).

Core themes	***Sub themes***
1. Motivations for becoming a paramedic.	1.1 Jobs for the boys. 1.2 Safety and gender. 1.3 The wounded healer.
2. A hidden toll.	2.1 It's just not a healthy job. 2.2 Coping with humanising moments and connections.
3. Pressure of performance targets.	3.1 Impact on patients. 3.2 Impact on staff.
4. Organisational support.	4.1 Peer support, debriefing and humour. 4.2 Management support. 4.3 A culture of shame and denial.
5. Processing emotions.	5.1 Anger and projection. 5.2 Attitudes to 'regulars' and 'timewasters'.
6. Seeking support	6.1 Reflective space. 6.2 Support from family. 6.3 Referral to outside agencies. 6.4 Use of antidepressants and counselling.
7. Becoming resilient	7.1 Learning to detach. 7.2 Technical versus caring work.

3.10 Theme 1 – Motivations for becoming a paramedic

A common motivation for becoming a paramedic originated from a desire to help and care for people, alongside a belief that it was an exciting 'masculine' job. The profession seemed to attract women who were 'tomboys' and those who had strong and influential (positive) male role models. Participants appeared to use the job as a means to work through and address some of their past experiences from their biography as illustrated below.

1.1 Jobs for the boys.

For women the ambulance service was seen as a masculinised occupation. In the past they had to know someone in order to get into the profession (a closed shop), '*you kind of proved yourself, you became accepted by people and then if they thought that you could do front line work you then got taken on'* (Ann). Women regularly encountered prejudicial attitudes about whether they could cope with the demands of the role, as Ann recalls '*Yeah women couldn't lift and women couldn't do this and women couldn't do that and you kind of had to really prove yourself to them'*. To deal with remarks and questions over their ability, women adopted traditional 'masculine qualities' as a reactionary stance.

'Yeah but we do have to be quite macho…..as much as we can look very girly and we can turn on the girly charm and everything else we are actually quite boisterous and quite macho' (Ann). From Ann's biographical interview this was not a new experience as she described developing a tomboy identity during her childhood due to paternal influences.

'My dad used to call me Billy because he wanted a boy and they wanted to call him William you see so (laughs), they used to call me Billy when I was growing up. He used to dress me in overalls and take me to work with him and things (Sue: did he?) yeah desperately trying to make me as boyish as I could possibly be' (Ann).

Identifying with key male role models in the family was also pertinent to Dee whose father left when she was four. Key attachment figures when young included her granddad and an uncle who was a paramedic.

'My uncle was quite a strong influence. He was in the ambulance service from when he was a cadet at the age of 16. So um I don't know. I just never wanted to do anything else' (Dee).

For female participants the notion of '*caring and helping'* was also prominent in their motivations to become a paramedic '*just helping people, wanting to look after people'* (Bryony). However, these experiences contrasted with those of male paramedics, who were drawn to the work because it was considered exciting:

'So being a paramedic kind of allowed me to thrive off excitement, the excitement, the unpredictability, (Fred). This comment is in keeping with Fred's biography of previous occupations *'when I look back on the previous jobs I did, they were all a bit edgy'* (Fred).

1.2 Safety and Gender

Ann discussed safety and how she felt very vulnerable working in the car on her own. At work she experienced a naked man (possibly psychotic) go berserk, he punched her car and she said '*I just ran'*. Not wishing to minimise the effect of this

incident, which must have been very scary I did wonder about the connection between her feeling unsafe and her previous life. I was reminded of the conflict between her parents and how she used to stay upstairs to keep out of the way; her parents said they never noticed she was there. There was also a history of conflict and aggression with her ex-husband, and I wondered if feeling unsafe at work was predominantly to do with that rather than the reality of actually being harmed at work.

During the interviews Carol also talked a lot about not feeing safe at work:
'*I do not feel safe at work. (Sue: you don't feel safe) I have nightmares about being raped, about being stabbed, at work. (Sue: Do you?) and I carry that in me. I think about it in every single job I go to. I think that one day it could be me'* (Carol).

One can empathise with this, as paramedics do attend difficult situations with violent drunk people. However I did wonder whether these feelings were a projection from Carol's earlier life, when she had been raped, sexually abused and had had violent controlling boyfriends. It was interesting that she had chosen a job in which some aspects of her earlier life could have been replicated. The following dream illustrated this clearly:

'*When I dreamt I was raped at work, I thought oh right here we go then. (Sue: you dreamt?) I dreamt that I went to a chest pain at work. As I was trying to leave the property this chappie in the dream got my hands behind my back, undid my uniform and raped me in the hallway and nobody came and nobody checked to*

see if I was all right. It's a genuine fear at work that I feel under threat a lot.' (Carol).

When I asked Fred about how safe he felt at work his response differed to those of the women I had interviewed:

'Any other time I felt dangerous? Probably there were one or two times when something was kicking off I felt a bit exposed but I was quite lucky. I know it sounds a bit smug but I'm a big bloke and generally speaking I didn't get that stuff that more vulnerable people got …….whereas most of the time you know I can with my physical presence I can relax a little on that front. Because most people won't take a pop at me partly because I look quite miserable and because I'm big' (Fred).

Greg also did not appear doesn't seem to have an issue with safety.

'I suppose you could say I sort of developed a spider sense. I'm quite proud of it to be honest that I can actually read people quite quickly and understand what's going on. It's about understanding. I see a lot of people out there go out there and wonder why they've been assaulted and when you actually see the way they interact with people, you can understand it' (Greg).

1.3 The wounded healer

Motivations for becoming a paramedic extended to other reasons which were closely linked to individuals biography and this is embodied under *'wounded*

healer'. This sub-theme represents how the participants in the role of paramedics attempted to understand and counterbalance some personal issues in their own biography. Many had had a range of difficulties in their earlier lives and paramedic practice offered them an opportunity for reparation.

*'Umm you find a lot of us we all went out on a works do a little while ago and had a few drinks and stuff and we were all talking about it there and there were so many of us that were in this group out who had had awful or what could be deemed as awful upbringings' (*Ann*).*

Carol described how she felt the profession had given her self-esteem which was lacking in her past life.

*'We are noble people who are suffering constantly. Which really if I look back on my past, I've been suffering constantly and there was nothing noble about it. Perhaps I was trying to justify it and make it noble in a noble job' (*Carol*).*

Often the theme of wanting to care for people came through as a form of reparation for not being cared for earlier in their lives.

*'Well I changed schools when I was 13 because I just as I say I had such trouble at school I was quite badly bullied …….yeah I can remember being caned by a nun….I know it sounds really sad but just helping people, wanting to look after people' (*Bryony*)*

The following selection of vignettes expands on the biography of study participants whose accounts illustrate the notion of reparation.

Fred

Fred didn't recall difficulties in his biography; he wanted to become a paramedic because he wanted '*an exciting job'.*

'I had a pretty stable really childhood. Um there were certainly no massive traumas in my childhood that I can remember. I think I'm fairly good at burying things. I don't remember bad things but I don't think there were any major traumas in my early life. There were no huge deaths or relationship issues or massive shifts' (Fred).

What I found contradictory here was that Fred's parents had split up when he was 16 which is when he started to leave what he called an "edgy" life, becoming disengaged with education and doing various exciting jobs. I wondered whether the 'edgy' life and need for excitement was a way of managing emotions around the parental split.

Greg

Greg came from a happy background whose family had some financial difficulties. He had academic difficulties in school which were never addressed and were an issue throughout his school life. He also had a difficult teacher who was with whom he didn't get on with.

'I felt very under-confident. And with that tutor, that teacher as well, I didn't enjoy school at all' (Greg).

Greg joined the police service but left soon after due to a sergeant who had a strong and negative impact on him. This reminded me of his school years and struggles with academic studies and teachers.

'And he was quite aggressive towards me at the time, and you know I mean probably that's more on reflection, he probably had a different slant on it. It didn't make me feel very confident in the job at that time. I just wanted to get out. And so I came out, went back home' (Greg).

Greg went on to become a paramedic and enjoyed it. He completed a degree and went on to become a tutor which he suggested enabled him to work through his earlier difficulties around failing academically.

'So I didn't reach the full potential that I had. But then I look back at what I've done now. I've managed to get the degrees you know so' (Greg).

Eve

At the age of 10 Eves parents divorced and her father left. It was an unexpected event. She vividly remembers being told and her response which was '*if I'm really good will he stay*?' She had an excellent relationship with one set of grandparents '*The highlights of my childhood were the days I spent with them….they were always there for me'*. Eve decided she wanted to be a paramedic at the age of 11 after watching Casualty on television. On Christmas day aged 15, Eve's grandfather became very ill. Paramedics came to the house and took him to hospital, '*they were absolutely fantastic, seeing them, inspired me'.* Unfortunately her grandfather died 4 months later. She cites this as one of the triggers for joining the ambulance service:

'Then I kind of made a little promise to myself that I was going to do it for him. So that was kind of my, I'm going to do it and I'm doing it for my grand-dad'.

3.11 Theme 2 – A hidden toll

2.1 It's just not a healthy job

Although paramedics enjoyed many facets of their work (variety; ability to use a range of skills; rewarding aspects), there was a health toll which could manifest itself in physical and/or emotional problems.

*'Yeah, my health has suffered like I say physically I've injured my back lifting and handling doing things like that I made myself ill. But mentally, my mental health, that's just suffered just as much' (*Greg*).*

'You didn't seem to see people around, who were retired ambulance people that lasted any sort of time, (i.e. they died soon after retirement). *Now I don't know why that is. Maybe it's the nights. Maybe it's the adrenaline. Maybe it's the stress. I don't know. But it's just not a healthy job' (*Fred*).*

'You know everywhere I go in XXXXX there are ghosts. Everywhere I go I think yeah a hanging there, a [?] there, a kid with a broken arm there, everywhere I go all over. You do it long enough everywhere you go. But you can't be dragged down by that' (Fred).

It became clear during the interview that some individuals had experienced PTSD 'symptoms' which had interrupted their daily routines:

'I wasn't sleeping properly at all because I was so worried about work and I was really tearful. It was just atrocious' (Eve).

'Six months to a year I was scared of the dark. I wouldn't walk the dog in the dark, wouldn't sleep without the light on …didn't like closing my eyes in the shower, that's how bad that had got from these jobs …and even now 13 years on I could still tell you what each one of them was wearing …and you know it's all those things that they don't go away but you don't have the same feelings when you think about them it's almost like you numb off to it somehow' (Ann).

'*Like the hanging one was intrusive, it popped into my head. Like a silhouette. It was such a haunting image. One in particular, I thought I don't really want to be seeing this. This isn't good that I'm looking at it. And it keeps. My eyes are shut and there he is. Oh gosh, open your eyes. That's not a good thing'* (Carol).

The Paramedics discussed how remaining compassionate and caring whilst at work was more difficult when they also had their own personal issues.

'It's hard when you're tired and you're constantly trying to reassure and put on a smile. That can be hard sometimes when you're tired. Um but yeah I seem to' (Dee).

'And I suppose the worst point in my ambulance career was going through the mill myself and being expected to be nice to people and I found that really hard. That

*was really hard. I found myself getting really, not being nice to people who'd overdosed because I had it at home so many' (*Fred).

The biographical interviews illustrated how the combination of difficult personal and work issues could lead to PTSD symptoms.

'…..within 2 days I had this frightening creeping blackness creep over me….and I thought this is it. I'm going to die. I was off sick for 2 weeks at that patch. I was a bit of a state and it was a very dark time with the relationship ending, the real let down of that, the scumbag cheating on me and then the ambulance issue and then thinking I was going to die. I was in a bit of a funny place' (Carol).

Greg described PTSD symptoms following his attendance at a gory murder scene. Suffering from sleep problems one night he got up to bottle feed his child:

'And I froze and I couldn't go on and I just couldn't move. I remember it now. I stayed there. I mean, it seemed like hours to me but it was probably only a minute or two, something like that. But I just couldn't actually move to go downstairs. And in the end, the only way I could move, was to actually just throw my body weight forward. I threw my body weight forwards. And it just forced me to go down the stairs. And I went down the stairs. And it was just like that. You know, I took a long time to get over that' (Greg).

2.2 Coping with humanising moments and connections

What emerged from the interviews was that making a human and intense connection with patients increased stress reactions. Ann describes how she had got to know an elderly couple who were on route to hospital in the back of her ambulance.

'But something very little will make you feel very emotional I had a little old couple who sat in the back of the ambulance and they were in the 80s she'd broken her hip and we were taking her into hospital. They'd never been apart since they got married ….they'd never spent a night apart and they held hands all the way in, in the back of the ambulance and he cried and he said "I've never spent a night without her" (Sue ahhhh), exactly it made me well up. Isn't that funny I can go to somebody who's died and the whole family are crying and I can shut off to that completely (Sue yeah) but …this little old couple that had never been separated made me well up the same as it's just done (to me!) isn't it funny' (Ann).

The participants were united in finding dealing with children the most stressful incidents, particularly if they had children of a similar age.

'Major ones that I feel impacted upon me is I suppose if I start off with um I've done probably six or seven um cot deaths of young children um. The first one was obviously very difficult because I just had um my youngest….. It was unfortunate but it was a question of me looking back and just seeing my own child there' (Greg).

Bryony described one traumatic road traffic incident involving an elderly woman who was dying, who reminded her of her mother:

'As I say I'm fine if I don't think about it but I still get moments in my car …..you know it makes you get images and things in your head…..she was in her 60s the same age as my mother' (Bryony).

*'Even the little things that maybe get to you, maybe someone was wearing the same coat as your mum and everybody else has those experiences' (*Bryony).

Fred discusses how patients suffering injustices affected him.

'And what I always found is that the stuff you remember wasn't necessarily the stuff that was obviously horrible. People think you must remember really gory, horrible things but I got equally upset by things that I saw were like massive injustices. I remember going to a guy who was having a massive nervous breakdown. He'd been bullied almost to death by his neighbours…..They were just constantly doing things to him, winding him up, made his life a living hell to the point where he had a massive breakdown, he was a gibbering wreck. And I remember getting really angry at the injustice of it' (Fred).

3.12 Theme 3 - Pressure of performance targets

A recurrent theme from the interviews was how participants' work had changed as a result of policies around performance targets and standards. Policy changes included the introduction of the single 'manned' car, the rapid response vehicle (RRV), in 2005. Increasing rationalisation and centralisation of services within a performance target culture meant ambulances were required to arrive within certain time frames, in particular the category A (serious incident) target of 8 minutes. Extensive work auditing and monitoring meant that paramedics had to account for themselves within set time frames e.g. amount of time to deliver the patient to hospital, time to handover and report back for the next job. These pressures seemed to impact greatly on patients and staff.

3.1 Impact on patients

One of the most concerning aspects of the targets culture was how it impacted on patients. Often the RRV would arrive within the 8 minutes target, staffed by one paramedic to assess and stabilise the patient/s. However if the patient required ambulance transport to hospital there was sometimes a delay in the ambulance arriving. This could lead to the lone paramedic coping single handed with difficult situations. The following quote illustrates a scene with a patient suffering an aneurysm.

'An hour and a half and he just kept saying. ….he was completely grey. Had no radial pulse couldn't get a line in cos he was completely shut down and he just

kept saying over and over again 'I think I'm going to die, I think I'm going to die' I was thinking 'oh you probably are' (Ann).

Sue. 'And you were sat there for an hour and a half?

'On my own yep yep' (Ann).

Dee also described waiting for an ambulance. She had arrived in a RRV within the eight minute target but was unable to provide appropriate clinical care for the patient.

'There's several situations we've got on scene and waited an extensive time then for an ambulance. And I think one that stands out is a low chest pain that I had. And I think I waited about 45 minutes for an ambulance to turn up and he still had chest pain and I'd done everything I could do and he still had the chest pain. 45 minutes for all the family and yeah, a guy with chest pain that needs to be in hospital' (Dee).

3.2 Impact on staff

Professional staff spent a significant amount of time and effort in the exhausting monitoring of activities. If they didn't meet a target they would receive an email asking them to explain why, yet from their perspective their priority was clinical outcomes.

'From job to job and I try and go as quick as I can so I hit my performance targets and then everyone's happy. If you don't hit your performance targets, you get an email to find out why you're so slow. Why didn't you make that in 8 minutes then? No pressure hey. It's not about the patient. It's always about how quickly you get there. It's never about clinical outcome. No one ever gives us feedback on our performance or anything' (Carol).

'But those people would say my job's on the line. Every time I go to the SHA… I'm told by the chief executive of the, get it together or you're out. As blunt as that. 'Get your shit together. Come in on budget or you're out the door.' And when you're faced with that sort of pressure, I'm sure it concentrates the mind……I mean to be fair to them it concentrates the mind and they're talking a different language because they're governed by a different language. Performance managed by a different sort of culture. Um but I just found that a bit depressing actually. I just thought what am I actually doing here?' (Fred).

Many of the paramedics commented on how the pressure of meeting targets had affected their work. They felt they had less time to care and were constantly rushed.

'Um we're not given time to care a lot of the time now. They've really cut back on our time at hospital. They've really cut back on our time if you're on scene. Once you get to a job after 20 minutes, they chase you on the radio' (Eve).

'You have to hand over very quickly as soon as the nurse is ready to handover um and then you have 15 minutes in which to clean the vehicle and it might be irrelevant this bit but people aren't cleaning the vehicles properly because they know they've only got 15 minutes so they're cutting corners there which is a false economy because then you're going to have infection problems' (Eve).

Some paramedics felt being rushed meant they had less time to go back and find out what had happened to the patient in order to learn new skills.

'You could say to the nurse that's looking after them, 'what's happened to Mrs So and So?' 'Oh it's a PE. (pulmonary embolus) And this is what happened and this is why we think it.' And you learn loads that way. But there's no time for that now' (Eve).

Eve also commented on the loss of pride in doing things well.

'And you know in the past all the old ambulance men that had been around for years they used to have very specific ways of folding a blanket, a sort of ambulance fold and they used to take real pride over that. It was quite practical because you could just roll it out and use it on your carry chair or on the stretcher or whatever. It's a very practical fold. But it took longer to do but it looked very neat and tidy as well. There's no chance of doing that now' (Eve).

Some paramedics commented on the how changes in technology reduce interaction and support between colleagues:

‘*But again it’s about those human issues. I’ll go right back to 15 years ago when the radio system changed so you couldn’t hear everybody on the net. We’d hear, there’d be this banter, an awareness of all your mates and you felt like a team and if there was a cardiac arrest on and you had an urgent job and you were struggling back to the (hospital), you’d have 5 minutes to help them’* (Fred).

*‘You’ve got some lovely technology now but look what you’ve lost with it. Now you’ve got 200-300 people every day on the end of a texting system. You don’t get ‘thanks. Good night.’ Or ‘we really appreciate what you’ve done today’ or ‘yeah brilliant thanks’. You might get thanks as a text message if you’re lucky but generally speaking it’s not encouraged. So suddenly instead of having a cohesive group of people that used to be on station together and have a really good laugh and feel that camaraderie, ……you send them text messages all day and that’s how the organisation, it’s just like a giant computer centre through your text message, very remote, very non-personal’ (*Fred).

Fred was very scathing of his time working in management and how the culture changed with the introduction of performance management. In particular he found it hard to reconcile his values about how people should be treated against the imposition of the target culture.

‘I found as a senior manager, I was kind of banging my head against a brick wall, both in terms of culture because any sort of non-ops imperative cultural message just didn’t get a side-ways glance. It was just not on the agenda. There was no

*room for touchy-feely, tree-hugging, let's treat our staff nicely and try to improve retention and sickness that way. It was all, like you-know, how can we change our sickness policy so people don't leave early and that kind of stuff' (*Fred).

*'I'm critical of it (management) because of the contradictions. The contradictions between allowing, you know, putting someone out there to do all those crazy things you have to do and then treating them like a kid when they're back on station you know. The contradiction between your job when you're out there with patients and the public and your position and status within the organisation is just completely bizarre……. Before the Standards and stuff came out there was still the same thing, still very lacking in open mindedness and insight, very sort of quasi-military or very command in control. You know they've always had a reputation for being like that. And I honestly don't think that people with radical ideas ever make it anywhere in ambulance management because they don't play the game. They don't, and I've experienced that. If you don't, I don't know, maybe it's just me but I think unless you're prepared to be part of that culture and embrace that culture then you're not going to get on unless you're incredibly lucky or something bizarre happens' (*Fred).

Changes to working practices in the organisation, seemed to have eroded staffs trust and attachment to the organisation. As a result of this paramedics felt uncared for:

'All they're worried about as managers is performance. I suppose to be fair to some of them they have you know pressures on them as managers to do this and

do that and I think generically within the ambulance service we do not care for our staff in the way that we should do' (Greg).

'Seeing how badly we're treated at work and they really don't care about us……None of it is about us as an employee. We are just people that push buttons and we could be robots or people that don't even speak the language. It doesn't make any difference as long as you turn up and trigger a computer number and then just drop someone off at the other end. And that's a real shame considering how hard we all seem to work for it and how much I wanted this' (Carol).

Carol feels there is no support at work, she describes how staff use alcohol to cope and how she had relied on it in the past. She also describes the relentlessness of the job and feeling like a '*robot'* and how she feels tired and finds it hard to recover from shifts (despite her rest days). When she has time off sick she feels much better. Yet she continues with the job: *'I cope because I'm me, because I'm used to coping. You put me on a desert island, I'd cope, wouldn't I? This is my makeup, the way that I am'* (Carol). She appears to take great pride in her work, going back to the hospital to check that she had made the right decisions etc. Carol had had to cope with neglect in her childhood and she describes the strategies she used to protect herself:

'So I wondered if that was the problem that I just kind of shut off from my parents, that they didn't take proper care of me so I withdrew to take care of myself. To

protect myself and I think that's how I coped over the years with the stuff, is that I've withdrawn to take care of me because they didn't' (Carol).

I wondered if she was using the same strategy at work. Carol said she prefers working alone in the RRV, because she feels colleagues are a '*liability*'. Carol prefers making her own clinical decisions and being responsible for them, rather than having to supervise others (in particular ECAs who are unqualified).

The paramedics also cited relationships with control staff as poor. This was commonly related to when they were waiting for ambulances to back up single manned cars when attending life threatening emergencies. In the past control staff were ex clinicians who knew the ropes and could provide support and clinical advice whereas now they tended to be administration staff. Ann describes the problems faced in her relationships with control staff:

'In the past if you had a bad job you always were rung up and say "oh do you want to go and grab a cup of tea or. ..are you alright now" – we don't get any of that now' (Ann).

'They don't have any qualifications or anything else they're 19 year olds that have been plucked off the street to do a job' (Ann).

'They kind of just think that they're in charge of us because they move the vehicles around really…..oh there's people that have got so militant at work now that they say 'were not calling them control anymore were calling them dispatch'

*ummm you hear people over the radio calling them dispatch because they just will not call them control (laughs) cos they are in control of us!' (*Ann*).*

3.13 Theme 4 - Organisational support

4.1 Peer support, humour and debriefing

Paramedics described how the best form of support came from talking to their crewmates. However this was often a discussion of the clinical aspects of the work i.e. did they do the right thing, rather than offloading how they are feeling.

'And I think this is the peer support debrief seems to be better than anything else than going and sitting with somebody else who doesn't do your job' (Ann).

'Yeah, I think 2 heads are always better than one. ….You can discuss things' (Eve).

'*No and you, no matter how proficient or competent you are at the job, you've always got something at the back of your mind - could I have done that better? Could I have done this? If you have a crew mate to talk to about it is great but to walk away and be on your own, I think I would have gone mad actually or madder'* (Bryony).

There seems to be an aspect of guilt '*Could I have done better'*. The use of the word '*mad*' seems to suggest Bryony felt the job has had an impact on her feelings. Perhaps one way of offloading their feelings was through 'whinging and moaning' with colleagues and this 'anger' was a way of venting their feelings.

'I know it's a bit of a cliché but ambulance people really do depend on their workmates. Because workmates instantly understand the problem and also you don't want to take shit home all the time you know. …So ambulance people are really good at whinging to each other about things. And actually whinging is I think you know it sounds negative but it's actually quite a healthy thing to do. When there's anxiety there, you need to get rid of it somehow. And I suppose people get rid of it in all sorts of ways. Um, yeah. It's a cliché but it's really true that ambulance people paramedics talk to other people and there are some really close friendships' (Fred).

The Paramedics indicated that they needed some sort of a debrief after difficult jobs. Ann described how when working alone in the RRV she attended a suicide on a train track, she had asked for back up from an ambulance crew and got questioned as to why she needed one. After explaining she needed support as '*she didn't want to deal with body parts on the track on her own'* they sent an ambulance with two other colleagues. Afterwards the ambulance staff were given time off road to so they '*could talk through the job and debrief each other*' however Ann was asked to go back on standby. She had no one to talk to; she had formed a connection with the patient when attending him the day before. It seemed the isolation was the most difficult to bear and was actually the turning point for her deciding to leave the job at the time.

'And I thought ummm so I'm just going to sit here on my own and think about it now…..and its bizarre that you know I think if I'd gone back with the crew and chatted to the crew had a little bit of banter and a little bit of er it's not a laugh at

someone else's expense but something else comes out other that the morbid bit of it …then you remember that rather than the job itself… I think that was the turning point for me last year where I thought I don't know if I can do this now on my own in a car without any support it's very difficult' (Ann).

Ann described the role of humour in processing difficult jobs.

'Do we want debriefing after jobs or do we just want to sit around in a group and chat amongst ourselves? I think on the whole, most people would say, actually I just want to sit with the colleagues I like, the funny ones that would just make me laugh for half an hour and then I'll be all right again'. (Ann).

Ann also described another incident where a colleague had attended a traumatic job dealing with the death of children. He had also previously been assaulted and almost got strangled. When she said the word '*strangled*' I noticed she was swallowing a lot and I wondered whether she was trying to swallow her feelings. She went on to explain how her friend had recovered from the incident and had returned to work and '*he was fine now'* but went on to say the reason why he had time off work was that he had tried to hang himself. Ann presented this information as a jokey off the cuff remark at the end of our conversation. I wondered if this had affected her more deeply than she thought. Like many paramedics she used humour to cover her emotions, which seemed to work well.

'*He seems to manage very well with things but actually (laughs) that's probably not true because he tried to hang himself about 2 years ago'* (Ann).

Bryony also described how one road traffic accident which she found upsetting led her to getting a job 'off road'. The feelings the job had caused had never been processed at as the following quote shows.

'Yeah that was in XXX yeah well over 2 years ago now and that was the one with the head on drunk driver (starts crying…….long silence can't speak). (Sue – it's quite upsetting isn't it?) (silence……) I promised my husband I'd go and get more counselling (crying), (Sue- both laugh together – did you?) yeah never seem to get round to it (Sue- no) I really should do it (sniff sniff), I'm alright if I don't think about it (Sue – really) Yeah yeah (laughs and cries sniffs.) Yeah just one idiot drunk driver (Sue – uh huh) (crying) killing 7 out of 9 people (rustles tissues out of packet) ……yeah that tipped me into coming off the road……yeah its all the lack of support, (Sue – right) the debriefing em you know no proper debriefing (Sue – No debriefing, no support?), what they did do was pretty crap and it just didn't feel like there was any support for you at all' (Bryony).

Carol describes the helplessness she feels when dealing with hangings:

'Over the years no one has ever helped me about any of those hangings. Five hangings last year. (Sue: five!) Yeah. (Sue: god!) Three of them lived. One of them was unconscious and my terror, the helplessness when I got to him because he was; he'd hung himself ……He was just hanging there unconscious when I got to him. He was a great big chap, probably 16 stone and I thought, oh my god, if I don't get him down, he's going to die. It's down to me. The helplessness was just

unbearable because I didn't know what to do with him. I couldn't cut through the rope because it was a big rope. They don't always have scissors on the vehicle to cut through it and if I ch, ch, ch, fight him for 20 minutes to cut through, he'd be dead before then. So I was trying to lift him up and thought I don't know what to do with him. So I just undid the knot which everyone hates you doing. I let him just fall to the floor' (Carol).

Paramedics appeared to want to be offered a range of interventions to suit their needs in terms of debriefings.

'No. Well no. Debriefing's a difficult one. Debriefing is, I mean, I've thought about it from all sorts of angles and I suppose my feeling about it is that people should have access to it, should maybe even be offered it but that it shouldn't be intrusive because some people let it in in different ways. There's no one size fits all in that sort of stuff' (Fred).

4.2 Management support

In terms of management support Ann felt the managers didn't help much and would just turn up and say:

'*All right then*' (laughs) [said in a loud voice].

Sue: what, is that is that your experience then of it then…kind of "all right then" rather than a kind of "How are you feeling?" and does that help?

No not at all, no most of the time you want them to go away (laughs).

Sue: you want them to go away because?

Because they're our officers, they're management and we feel that there just there to hurry us up to get back on the road.

In contrast to this Bryony found her manager very supportive:

'Well she's an ex-nurse. So she's very patient-led. She is really supportive and she totally understands people trying to get the work-life balance… She doesn't want to lose people from the job but she's very supportive with encouraging you to do more training, more courses…..When I have an appraisal with her, you feel it's an appraisal whereas for the previous 9 years of my working life, I either didn't have them or it was a bit of a 'oh well you're all right, aren't you? Just scribble that down a bit and yeah make that bit up' (Bryony).

Also Carol describes an incident with her manager in which she felt very well supported following a difficult incident.

'He sat with us while we did our statements. He did a debriefing. He discussed it with us over and over again……He tried his best but nobody in the services is trained to help us in critical incidents like that. We never get a debriefing ever……so, he did really well. We sat down individually we talked about it…..We went through it on a flip chart about the good and the bad points….He was trying

his best. He developed a new policy to say we really need to have a structure, post-incident for everybody that's involved' (Carol).

Yet despite this support on the whole Carol believed management were generally unsupportive as she described:

'They try but they don't know what to do with you. Are you okay? And everyone goes yeah. We don't talk to you because you're a XXXX and you live miles away. If you come down here, you're just going to annoy us by patronising us with stuff you don't even know what you're talking about. So we all go, tell you what, you stay where you are and we'll have half an hour off the road' (Carol).

4.3 A culture of shame and denial.

It emerged from the participant's reports that there was a culture of shame in which they felt it was not ok to talk about feelings. Carol discussed the issue of shame and how she is used as a '*confidante*' at work because people feel they can't talk openly about how they are feeling and how the job impacts on them.

'I know I'm not the only one because we talk about it at work. They come to me with it now to talk to me about it, especially some of the emotive stuff that we see because there's no openness about it. People are ashamed to talk about this stuff' (Carol).

Dee discussed how she felt she needed to keep control of her emotions due to her role of being a mentor to students:

‘It's tucked away from the family but it's also tucked away so I can function at work. It has to be. Especially because I'm on the mentor vehicle so I've got students. I can't start melting down. I just can't so (Dee).

Dee feels she needs to control her emotions to ‘protect’ her students. However by denying her students the opportunity to see her vulnerability she seemed to be perpetuating the culture of shame. The contradiction was that she would seek support from her friends or her team leader who she trusts. *‘I think I'll probably take it to my clinical team leader and talk to her’* (Dee).

What was also interesting during Dee’s interview was that she seemed to be testing out the notion of whether or not her mechanism of ‘*tucking it all away’* seemed to be useful. The interview seemed to be a way of forming an emphatic connection with me as the interviewer. This seemed to be the case for most of the interviews.

‘Yeah. Yeah. (um). So, yeah. I think you tuck a lot of it away. And I wonder if in years to come it will just all come out. They say, don't they?’ (Dee).

Greg had never had any counselling to manage the difficult jobs he had witnessed he was very concerned about it going on his medical records and affecting his career prospects for the future.

'I've looked at it and I suppose if I'm honest I just I find it very difficult to sort of actually instigate things like that. Whether I could actually do it or not is a thing, um I know for a fact that I go through periods where I was really suffering with that and somebody actually talked about the counselling and I discussed with somebody with regards to mental health team and things like that and they were sort of saying if it was sort of within the mental health side of it, it would go on the medical record and things like that so' (Greg).

3.14 Theme 5 - Processing emotions

Where participants had not processed emotions through peer support or counselling they remained unresolved and presented themselves through anger and projection and poor attitudes towards patients labelled as ‘timewasters’.

5.1 Anger and projection

Anger was often used as an outlet for the stress they felt and was often aimed at small things. Ann describes how the stress she experiences manifested as anger.

‘A couple of years ago I would have said no, I would have said oh no were completely normal and yet the stss stsss, what we do now I’d say a couple of years on I’d say that it manifests itself as anger, I think, because I’ve noticed in the last couple of years that I just get really angry (Sue. uh huh) about really irrelevant silly little things …… you kind of take that emotion I suppose, shut off to it and then you direct it at something or someone else maybe (Sue, ummm) don’t know’ (Ann).

Ann can’t quite say the words stress it comes out as *stss, stsss*, but yet she seemed to have awareness that the job and perhaps her past life have left her managing her emotional life through anger towards small things. For example she was becoming more assertive of policies and unrelenting change in the service often out of frustration and feeling really stressed.

'A little bit militant against …well you start fighting against things instead of just accepting change and going with the flow, when you start getting angry by change …maybe its stress reaction I don't know but it's when I'm going home and I'm feeling so wound up' (Ann).

The demands of work and the pace of reforms led many paramedics feeling side-lined and unable to cope. Their anxieties were often negatively verbalised, and they harboured ill feeling and anger towards their employees as described by Carol:

'And all he does is moan and he's been in the service a long time and you know how unvalued he feels because he's constantly making sure everyone knows about it. They did this. They did that. They rang me. They did this. They're telling me to do this. It's always control. It's always somebody else's fault. It's always the patient' (Carol).

Ann described how the anger she felt could be projected into others, she described how she felt angry towards a student who was '*showing off*' by saying she was '*out there saving lives*' on her Facebook page and criticising experienced paramedics. '*I'd kinda directed this anger at her',* (Ann).

Ann also could not bear boredom. When on standby in her car Ann felt the boredom was unbearable and this manifested itself as anger:

'Bored stupid! Absolutely bored stupid and there is nothing that makes me more angry than boredom! (laughs) it's bizarre isn't it that's the emotion I get with boredom I get angry (Sue. yeah) it's a funny emotion to have with boredom but…' (Ann).

5.2 Attitudes to 'regulars' and 'timewasters'

When emotions cannot be worked through they can be projected onto others. For some participants they appeared to differentiate patients into categories of 'deserving' and 'non deserving'. The deserving were those who were considered to be 'genuinely ill'. Whereas patients labelled as non-deserving included: regular callers, patients with mental health or alcohol problems and patients with 'social' rather than medical problems. Such patients were also referred to as 'timewasters' or 'regulars' and were less likely to receive attention and compassion. This judgement on whether to communicate empathy, respect and compassion may also be a reflection as to the emotional reserve of individuals:

'And the patients I've lost a lot of my compassion ….whether this is compassion fatigue or what have you, if I go to somebody whose truly ill and worthy of compassion…then they get it you know and I'll spend all the time in the world looking after them' (Ann).

'I think the ones that really wind me up are the people who are doing it for attention or sympathy….you know I've taken an overdose. I've taken 10 paracetamol and I want to die that sort of thing …but you can't say that they don't feel absolutely dreadful at the time and it is a cry for help isn't it. But sometimes I find it hard to

muster the patience (laughs) …I wouldn't say I'm angry with them its more the people that get drunk and lie in the street and just won't get up and I think 'oh for goodness sake' em …and it's because we know that they're using resources that they don't need to use you know, that makes me quite angry' (Ann).

Carol likewise described patients calling the emergency service for 'falls' as 'timewasters'. This was because the attending paramedic had to go into the home and get the patient up and following assessment no medical injuries were noted, which she found a frustrating misuse of the service:

'*I still have to go on blue lights to a fall to someone on the floor who is not usually hurt because there's a great gap in the system where nobody picks up people who aren't hurt and fallen. So they send an ambulance. Who are they supposed to call? I get really angry thinking why are you wasting all our time but there's no one for them to call'* (Carol).

What was interesting was that Dee didn't seem to call people 'timewasters', and divide them into the deserving and undeserving. This could be because she was working on the mentor vehicle and had to be more professional. However her big bugbear was rude people.

'I really hate rude people. I don't think there's any reason whatsoever for people to be rude. Sometimes I can be quite blunt with people, as in why are you being so rude?' (Dee)

3.15 Theme 6 - Seeking support

6.1 Reflective space

The actual process of doing the interview was a means in which participants could use the interview as a reflective space. Particularly if they had not had sought support elsewhere, as Greg's interview illustrates. During his interview Greg described a number of difficult jobs he had attended at length, including a young 17 year old dying of a cardiac arrest; attending a particularly gory double murder and a fatal accident involving a family. When I asked if he had ever spoken of these incidents he replied: '*not really. I suppose it is something. It's difficult to sort of say because I've never spoken about it to be honest' (*Greg). What was interesting was I was the first person he had spoken to. I wondered whether doing the interview was a safe reflective space for him to begin to explore these jobs.

On reflection with this interview it became apparent that Greg was still suffering from emotional distress from these particular jobs. However although the jobs he witnessed were traumatic and not to underestimate the impact of witnessing them on his psyche, it seemed that the focus on telling me about all these awful jobs were a form of dramaturgically enacting out his lifelong emotional distress. During the first interview he relayed the cardiac arrest of a 17 year old as follows:

'There was one black Labrador. They had a black Labrador and the dog was just sat there throughout the whole thing. He just sat there looking at us. He didn't bark' (Greg).

In a sense the black Labrador represented his depression ‘the black dog’ with which he suffers. However when I reflected this back to him at a later date he did say that he felt the jobs were so awful and had affected him so deeply that he did want to use the interview of as a means of exploring them. Despite me encouraging him and sending him psychotherapy and counselling contact details via websites he was very resistant to it.

6.2 Support from family

The paramedics described the support they got from family and friends as really important. The type of support seemed to be clinically based rather than emotive, and was most helpful when partners also worked in the health or emergency services. Ann described the support she got from her partner who worked in the medical profession.

‘Yeah yeah sometimes I do go home and say would you have done that? Did I do the right thing? And he's quite good actually. He's very blunt. ……He's very good for talking those things through with but he's not very good at talking about feelings’ (Ann).

Carol described her supportive partner who worked for the emergency services.

‘That helps me be more resilient I think because I don't feel so isolated now. It's all very well being Joan of Arc on the hilltop isn't it but it's also very lonely. Cause you're on your own with all this terrible stuff that you're seeing, with this chaos and mayhem. Without somewhere to put it, it starts to rub off on you’ (Carol).

The depth of continued home support seemed important to individuals in terms of encouragement and in developing ways of coping with work.

'I have a really supportive family….my mum is just fab, my dad too but my mum is very special' (Bryony).

'As in the key factors that help me cope, the key factors that – being part time is the I suppose the initial thing that sticks out; being within a good supportive team in my team at work and having a good clinical team leader; having a good support network at home should I need it and want it, um. I suppose those are the main 3 things really' (Dee).

At the same time the paramedics described that their family wouldn't be able to understand what they did in their work which made the support they could offer limited. They also described how they would not want to burden their family with the things they saw.

*'I have as you know a hugely supportive husband but he doesn't do the job and he can't imagine what it's like pulling bodies out of cars or doing a cardiac arrest with all the family there or treating a child that's floppy and blue' (*Bryony).

'I couldn't talk to my husband about it because it was bad enough it was in my head, let alone putting it in somebody else's head' (Dee).

Greg doesn't seem to get support from home that some of the other participants did, his wife did not work for any of the associated emergency services. In fact Greg needed to be very supportive towards his wife who had suffered recent bereavements and so he felt he couldn't burden her.

'In some ways I think she doesn't understand. Well I haven't spoke to her about myself' (Greg).

6.3 Referral to outside agencies

Despite having symptoms of PTSD the participants continued with their jobs, sometimes having periods of time off work for stress. Some sought help through referral to outside agencies such as the occupational health service or their G.P who prescribed medication or counselling services. The counselling appeared to help depending on the type received.

'Yeah, I wonder if that's previous counselling. They teach you, don't they, a lot I think when they if you get a good counsellor they do teach you a lot about self-awareness, about how you're feeling and how to deal with those feelings. So I don't know if it comes from that. That was quite a few years ago but I think I learned a lot from it. Um So yeah that, that probably helps as well' (Dee).

'It's been a really long healing process. I've done lots of counselling and all that kind of stuff' (Eve).

Ann was quite sceptical of the behavioural approach to counselling that she received after a referral to counselling from occupational health. This involved sticking red dots around the home, car and other places whenever she thought of a nasty job she had to take deep breaths.

*'It is quite relaxing and I suppose it does work to a certain extent so you stop thinking about the horrible thing and you start thinking about breathing instead ……. The only thing I can say now is that I think it's an avoidance technique and you're not actually (laughs) dealing with what's gone on….I don't know' (*Ann).

Counselling could be obtained from the occupational health service. In the past this was available by contacting an anonymous and confidential telephone number; however at the time of data collection the current practice required paramedics to contact human resources in the first instance. Paramedics felt this to be inappropriate and a disincentive in seeking help.

'*And I checked out the occupational stress management policy…….There's no counselling service unless you ring up HR to find out where the counselling is. So there's no anonymity. There's immediate stigma. Well I can't tell somebody else that I've got a problem. So you can't access any help'* (Carol).

Greg also had a fear that accessing counselling support would be recorded on his medical records as he describes:

'Obviously if you go through the mental health route, it would go on your record; you know your medical records. That sort of didn't help a lot because I didn't really want it to be on there. Not that you know I'm ashamed of it as such but it is difficult if it is on your medical records to hide away and the implications of things like that. But then you know I might not have sat here suffering more. I don't know' (Greg).

6.4 Use of antidepressants and counselling

When interviewing Dee and Bryony it emerged they had suffered from depression in the past and had used anti-depressants which they had found helpful alongside counselling.

'So I had to admit I'd suffered with that and for the most part I've always been able to keep a handle on it' (Sue - yeah). 'Umm but I slipped oh a couple of years ago after the RTC (road traffic collision)…..and that really knocked me for six'. (Sue – yeah). 'and I didn't feel I could cope again so was medicated again …..and I've now not been on tablets for about for probably about a year now' (Bryony).

'I've been up and down throughout my life like I talked to you about my counselling. And then I was fine after that. Then I've had loads after that and then I've been I've had more counselling. So I've, I've been a bit all over the place if you like anyway so I don't know when I, when I, like, currently, currently I'm on anti-depressants. I take citalopram and I've been on them since January. The reason I went onto them was because I kept having sporadic lows, no pattern to them. I'd be absolutely fine and then I'd wake up one morning and feel like I didn't want to

get out of bed. I'd want to go to sleep again. They'd last for about 72 hours, then they'd pass but emotionally tiredness would take me about a week to recover' (Dee).

3.16 Theme 7 - Becoming resilient

7.1 Learning to detach

What emerged from the interviews was that collectively one of the main ways of coping with the difficult nature of the job was to detach from it. One of the ways in which this occurred was to mentally dissociate themselves from the traumatic event they were engaged in.

'The longer service you've been in the easier you find it to actually almost disassociate yourself with it …….you almost I know I've been in the backs of trucks working on people before and I've almost felt like it's not been me ……you know it's almost as if I'm actually just standing back somewhere watching somebody else do what I'm doing' (Bryony).

Other strategies were removing themselves from the incident or 'blocking off' from what they saw in order to remain emotionally safe and detached. Bryony explains:

'I think it was a family reunion, it wasn't a wedding but it was a family gathering and one of the uncles collapsed and died there so you had the whole family all on scene, all very distressed and um he was loaded and I went with him and he never regained consciousness and he actually died in the back of the ambulance and then they 'called it' [ended resuscitation], when we were in A&E. And while we were in A&E, we were picking our kit up and getting bits and pieces back from the job and the daughter of the guy came running in in absolutely floods of tears, threw herself on her knees, grabbed hold of her dad's hand and started shouting,

'daddy no!' and at which point you saw all of the staff, including me, all look at each other and go, 'OK I don't need to be here now' and turn around and leave because you just don't want to open yourself to that much emotion cause it's just, you just get too upset. You can feel yourself getting upset. The easiest thing to do is to remove your-self' (Bryony).

'I do find it quite easy to step out now and not let myself get too involved ….I either block my ears off and just focus on something else or I will remove myself from the room completely if I can. Sometimes you obviously can't and in that way I just concentrate on something else and try not to see or hear what's going on' (Bryony).

Bryony also described how her job off road manning the telephones allowed her to dissociate more as she was interacting on the phone and through a computer screen, rather than being directly involved with patients. Collectively the participants seemed unsure whether detachment had other consequences for their lives. Some felt it also affected them in their personal life.

'You become a complete emotional shutdown and not just to the jobs you go to but to everything in your own personal life as well' (Ann).

'What does it mean to me resilience? I suppose being objective, being able to stand back from it being able to compartmentalise things, you know, this detached, slightly detached thing that's going on. …….the ability to bury things or compartmentalise things and I suspect that's a lot of resilience. Not to take things

personally. ….it's a bad thing because I think I can be criticised for not engaging with things I should have engaged with like relationships or you know things outside work' (Fred).

Fred presents a picture of the need to 'bury things' and compartmentalise things he has seen, but again there seems to be a contradiction, on the one hand he sees this as a strength but is unsure whether it's good or bad as he suggests in the past he disengaged with people in his personal life who were in need.

The participants were unsure and reflected as to whether the strategy of detaching or disassociating was healthy or not and whether this needed to be addressed professionally.

'When we had a dead baby – I just go numb. I don't feel anything. I go numb for about 3, 4 days. And then something will start to surface…….if you blank it out, I think you're going to make it worse because you're putting a big lump under the carpet that's going to get bigger instead of lifting the carpet up and having a proper poke. Even though it's going to be horrible and uncomfortable, the more that you disassemble it and perhaps look at it in pieces at the time, I think it's probably the healthier for you long term' (Carol).

'I think you tuck a lot of it away and I wonder if in years to come it will just all come out. They say, don't they? (Dee).

'I'm aware that in the past when I tucked things away, at a point that they will just erupt and then I hit big big lows and I've gone for some counselling in the past' (Dee).

What was also interesting during Dee's interview was that she seemed to be testing out the notion of whether or not her mechanism of 'tucking it all away' seemed to be useful. In a sense the interview seemed to be a way of forming an emphatic connection with me as the interviewer. At the time she wasn't having any counselling but seemed to have a lot going on with family bereavements and illness. I wondered whether she was using the interview as a space to start to explore her feelings. This seemed to be the case for most of the interviews.

Finally Bryony described what resilience meant to her:

'Building up the ability to cope with it. So it's not just coping but it's the learning to cope as well. For me it's almost like building yourself an armour so that you, over my ten years, I always say my resilience has increased because as I've been exposed to more and more things, my coping mechanisms have improved and it's got probably better in some ways but in other ways I think it hides as well what's really going on for some of us. For me, I think my coping mechanisms only take you so far and you build resilience because of those but I think eventually you do actually run out' (Bryony).

On the one hand she felt she was building up resilience and was learning how to cope but on the other hand she seemed aware that to do that she needed to build

up '*armour*' which she felt hid '*what is really going on for some of us'*. I wondered whether the armour hid the true extent of her feelings, which if unleashed would threaten to overwhelm her. In a way the human bodies defence mechanisms of dissociation, distraction and as she described 'armour' did seem to keep her working and resilient but it seemed to be at a cost in which it would later affect her through depression.

However Greg explained to me he had never used dissociation and described himself as very empathetic. Greg had suffered emotional distress from all the traumatic jobs he had been too and mentioned he was often 'emotional' but got through it.

7.2 Technical versus caring work

The paramedics explained how they had used detachment and compartmentalisation in order to cope with the job. When dealing with the more traumatic jobs which required more technical skills jobs paramedics seemed to be able to detach more. Some seemed to like this type of work.

'Oh god yeah. I loved them. And it was, throughout my career in the ambulance service, everybody loves those big jobs because they challenge you. It's a bit like you hear people in the military saying, 'I can't wait to go to Afghanistan' because you know there is this thing that you're trained to do that and it's a personal challenge as to how you'll perform when it happens. And I used to love the intensity of it' (Fred).

'I also feel some people are drawn to trauma because actually the absolutes are really clear. You don't have to get into emotional issues. Someone's half dead with their head hanging off, all you have to do is stick needles in them and get fluid and deal with all the sexy stuff you see on telly. You don't have to connect with them at all. If you go to a little old dear who's been, who's lonely or somebody who's suicidal or you know and these are the jobs we get. The big trauma jobs are point two percentage of our workload. Point two, I mean it's a fifth of one percentage of our business is big, is big trauma. And the longer you go through the ambulance career, because we all like trauma because it's you know it's that challenge, it's that buzz, oh wow what's going to happen and it's a bit unpredictable and there's a lot of lights and people are watching, there's lots of agencies involved, oh you know, the big 'I am'. You go through your ambulance career always wanting that trauma. ……And the thing about trauma is you don't have to connect with people that much usually especially big trauma' (Fred).

It became obvious as I was interviewing that the 'trauma' type of work which required technical skills was seen as 'real work', was more highly prized and sought after by some of the paramedics (particularly the males). However for those paramedics that enjoyed the routine work which involved more caring seemed to be less able to detach and found the work quite stressful. Eve described herself as very caring but not very good with cardiac arrests (in fact she was quite afraid of them). Eve prided herself on being caring and saw this as an important part of the job.

‘They go to a little old lady in pain on the floor. That's a boring job. We go to lots of those but to that little old lady, that's a huge life changing experience. She's going to be really upset. She's in pain. She's not sure whether she'll be able to come back to her house and be independent again because she's just broken her bones. It's a huge thing and yes, for us its bread and butter work. It's a bit dull. There's no glory in that but you need to be really caring in that situation and the gung-ho types are just, 'oh come on love, get up. We'll get you up.' Put a bit of morphine in because that'll make me feel like I'm doing something macho whereas I'd be a bit more, 'okay well don't worry about it. We'll get you up.' All the niceties and things as well. So I don't think it's that they're not caring. It's just that. Well sometimes it's that they're not caring. I think other times, it's just that they're not interested’ (Eve).

However there was a real contradiction, as despite her view of herself as not very good in cardiac arrest situations, she did actually manage them well as the following quote shows:

‘But I took the lead because I thought well I’m here with 3 ECAs, (Emergency care assistants), there’s this paramedic who’s obviously having a bit of a moment himself and there’s me and I’m the most experienced and I’m going to have to do this and I got on with it’ (Eve).

Fred describes how being empathetic gave him a warm feeling, he seemed to get a lot from this side of the job as illustrated in the following.

'Because I'd been to her so often I used to give her a big hug and say you know, 'you're all right. It will be okay.' And um that's lovely. It's so nice to be able to do that, you know. And again that's not so much control but the ability to exude empathy to help someone in a clear and obvious and quick way just to get through that. It's a really lovely thing. Gives you a warm feeling. I think much warmer than a successful cardiac arrest' (Fred).

Dee also had an empathetic approach to patients as she described:

'You just. Some people call them a waste of time, don't they? I don't like to call any patient a waste of time. No one, no one wants to be addicted to drugs. No one wants to be an alcoholic. No one has ever asked to be assaulted or end up in that position. Um' (Dee).

Bryony discussed how she had compassion towards patients with mental health problems because of the suicide of a family member which had impacted on her greatly.

*'She's always been in the back of my mind when I've been working and I've been to people with panic attacks' (*Bryony).

Chapter 4 - Reflexive account of the interview process

Researchers need to be aware of how their own positions and interests are present at all stages of the research process. These include who they choose to study and why, the questions asked and those not asked. It also includes the methods of analysis and choice of presentation of findings. Reflecting on this is important in order to produce less distorted accounts of the social world (Herz 1997). Reflexivity is a process of continually reflecting upon the experience of the research encounter in order to lead to a deeper awareness, away from a partial perspective and interpretation. It is important to note the position, perspective, responses and interpersonal dynamics that the researcher and the respondent co-create (Frank 1997, Finlay, 2002).

During the research I noticed 3 voices being around:

1. Me as an insider as a previous emergency nurse.
2. My younger 18 to 21 year old self who found the job very difficult and used "dissociation" to cope.
3. Me as a senior lecturer who teaches paramedics.

On reflection I think the reason for choosing to research paramedics and resilience was that at an unconscious level I wanted to work through my some of my early experiences as a nurse aged 18-21. I think I wanted to understand why I had used dissociation so much to distance myself from the patients whilst I was training. This doctorate has helped me to understand that more. Whilst teaching in further education I had completed a master's degree in sociology from Leeds University and ever since doing the research I had always thought much about

what isn't said and what isn't made public in interviews. It was through the Modules Affect, Emotion and Society and Researching Beneath the Surface which were option modules for the doctorate I saw psycho-social research as a way of going deeper (beneath the surface) and extending my learning from the sociology masters. I was also interested in the psychoanalytical aspects of the research which complemented my social science interests.

Psycho-social research using FANI is concerned with gathering data using unconscious processes, there is a need to identify unconscious communications, and to gain insight into unconscious motivations and anxieties (Clarke and Hoggett 2009; Clarke 2002). This can be thought through the following concepts about using the following processes: transference, counter transference, and projective identification. Awareness of these processes allows reflection and thoughtful response rather than unthinking reaction from the researcher. However it may not always be possible to deploy these concepts in social research. It may be easier to focus on one's own projections and transferences, rather than to identify the others' internal dynamics (Brown, 2006). Hollway and Jefferson (2000) make use of the concepts of transference and counter-transference by explaining how one of Hollway's interviews was permeated by her transference to the interviewee as a daughter figure. I will go on to explain how the interviews I conducted were affected by my own projections and transferences.

Transference can take place from the participant to the researcher and vice versa and can be described as what the researcher or participant feels physically and emotionally during the interview. Transference consists of unconscious reactions

based on the life histories of both the participant and the researcher. For example during Greg's second interview he became very upset and started to cry. I felt very strongly that I didn't want him to cry or express such deep emotions and that I hoped he would stop. This could be related to my life history as I had a very strong working class father who "never cried" and I was shocked at Greg's outpourings of grief. In comparison when women cried during the interview, I felt more able to 'sit' with it and provide a more containing influence. I believe I have strong stereotyped unconscious feelings about gender and men crying due to my father. My current partner is also a 'very strong' male who never cries. Also I wondered whether Greg was projecting his feelings into me about wanting to shut off to his feelings. When we discussed this he said he had picked up very strongly that I had a feeling of "please don't cry in front of me". I was quite surprised when I heard this as I thought I'd hidden it well. He also said that he was also trying to hold back his tears due to shame, embarrassment and knowing that after the interview he would need to continue his working day. It was quite enlightening to be able to share this with him. Although after discussing it he seemed to want to leave quickly and I wondered if he had found the process of me admitting to him that I didn't want him to cry uncomfortable. I came away with a feeling that in some way I had failed as a researcher as if only I had had more counselling skills I could have contained his feelings more and he would have felt more held. This appears to be the difficulty with this type of research as further counselling skills may well have improved the encounter. The transference involved could have affected data collection as Greg may well have felt he had to hide his emotions from me during the interview. However by noticing these feelings during the interview I was able to understand his feelings about being emasculated.

Countertransference is the response that is elicited in the researcher by the participant's unconscious transference communications and projections. It is when the researcher acts on the transference, these could include the feelings evoked during the interview for example when Greg was describing the murder scene he visited he talked about an "*eviscerated body, slashed open with the guts hanging out and the smell off blood".* During the interview it felt like it was just gory story after gory story and I just wanted it to end. On reflection afterwards I realised I had been disassociating during the interview in order to cope with it. In one respect this enabled me to continue to listen to his stories, which he had never fully expressed before. I think I was shocked at the amount of gory traumatic jobs he had attended and been unable to fully process his emotional reaction to them until the interview with me as he mentioned it had '*been the first time he had spoken of it'*.

Other feelings I experienced whilst interviewing included maternal feelings towards Bryony who was very tearful during the interview in which she discussed her life history and the difficulties she had had with depression over the years. I felt very motherly towards her and I think she sensed this. Having suffered depression in the past myself I empathised with her. Out of all the interviews she seemed the keenest to engage and meet with me. With Ann and Carol I seemed often to lapse into tutor role. I recall during the interviews advising Carol on the types of modules she could do as she wanted to work as an Emergency Practitioner and needed a degree to do this. I realised I needed to be aware that I sometimes lapsed into this role and be more aware of it when interviewing.

As a result of the containing function of the interview the counter transference can also manifest as how the participant behaves during the interview as a result of the transference from the researcher. Countertransference can also be how I felt physically and emotionally after the interview including dreams. When interviewing Carol she described a dream in which she was being sexually abused at work. She also discussed at length her early childhood difficulties with sexual abuse etc. and discussed how she '*shuts down*' in order to cope. Interestingly after the interview on the long drive home I too felt 'shut down'. After conducting the interview with Carol I didn't want to transcribe it for a long time and I also took a long time to contact her to arrange the second interview, I felt she had projected the feeling of '*being shut down'* into me. It also felt as if I was experiencing some of the fear she had felt when she described her PTSD symptoms:*…suddenly everything sank in and this blackness started to creep over me. And I thought I'm going to die. I'm going to die. It's coming for me. Death's coming for me. I kept wanting to look over my shoulder thinking there was something behind me.* (Carol). During this phase of the interview I became very uneasy listening to her and actually began to experience some of her fear whilst in the room. I wanted to leave and during the time I was with her I had to constantly reassure myself. I did this by really concentrating on my listening, this was the third interview and my listening skills were improving due to having transcribed earlier tapes and realising my mistakes where I hadn't listened well.

Projective identification is where a thought, feeling or emotion that is perceived as too anxiety provoking or painful is projected onto another who becomes influenced

by the projection and begins to behave as though he or she is in fact actually characterised by the projected thoughts or beliefs (Klein's 1946). When interviewing Ann she started to talk about the elderly couple in the ambulance and how they hadn't been apart from each other for years and she had become very tearful whilst discussing this. I also felt very tearful, it seemed as if she couldn't cope with holding those emotions herself and was in some way projecting them into me. I also remember clearly feeling very sad when transcribing Bryony's interview, she had described how difficult the suicide of a close family member had been. During most of the interview she was very tearful and this seemed to affect me as I also felt tearful during the interview when she talked about this and whilst transcribing the interview.

I have always been sceptical of the notion of vicarious trauma and the effect sensitive interviewing has on the researcher. (Dickson-Swift, 2007, Elliott,et al, 2011, Finlay, 2002). However during the year I was conducting the interviews and transcribing I kept diaries. One diary entry describes how I felt when conducting the interview with Greg where he describes a particularly gory murder scene "*Yuk, it's in my mind that terrible murder scene he described"*. During that year I also remember suffering from insomnia and a variety of physical complaints that in the end turned out to be stress related. I also remember the day of my progression exam, which I had prepared well for, I nearly knocked over a cyclist on the way to work (I was so tired I didn't see him). On that day I was nearly knocked over myself by a car and also witnessed a mock car crash for the TV programme Casualty. I remember vividly feeling at the time that my life was '*a bit of a car crash'*. Also at the same time my family and I were heading off to Cornwall for a

weekend break and the car, once packed, "*died*" on us. Although I wish very much to avoid 'wild analysis' that psycho-social research can be prone to, it did seem to me on reflection that what was happening to me was dramaturgically linked to the many interviews in which paramedics described at length gory jobs and car crash scenes. However I am also aware it could also be just coincidence.

During the interview I noticed that Ann would swallow hard when referring to highly charged topics (e.g. her ex being aggressive) and she presented these topics to me in a jokey way with laughing at the end, as if to minimise the effect talking about it could have on her. Many of the paramedics I interviewed used humour as a way of managing speaking about highly charged topics which I felt I also engaged with. I also found myself using humour to manage the interview process for example when Bryony became upset.

During Bryony's interview, when transcribing it and writing up the case studies I noticed the many references to children. When discussing her manager she says: '*My friend had a prem baby and they had no family in the area and I was the only one who was around and she literally let me go at the drop of a hat and help them'.* Also with the RTC that had '*tipped her over the edge'* into getting the job off the road there had '*been a kid in the back of the car'*. When describing the impact of identifying with patients she had said '*the kid was on the same push bike as my child*'. Yet Bryony didn't have children. Alongside this she discussed that she felt she was like the grim reaper when dealing with cot deaths. Also she refers to the incident in which she describes herself as dissociating by the child saying '*Daddy No'*

I remember talking to her during the first interview about the fact that she had no children and she said that she had tried but it just hadn't happened. We had never really talked about how she felt about not being able to have children. Interestingly I had found it really difficult to transcribe the last section of the interview where she briefly mentioned she had no children. Perhaps it seemed to resonate with me as I had had years of finding it hard to have children and had been put on the IVF waiting list prior to being able to conceive. It was only much latter when re reading the interviews and writing it up as a case study that I had a strong feeling come through about her grief about not being able to have children and the link to the child in the back of the car with the RTC that had '*tipped her over the edge'*. When I met with her to discuss this she did agree that not having children had been a big issue for her.

When I interviewed Eve I was very aware of the surroundings I was in, in particular the child-like decoration of the room; there were big pink daisies everywhere (which reminded me of my own 10 year old daughter who is called Daisy). I was very struck by her comment that when her parents had split up she had thought '*if I'm really good will he stay*?' When I went to the toilet I noticed there were photos of her in her brownie uniform, everything about the whole environment seemed to be stuck at that ten year old phase. As mentioned in her biography she had a very close relationship with her grandparents. At the time of her grandfather going to hospital she described the paramedics as '*fantastic*'. I wondered if despite them being fantastic at the scene, because he died 4 months later that led her to have a fear of death, which related to her fear of doing something wrong and her fear of cardiac arrests. I found that during the interview I seemed to become obsessed

with analysing her fear of cardiac arrests and trying to find links, in particular in relation to the parental split at age 10 and the grandfather's death. However when I asked her about this she said the parental split hadn't impacted on her much as I thought, it was a sensitive split and she continued to see both parents. I think the reason I was so fascinated with this was because I had a daughter of the same age (10).

4.1 Conclusion

These unique findings from the Free association narrative interviewing method (FANI) enabled a psycho-social exploration of how paramedics 'survive' their work in terms of their, job satisfaction, morale, attrition and mental and physical well-being. The reflexive chapter gave insight into unconscious motivations and anxieties of the researcher and respondent by focusing on the researchers transference, counter transference and projective identification processes (Clarke and Hoggett 2009; Clarke 2002), rather than to attempting to identify the others' internal dynamics as in psychoanalytic therapy (Brown, 2006).

The following discussion chapter uses the theoretical framework of the 'resilience construct' (Luthar et al, 2000; Ungar, 2004) and examines how paramedics in this research study were able to draw upon a range of resources to assist them in dealing with negative experiences and situations and enable them to 'bounce back' from adversity (McMurray et al, 2008). To date very few studies have explored the specifics of occupational related stress (Lau et al, 2006) and even fewer from the paramedic profession's perspective (Bounds, 2006). The findings from this research study appear to fill this gap. The discussion chapter will explore the motivations of paramedics to join the profession in relation to 'working through'

earlier defences of their biography, exploring concepts of the ‘wounded healer’ (Guggenbuhl – Craig (1998) and gender differences (jobs for the boys). The discussion also explores the ‘hidden toll’ of the job in relation to the findings of the literature review which demonstrated that there are many physical and mental effects of stress on the health on paramedics (Sterud et al, 2006).

The discussion also considers the pressure of performance targets and the outcome of policy changes which impacted on working practices and relationships and placed considerable stress on paramedics in this study (Okada et al, 2005; Dollard et al, 2007; Jenner, 2007; Regehr and Millar, 2007; Nirel et al, 2008). The discussion chapter also explores findings from the literature review in relation to how paramedics in this study sought support to maintain resilience, through informal methods such as the use of a reflective space (storytelling with peers), support from family and friends, use of humour and taking time out. Formal methods of support will also be explored in relation to the literature review findings on management support, critical incident stress management interventions (debriefing) and referral to outside agencies i.e. Gp or occupational health (use of antidepressants and counselling).

The discussion chapter will explore the need for a change in culture from one of shame and denial to one which is more open and accepting of paramedic’s emotions and vulnerability. Paramedics work in a culture in which they are expected to adhere to a strict hegemonic masculinity which severely restricts the expression of emotion (Boyle, 2005, Steen et al, 1997). Therefore healthy mechanisms of processing emotions were unavailable to paramedics in this study. This resulted in anger and projection by the paramedics towards undeserving patients (those seen as timewasters and regulars). Whereas deserving patients

(i.e. acutely physically unwell were treated well. When paramedics spent time with patients and were able to identify with them this led to increased symptoms of distress as paramedics were unable to perform the strategy of emotional distancing that usually protected them (Regher et al 2002). Becoming resilient meant learning to detach (via emotional distancing and dissociation) and splitting work into the valued ‘trauma’ versus the unvalued ‘caring’ categories. This has grave implications for the paramedic profession which will be discussed in light of the recent public debates on compassion (Francis Inquiry report, 2013). The discussion chapter will also explore the strength and limitations of the study and will include a reflection of the methodology and use of FANI. Following this, the conclusion and recommendations will be presented which focuses on methods of building resilience into training and supervision for paramedics.

Chapter 5 – Discussion

This study provides an in depth understanding of paramedics' perspectives on resilience. Resilience is an individual attribute, which is affected by personal autobiographical experiences, training and education, and working practices (including management structures). Resilience is also the property of the relational aspects of the whole system (both conscious and unconscious) in which paramedic's work. The two distinct aspects of this research are that it uses a psycho-social theoretical framework and a method of data collection (FANI) which encouraged me to focus on participants biographies to analyse how paramedics 'survived' their work. This distinctive approach enabled a more in depth analysis than traditional qualitative research. Psycho social studies unique lens relies on psychoanalytic concepts to explore the affective, unconscious dimensions of human relations. The premise of Psycho-social studies is that the unconscious mind plays a role in the construction of people's reality and the way in which they perceive others and the world around them. The unconscious also plays a significant part in both the generation of research data and the construction of the research environment (Clarke, 2008, Hollway and Jefferson, 2000). This unique perspective was valuable as it allowed the narratives to unfold without interference from me. Participants' were allowed and encouraged to 'tell the story' in the order that was important to them thus allowing aspects of their unconscious mind to come through in their narratives. This in turn revealed much of their biographies and how these had impacted on their decision to become paramedics and how they experienced their work. Participants' biographical data provided a deeper understanding of the motivations that led them to become paramedics, embracing

notions of the ‘wounded healer’ and ‘gender differences’. Analysis of biographical data uncovered the hidden toll of the work in relation to health, as the job seemed to bring pre-existing mental health problems to the fore. Biography also impacted on how the paramedics coped with humanising moments and connections, which led to further distress. This distress was further compounded by the impact of recent performance targets and changes to skill mix, which appeared to threaten paramedics’ traditional methods of support.

Participants’ accessed a range of support. These included informal methods (storytelling with peers, use of humour and support from family and friends) and formal methods (management support, debriefing and referral to outside agencies) within the context of an organisational culture of shame and denial. Where support was accessed and utilised in order to process emotions arising from their work, paramedics’ resilience was enhanced. When emotions remained unprocessed, paramedics resorted to other strategies, including displays of anger and inappropriate behaviour towards ‘regulars’ and ‘timewasters’. Other strategies used by paramedics were emotional detachment and dissociation. The study’s findings unveil a rich and unique account of how paramedics survive and become resilient.

5.1 Motivations for becoming a paramedic

The use of psycho-social methods (FANI), with its emphasis on biographical data, provided a deeper understanding of the motivations that led participants to become paramedics, embracing the notion of the ‘wounded healer’ (Gugganball Craig 1998). Paramedics appeared to use their work as a form of reparation to

make good previous personal experiences e.g. early family unhappiness or illness. These findings are similar to those of Firth Cozens' (1992) study on doctors entering medicine. Firth Cozens (1992) argues that some people become professional carers as a response to their own experiences of being cared for in early childhood, including difficult relationships with their carers. Insecure attachment in childhood increases the chance in adulthood of developing a 'compulsive caregiving' style (Bowlby, 1969). Becoming a professional carer may be a psychological way of managing unconscious anxieties about being needy and dependent. Professional carers may invest enormous amounts of psychological time in 'not being patients' i.e. not being needy and vulnerable (Adshead, 2005). This may have implications for their ability to be compassionate towards patients.

This study found that paramedic work enabled the individual self to continue to develop, be enacted upon and emotionally repaired. This supports the notion of the wounded healer (Gugganball Craig, 1998). It appeared that many participants were replaying much of their life through the paramedic role. Specific aspects of paramedic work triggered elements of previous childhood experiences. So work, on occasions, became an arena in which paramedics unconsciously acted out defences from their previous lives. Honeth (1995) argues that there is a primary need for social recognition, (including respect, love and esteem) alongside mutual recognition which is essential for self-realisation to enable the development of one's identity. When individuals experience emotional or physical rejection or lack of affection at an early age, as did Ann, Dee and Carol, this can affect their attachment style and may impact on how they perform in the work setting, build working relationships and interact with others in certain circumstances.

Childhood interpersonal dynamics and attachment patterns can reappear in adulthood and become enacted in the workplace with all the struggles, longings and attachment behaviours they contained (Roman, 2008, Braun, 2011). Carol's recollection about how '*unhappy, un-listened to, un-nurtured'* she felt in the job, were perhaps a transference of her own parents lack of support leading her to believe managerial support was also absent. The organisational structure became a container into which she could project her bad objects. This has implications for how paramedics are recruited e.g. interview screening, psychological profiling, and evaluation of their ability to be empathetic and compassionate.

Many participants recounted how the job became a means to resolve poor self-esteem and feelings of lack of recognition originating from their childhood working class environments. The notion of regaining self-esteem and pride resonates with the narratives of working class men in Sennett and Cobbs' study (1993). Sennett and Cobb (1993) found that, despite being employed and not officially poor, participants were sufficiently insecure economically for it to affect their identity, causing feelings of failure and self-blame. They saw their work as a sacrifice (to enable their children to have a better life than theirs) which enabled them to gain respect in the family and recover self-control. However the hidden injuries included resentment, hostility and shame. Similar findings were echoed in my study particularly for Greg, Fred and Carol. In Greg's case he was left with many unresolved feelings about negative and challenging school experiences which he sought to redress by studying and successfully becoming a paramedic and gaining a degree.

Reay (2005) noted the everyday humiliations and character insults experienced by working class children which left them feeling dumb and socially inept. To understand the effect of class beyond the material impact, one needs to understand people's aspirations and defences, in other words the affective qualities (Walkerdine 2001). For many the pride of the job - as Carol put it being '*noble*' - was a way of repairing early aspects of their lives growing up in working class environments. This is consistent with studies exploring the dynamics of shame and pride within working class communities. For example Rogaly and Taylor (2007) identified that for working class people structural and class inequalities remained firmly in place, but there was a sense of pride in being able to do practical manual jobs. This has implications for enabling career progression for paramedics which in part has been met by the move to training in higher education institutions with its emphasis on lifelong learning.

Biographical data revealed that for women paramedics having male traits or dispositions eased their entry and acceptability to the male dominated culture of the paramedics. Characteristics such as e.g.'*tomboyishness*', '*geezer bird'* and being '*one of the lads'* played a role in being accepted into the male culture. For many participants being a tomboy was part of their early biography, and the job suited this earlier aspect of their lives. Male paramedics seemed to be drawn to the profession because it was considered exciting and '*edgy*'. For females the notion of '*caring and helping'* was prominent in their motivations to become a paramedic. However this aspect was underplayed in contrast to its construction as an exciting job. Being caring and compassionate was not considered as

important as the technical and clinical skills which were highly prized. This was evident in Eve's account in which her caring and compassion was not valued as much as her ability to carry out a cardiac resuscitation. Caring is traditionally viewed as a 'feminine' trait, and often dismissed as unimportant. However caring is an important skill for paramedic work, and needs to be as highly prized as technical and clinical skills. This has implications for managers who need to avoid a dismissive or contemptuous attitude to caring. This is particularly pertinent in light of the recent drive in the NHS to improve compassion due to findings of the Mid Staffs Inquiry chaired by Sir Robert Francis. An understanding of compassion needs to be integrated in the paramedic curriculum and continuous professional development.

There also appeared to be a gender division in attitudes to safety. Women felt less safe in their work than men. This was, mainly associated with previous experiences rather than the reality of paramedic work. This is supported by Hollway and Jefferson's (2000) study about women from housing estates, which showed that, despite feeling unsafe, there was no tangible reason for this. Such feelings were linked to the womens' childhood and gender experiences. Gender is a common predictor of intimidation, sexual harassment and sexual assault for female paramedics but not verbal abuse (Koritsas,et al 2009). Some researchers have reported that female paramedics are more likely to experience some form of workplace violence than males (Arnetz et al, 1996) whereas others have reported the opposite (Vanderslott, 1998). The key variables for increased violence appear to be qualifications (fully qualified paramedics experienced more violence than students), how paramedics respond to a call (verbal abuse was more predictive if

a two person crew attended rather than a single person) and hours spent in direct patient contact (the longer time spent the more the risk), (Koritsas,et al 2009).

5.2 Hidden toll of the work

Biographical analysis uncovered the hidden toll of the work in relation to health. The job appeared to bring pre-existing mental health problems to the surface. Paramedic work is recognised as having a negative impact on the physical and mental health of staff (Sterud et al 2006, Okeefe and Mason, 2010). Bryony, Carol, Dee, Eve and Greg all described having suffered periods of emotional distress and PTSD symptoms (intrusive recollections, numbing of responsiveness and sensitivity to stimuli reminiscent of the trauma) following their involvement with traumatic incidents. Generally 'PTSD' symptoms did not impede the paramedics' ability to remain in practice. Although some paramedics had to take sick leave due to PTSD, these episodes were transitory and more in line with resilience through 'recovery' (Bonnanos' 2004). 'Recovery' connotes a trajectory in which normal functioning temporarily gives way to symptoms of depression or PTSD.

Data from this study suggests that factors exacerbating PTSD symptoms were poor quality contact with supervisors, staff communication and colleague support. These findings are consistent with earlier research (Van der Ploeg, 2003). Contributory individual factors such as personality style and coping mechanisms have also been cited as factors exacerbating PTSD symptoms (Sterud, 2006). The relevant impact of work based and individual factors in explaining variance in PTSD is not known. The data from this study suggested that paramedics

displayed a distinctive ability to survive their work despite its ‘emotional’ knocks and setbacks.

Data from this study suggests that humanising moments and intimate connections with patients could act as reference points to paramedics’ earlier lives and evoke distress. Study participants disclosed episodes of identification with patients which at times triggered recollections of the past. Other studies suggest that identification with victims of injury is a strong predictor of traumatic stress reactions amongst health care staff (Dyregrov, 2002; Dyregrov and Mitchell, 1992; Jonssen et al 2003). For paramedics emotional empathy was strongest when they could identify a personal connection with those under their care, and when humanistic qualities were exhibited among the chaos of the clinical scenario. These emotional connections sometimes led to paramedics exhibiting symptoms of distress and anxiety, as they were not always able to distance themselves emotionally. Consistent with other studies (Dyregrov, 2002; Dyregrov and Mitchell, 1992; Jonssen et al 2003), identification seemed to adversely affect participants when children were involved. Greg suffered severe PTSD symptoms following the deaths of children he attended in part because he had similar aged children and identified with the accident victims.

This study also supports Regehr’s (2007) findings that even small, less overt, events could trigger helpful or unhelpful emotional responses and behaviours due to empathising with patients and their families. Paramedics identified with some patients because they reminded them of their own family members. This study’s biographical data found that Bryony, displayed empathy and increased tolerance

towards patients with mental health problems because a family member had committed suicide. Bryony noted that a woman involved in a road traffic collision was a similar age to her mother. By contrast Ann's emotions were stirred when witnessing the tenderness love and concern that an elderly couple had for each other during their transfer to hospital. Arguably identification can be valuable in reminding clinical staff that they are dealing with humans rather than bodies that need fixing. However such Identification may increase paramedics' susceptibility to emotional distress, making them unable to distance themselves and focus on clinical tasks. This has implications for debriefing, if paramedics have time to talk and reflect on incidents, give each other practical and emotional support this may increase empathy and reduce stress.

5.3 Impact of performance targets

Paramedics encountered many obstacles in their daily clinical work which they coped with to varying degrees using a range of mechanisms. However the recent introduction of performance targets and changes to skill mix threatened traditional methods of securing emotional and co-worker support. Hoggett (2009) argues that a particular feature of the New Public Management was the audit explosion which focused on the performance of public sector employees. Paramedic's performance is increasingly under intensive surveillance and regulation by standards and targets, which have changed the nature of their professional work and relationships. Failure to achieve national response time targets triggers emails by managers demanding full accounts for breach of targets. This has led to frustration as the paramedics felt the focus on targets and audits directed attention

away from the reality of the patient and staff experience '*it's never about the clinical outcome only the target* (Carol).

The introduction of the single manned RRV had additionally resulted in limited opportunities to debrief and reflect with experienced colleagues. Ambulances and cars are now stationed on geographical standby points, reducing the time spent back at base. This was illustrated by Bryony when she highlighted her sense of isolation following the incident on the train track, when she had to go back on standby, not back to base to debrief with colleagues.

Another change is that paramedics are now teamed in ambulances with unqualified emergency care assistants (ECAs) and therefore don't have the support of another paramedic to share decisions with. In the past paramedics worked with other qualified staff (technicians). The concept of '*two heads are better than one'* described by Eve and others was clearly evident in this study. The restructuring of work roles has also affected the teamwork, support and camaraderie which used to occur in the crew room. In Greg's words 'the *teamwork was lost'.* Fred described how changes in technology, from radio to texting, meant the loss of camaraderie. Previously paramedics were able to hear colleagues on the radio and support them if they were nearby. Technological changes have made the job feel more impersonal: *'We are just people that push buttons …. we could be robots'* (Carol). Paramedics missed radio contact and their mangers personal thanks at the end of a shift.

The targets culture also impacted on opportunities to learn from a job by returning to the emergency department to see how a patient was doing and check if they had got the right diagnosis. Paramedics also felt unable to restock and clean ambulances and present them professionally (e.g. blanket folding), as described by Eve. This study also found that paramedics disliked their control staff. In the past control staff tended to be paramedics who had come off road, but who knew the ropes and could provide clinical advice. Now control staff are administrative workers with no clinical experience. Their main mandate is to ensure performance targets are met which frustrated many of the paramedics.

These changes frequently resulted in poor relationships between managers and paramedics. The managerial focus on targets was experienced as an onslaught on the paramedic's professional status and ability to monitor their own outputs and decide on priorities. Hoggett (2009) cites Miller's (2005) concept of *virtualism,* where audit cultures draw the attention of professional staff away from the actual experience of service users, and the audits act as a proxy or stand in for the relationship. Baudillard (1994) uses the term *hyperreal* which means that it takes an '*as if'* quality. The further removed the manager is from the front line the more they are taken in by the illusion that they have helped to create. Through splitting (a predominant strategy of the paranoid schizoid state) managers tend to identify with the idealised commercial management which was seen as the only solution for both their individual and organisational survival. As a result management tended to go into 'over control' and create a climate in which initiative was frowned upon (Lawrence, 1995, 1997, Sievers, 1999). This is illustrated in Fred's remark: "*anyone with any radical thinking never makes it in the ambulance service"*

These findings are consistent with Lipsky (1978), who argued that unresolvable public value conflicts can find expression in contradictory policy frameworks and demands which get passed down the line to street level bureaucrats. Paramedics thus occupy a 'dilemmatic space' (Honig, 1996) in which they cannot but fail to meet one set of demands or another. (e.g. response times versus clinical outcomes). For paramedics their loss of professional agency meant that their ability to deliver a service for their clients was compromised by bureaucratic regulations, which they were obliged to conform to (Wastell, 2010).

Front line professionals frequently respond to burdensome performance management systems by adopting tactics of 'strategic compliance' (Hoggett, et al, 2008) or '*svejkism'.* This is a range of subversive tactics, based on disengagement, through irony and cynicism that unmask the absurdities of new ways of working (Fleming and Sewell, 2002, Wastell et al 2010). Recently paramedics have been asked to complete Clinical Performance Indicators paperwork in response to their criticism that clinical outcomes were not prioritised within the response time targets. This has introduced more auditing, in which staff have to 'tick off' a range of interventions that they have completed (mainly around key improvement areas such as stroke, asthma, cardiac arrest etc). Anecdotally paramedics stated in this study that they use the time for completing this paperwork to give themselves some down time e.g. go to the toilet, get a drink or have a smoke. The implications of this are that current UK policy changes have severely impacted on traditional methods of support that were previously available and enhanced paramedics' resilience.

5.4 Informal Methods of support – storytelling with peers

This study has revealed that the paramedic's best form of support came from talking to crewmates which is consistent with previous studies (Alexander and Klein, 2001; Regehr et al, 2002a, Jonsson and Segeston, 2004; Regehr, 2005; Regehr and Millar, 2007; Essex and Benz-Scott, 2008**;** Halpern, 2009). However this was often a discussion of the clinical aspects of the work (i.e. did they do the right thing), rather than an offloading of feelings. This is consistent with Regehr's (2002a) findings that contrary to avoidance, some paramedics actively reviewed incidents, reframed as a professional learning experience to determine whether they could have provided better care. The positive effects of paramedics telling stories as part of their normal working day is supported by Regehr et al, (2002a) and Tangherlini (2000), who found that storytelling enables paramedics to develop an emotional distance from the patient, gives them a perspective on the situation, and is a culturally acceptable form for expressing concerns, fears and anxieties. Tangherlini (2000) found that paramedics didn't present themselves as "silent heroes, just doing our job" as portrayed in the media. Their story telling was often deeply cynical and self-deprecatory and they tended to present themselves as anti-heroes always ready with a sardonic quip, in even the most horrific situations. Tangherlini (2000) argues that this is part of the paramedic's tactical resistance to managers, patients and others they come into contact with. These studies have been criticised, Regehr's for lacking detail and Tangherlini's for lacking transparency regarding participant selection and methods of data collection (Mildenhall, 2012). However the studies highlight the useful role storytelling can have for paramedics'. Story telling is an under researched and

under rated coping mechanism. The significance of the spoken word and having a sympathetic audience to process emotions and build resilience cannot be overlooked and much more research into this area is needed (Mildenhall, 2012). The importance of storytelling as a coping mechanism is demonstrated in that the driver for conducting this research was paramedic storytelling sessions within a module taught at a university.

5.5 Informal methods of support – family and friends

Congruent with previous studies (Jonssen and Segeston, 2004; Regehr, 2005; Regehr and Millar, 2007) this study demonstrated that the support paramedics obtained from family and friends was important and most helpful when partners also worked in the health or emergency services. However this type of support seemed to be clinically based (talking over decisions) rather than emotive support (expression of feelings). This study found that participants were reluctant to burden their families with the things they saw, and as a result the support families could offer was limited. Consistent with Shakesphere-Finch et al's (2002) study, paramedics liked to 'compartmentalise' the home and work environments by not discussing work experiences with their family/spouse.

This study found that supportive partners are also helpful for repairing biographical experiences. This is illustrated by the support Ann, Bryony, Carol and Dee received from their partners. This confirms Roman et al's (2008) findings that destructive effects of difficulties from early biographical experiences can be transformed through the support offered in 'no matter what' positive relationships from husbands, partners, therapists, and teachers etc. This unconditional support

helps develop and maintain self-esteem, and enables those with difficulties resulting from attachment processes in early life to develop ‘earned security’ to help transform the working model of the self. About 40% of people in a normal population will have insecure attachment styles (Adshead 2010). Braun (2011) argues that we all bring our attachment patterns to the organisations we work in. Positive relationships with supervisors can therefore also help transform early experiences. It seems that participants who had good support from family, friends and supervisors were able to utilise this support to work towards resolving past biographical experiences.

5.6 Informal Methods of support – Humour

Consistent with previous studies (Scott, 2007, Bonnano, et al, 2003; Keltner and Bonnano, 1997) participants used humour to discharge highly charged emotions. Humour has been viewed as a defence mechanism, a form of denial, and a deliberate act of not wanting to address strong emotions which allow individuals to hide or suppress their feelings (Bowlby, 1980, Moran and Masam, 1997). This study supported the notion that humour reduces distress following aversive events, both by ‘quieting’ or undoing negative emotion (Fredrickson and Levenson, 1998; Keltner and Bonnano, 1997) and by increased continued contact with supportive people in the persons environment” (Bonnano and Keltner, 1997). Humour enables camaraderie, group cohesion and social support. Such positivity correlates with higher standards of work performance (Bennett, 2003). Most of the joking complies with professional etiquette, taking place ‘backstage’ (out of the public’s earshot) or in the crew room; it isn’t shared with family and friends and is never used when dealing with children or seriously ill people (Jonsonn and

Segeston, 2004). Humour enables the paramedic to place emotional distance between themselves and the situation, thus protecting them from the vulnerability of exposing feelings by forming a socially acceptable form of anxiety release (Halpern, 2009).

5.7 Informal methods of support – Time out

This study found that in order to survive the job, paramedics needed to process the emotions involved in distressing incidents. Without processing, survival in the job was problematic. Bryony's road traffic accident was so distressing it led her to getting a job 'off road'. Carol described the helplessness she felt when dealing with hangings. This study found that paramedics wanted to be offered a range of formal and informal debriefing interventions to suit their needs. As in Halpern's (2008) study this research found that informal methods included a 'time out' period off road, spending time with peers to informally debrief. However changes in work protocols had the opposite effect, reducing opportunities for time out and informal debriefing. Barriers to timeout periods included time pressures, in particular the need to 'clear' from a hospital department within fifteen minutes of handing over (Gatling and Ansell, 2008), and fears around confidentiality (Halpern, 2008). Some paramedics also welcomed more formal methods of support e.g. management support, formal debriefing and referral to outside agencies such as GPs and occupational health.

5.8 Formal Methods of support – Management support

Participants described that good support by managers who were trustworthy, able to listen, support staff and form good relationships was helpful. Where debriefing by managers did occur albeit informally as cited by Carol, this appeared to be welcomed. Managers seemed to dramatically affect the way paramedics felt about work and their sense of self (House 1981). However managers could also cause stress, particularly where there was poor communication, lack of support and poor feedback. These findings are consistent with other studies (Cartwright and Cooper, 1994, Landeweerd and Boumans,1994; Tepper 2000).

Carol stated that one manager was particularly good, due to a useful informal debriefing episode following a critical incident (despite the fact that it was framed around clinical decisions rather than emotional support). Yet overall she and many other participants were quite scathing of management. This study found that at times managers were unsupportive towards subordinates, corroborating findings by Alexander and Klein (2001) and Regehr and Millar (2007). However Alexander and Klein (2001) questioned whether this was due to an absence of care or whether paramedics were reluctant to admit their own emotional vulnerability and therefore engage with managers. It could be that managers felt they had to accept the bureaucratic changes and saw their role as enforcing these, rather than supporting staff. Regehr and Millar (2007) reported that paramedics found mangers/supervisors interrogational and critical when they most needed support. Mildenhall (2012) suggests that poor relationships between managers and staff may result from a lack of opportunity for face to face interaction, due to the ambulatory nature of the work and the need for paramedics to be on standby.

The rotating twenty four hour shifts also do not complement the officers' nine to five office hours. Subsequently there is a risk of managers being disconnected from their staff (Carriere and Bourque, 2008).

This study found that poor relationships with managers were often due to the lack of respect paramedics felt towards their managers. Perhaps the 'managers' were people the paramedics could project their bad feelings onto (and vice versa) and this projection led to a dyadic relationship in which communication affected both parties in a negative way. Dierendonck et al (2004) argues that, not only does managerial behaviour influence subordinates' well-being, but also the feelings and behaviour of subordinates affect how managers treat them. This is conceptualised as *the vertical dyad linkage or LMX – leader-member exchange* (as it is now called) model of leadership (Dansereau et al 1975). LMX theory suggests that leaders differentiate how they work with each subordinate and develop a dyadic relationship with them (Schriesheim et al 1999). Positive relationships between managers and subordinates are a mutual enterprise; how paramedics feel and behave towards their managers influences how they are treated and vice versa. However LMX theory has been criticised for neglecting the social or group element of relationships and using correlation designs (Hogg et al, 2004, Cogliser and Schriesheim, 2000).

The study is consistent with Halpern's (2008) findings that supervisors can support staff by acknowledging difficult jobs, listening to them and valuing their work. Barriers to supervisor support included, not recognizing incidents as stressful, fear of stigma or appearing weak, and fear of managing one's own and others'

emotional state (Halpern, 2008). Halpern et al (2009) found that staff were very keen to have their supervisor's support and were demoralized when this did not occur. Training is required for managers to explain the importance of their role in providing support, communication skills, basic counselling skills and recognising when an employee might need support. Further training could be extended to promote a positive culture of stress awareness and openness to emotional vulnerability, thereby reducing the stigma associated with emotional display. In particular transformational leadership or a relationally focused style is associated with higher job satisfaction, reduced stress, greater commitment and attachment to the organization (Cummings et al 2010, Leach, 2005). This includes one to one discussions, open door policies and improved communication. Mangers need to move away from supervision and acknowledge the need to show concern for employees via social contact and friendship (Sirota et al, 2005). There is little research on managers' views and this is required in order to counterbalance the current research findings (Mildenhall, 2012).

5.9 Formal Methods of support – debriefing

The NICE (2005) guidelines on the treatment of PTSD are clear: debriefing should not occur, but instead there should be watchful waiting followed by psychological therapy. Cognitive behavioural therapy (CBT) or Eye movement desensitisation and reprocessing therapy (EMDR) is suggested as the treatment of choice However Regal (2007) argued that NICE misinterpreted what psychological debriefing actually was, leading to policies which denied paramedics a range of choices for debriefing. Given the financial remit of NICE, perhaps there were also cost implications for not advocating debriefing, as paramedics would need time off

road and staff involved would need training. However this study's findings support the need for a formal method of debriefing to be available to those who want it, alongside the opportunity to access counselling (free and without shame or stigma) at any time.

Ambulance Trusts have recently been exploring the use of trauma risk management (TRiM), a model favoured by the Royal Marines (Jones and Roberts, 1998, Jones et al 2003) containing all the critical incident stress management (CISM) elements and using the 3 stage model of Psychological Debriefing (PD). TriM purports to offer different trauma support; yet seems to be practising CISM and PD under a different acronym. Jones et al (2003) suggest that the focus by TriM on risk assessment avoids excessive exploration of emotions or enforced catharsis as in counselling or psychotherapy. However as Regal (2007) pointed out PD was never intended to substitute counselling, psychotherapy or act as a stand-alone 'psychological' treatment. Unfortunately PD as reviewed by the Cochrane Reviews (Rose et al 2002) has been consistently and misleadingly viewed as a form of counselling or psychotherapy. Hence the NICE (2005) guidelines that debriefing should not occur. Whilst TRiM can be seen to be very effective in the military context it remains to be seen whether it can be transferred to other contexts such as the ambulance service.

5.10 Formal methods of support – referral to outside agencies

This study also found that referral to GPs and occupational health who could prescribe antidepressants and arrange counselling (as used by Carol, Bryony and Dee) was a useful mechanism for support, enabling more resilience than those who had not accessed either (as in the case of Greg). Most participants appeared

to be drawn to the interview process as a means of exploring their feelings and overcoming any shame and stigma they felt. Two participants (Carol and Bryony) took up counselling after the interviews which had '*opened things up for them'*. This supports Jonsson and Segeston's (2004) theoretical model of the 'container' (Bion, 1962, Crafoord, 1991) as a means of helping to manage PTSD symptoms in ambulance staff. The study findings support the notion that seeking support through others can be highly beneficial in managing PTSD symptoms (McCarroll et al, 1993, Dyregrov, 2002, Jonsson and Segeston, 2003). The exchange of thoughts and dialogue enabled the paramedic to modify or transform the inability to cultivate the unbearable experience (Bion, 1962, Crafoord, 1991). The paramedic is able to handle intolerable affects by dissolving them and projecting them into the corresponding person. The corresponding person then contains them and detoxicates them so they can be reinternalised by the paramedic. This study supports Jonsson and Segeston (2004) who suggest that the lack of someone to use as a 'container' can be one of the explanations for the existence of PTSD amongst paramedics. This was evident in the study as those who had not sought counselling (e.g. Greg) seemed to suffer more from PTSD symptoms. Those who had sought counselling seemed to be more resilient (e.g. Bryony, Eve, Carol and Dee). However longitudinal research is needed to explore whether the container function is useful in enabling paramedics to cope following stressful encounters.

This study found that one of the problems facing paramedics who wanted counselling was that access to it was via human resources (HR) which compromised confidentiality. A clear recommendation for ambulance trusts is to

enable staff to contact a confidential counselling service without managerial knowledge. It would also be useful to reinstate critical incident stress debriefing, which would enable staff to identify where further support (e.g. occupational health or GPs) was needed. Two participants found prescribed antidepressants very helpful. A key recommendation is to enable cultural changes within the organisation so that talking about feelings is no longer shameful but standard practice. A starting point could be training and education of managers in effective debriefing and support of ambulance staff.

5.11 Changing cultures

This study found a culture of shame and denial in which it was not seen as 'OK' to talk about how the job impacted on emotions. As in previous studies (e.g. Alexander and Klein, 2001), paramedics frequently used suppression of emotions alongside avoidance of thinking about stressful incidents. These strategies are a significant predictor of burnout and compassion fatigue (Prati et al, 2009). Paramedics favour these methods as they serve to hide their fear and vulnerability and protect their professional identity as emotionally strong. Paramedics pride themselves on being tough, but this coping mechanism is strongly linked to the development of PTSD (Wastell, 2002). Being tough is related to the paramedics' masculine culture. This study illustrated the shame around displaying and talking about emotional feelings within paramedic culture. Wheeler (1997) suggests that shame is always a sign of a chronically unmet desire or need, often hidden. Anger, blaming and depression may be signs of hidden shame and this was evident in this study's participants. Wheeler (1997) draws on Tomkins' (1987) and Kaufman (1963) in his construction of shame as a "modulator affect", which

functions to govern or modulate the intensity of other affects in order to protect the self. The modulator effect protects the self from 'interest-excitement' affects (Tomkins, 1987) which push or pull us towards a desired state. Shame is a safety regulator when the social ground doesn't feel firm enough to extend one's needs into it. Participants felt shame because of changes to their self-concept after witnessing a traumatic event. Their stable sense of self had been rocked. When shame was not named a lot of energy was used to hide feelings because people feared the risk of being publically unmasked. Paramedics with deep feelings of shame were most likely to have problems coping with traumatic experiences. These problems were compounded by their fear of seeking help in case this went on their medical records, or their managers found out, which could result in unmasking, as in Greg's case (Jonssen and Segeston 2004). However paramedics who sought external support (e.g. Bryony, Carol, Dee and Eve) to reframe an "inner" shaming voice and sought empathic connection via counselling were helped towards restoration of the self as a whole.

5.12 Unprocessed emotions

Where support was accessed and utilised in order to process emotions from the work this seemed to enhance resilience. When emotions remained unprocessed, paramedics used other strategies including displays of anger, inappropriate professional behaviour towards 'regulars' and 'timewasters', emotional detachment and dissociation.

This study found that a key mechanism used to process emotions was anger, manifested through a moaning and whingeing culture. Sudden explosions of

anger, irritability and sleep disturbances are characteristic of attempts to contain emotional responses to stress (Calhoun et al, 2002). Stress may be related to the job but also to past biographical experiences. Hoggett (2009) uses the term *ressentiment* which refers to free floating anxiety due to suppressed emotions that does not attach to objects but is a form of grievance. Hoggett (2009 pg 105) cites Steiner who argues 'that one of the key factors inhibiting psychological growth is the existence of resentment focused on traumatic experience where the patient feels they have been injured or wronged, If the patient is unable to address the wrong….the injury smoulders as a grievance'. He argues that *ressentiment* arises whenever a group nurses its grievances and indulges in the perverse and masochistic enjoyment of its complaints. It has long been documented that projection of anger onto subordinates is an institutional form of defence against anxiety, a way of managing and containing feelings in the health service (Menzies Lyth 1960). It would be useful to conduct further research into the experiences of student paramedics in light of the culture they are working in. Hoggett (2010) argues that one of the paradoxes faced by human beings is the difficulty of giving up their own unhappiness. His central argument is based on the theory of mourning (Freud, 1917) which states that loss needs to be mourned for and people need to let go of the past and move forward. Yet grief can also become a grievance and people can find satisfaction in anger and resentment and a form of righteous indignation in being wronged victims, keeping old wounds open. For change to occur, there needs to be mourning for the part of the self that has been affected e.g. an unhappy childhood. This requires a settling of past accounts letting go of the bad and taking on board the good, which might require forgiveness of self and others. It is likely that some paramedics in this study were

using the organisation as a way to act out grievances based around their biographical experiences.

This study found that participants who used counselling (Dee and Bryony), had begun to reconcile some of their anger based on biographical experiences and appeared more at peace with their job. Whereas for others (Greg, Fred, Eve and Ann) anger lingered like a grievance and they all wished to leave the job and move into other roles. Although this was possible for some, for others it was difficult because 'skilling up' required retraining and getting qualifications was a huge task to undertake. To some extent they were held back by their paramedic 'habitus'. 'Reflexive identity' (Giddens 1991) was in reality a hard road to take. Ann managed to move into training for another career only to be held back by financial constraints. Greg and Fred achieved qualifications and moved into training as a career. Carol is continuing with her education in order to move into teaching. Eve was the only one who used her work experience as a paramedic to sidestep into a different career.

This study found that when emotions could not be worked through they were often projected onto others. Some participants differentiated patients into two categories the 'deserving' (genuinely i.e. physically ill) and the 'non deserving': (regular callers, patients with mental health or alcohol related problems and patients with 'social' rather than medical problems). Non deserving patients were labelled 'timewasters' or 'regulars' and received little compassion. Research on 'inappropriate' call out of ambulances is less common today due to the introduction of triage systems from 1996 (Department of Health, 1996). However 'timewasters'

seems to be a colloquial term commonly used by participants to refer to patients who find accessing 'out of hours' care difficult or confusing e.g. patients with mental health problems (Lakhini et al, 2007), or calls made by altruistic 'public spirited' members of the public (Volans, 1998). Patients and relatives may also call 'inappropriately' because of uncertainty as to seriousness of conditions (Sanders 2000). Perhaps the media also fails to mitigate the issue (Newton, 2012). Snooks et al (1998) suggests ambulance services need to worry less about 'appropriateness ' and focus more on providing appropriate care, including social care according to need. Other services e.g. mental health services should also develop more out of hours care.

A psycho-social analysis includes the Kleinian notion of 'splitting' in which paramedics objectify and project their weaknesses onto patients through the label of 'timewasters'. Hoggett and Frost's (2008) concept of 'double suffering' is useful in explaining this phenomenon. When loss and grief cannot be worked through it can be projected onto others. It can also be embodied via ill health or enacted (via apathy, despair, alcohol or drug use). The original suffering turns back on itself and becomes double suffering. This was evident within the study e.g. when Carol states that she had used alcohol in the past to cope with the job, Carol's biography also revealed that she suffered from many on-going physical health problems. Greg, Bryony, Dee and Eve had all suffered from depression in the past.

One of the main ways paramedics coped with difficult aspects of the job was through dissociation (Cardeña 1994, Holmes et al, 2005). This study focused on

processes of dissociation rather than its symptoms. Using Browns (2006, 2011) model of 'dissociative detachment' or 'dissociative compartmentalisation', Paramedics experienced detachment through a sense of separation from everyday experiences. This included emotional numbing, depersonalisation, out of body phenomena, derealisation and a sense of being an outside observer of one's body or feeling disconnected, unreal or dreamlike, (Holmes, 2005, Brown 2006). These experiences followed traumatic events and reflect peri-traumatic dissociation (Marmar et al, 1998) in which paramedics display mild and transient detachment following stress and fatigue, (Brown 2006). Such symptoms do not progress to severe depersonalisation disorder.

The study also found that paramedics used compartmentalisation of experiences, as in Fred's need to compartmentalise and '*bury things'* and Dees '*tucking away'* mechanism. Actions, emotions and cognitions function normally but are not linked together. Such experiences were 'unbridgeable' and could not be overcome by a force of will, which is consistent with other studies findings (Holmes, 2005, Brown, 2006, Spiegel and Cardeña 1991). Similarly Regehr et al (2002b) found that paramedics use a form of visualisation whereby they focus on practical tasks, and emotionally distances themselves from the patient and their relatives. This unconscious automatic activity enhances paramedics' ability to do their job.

Dissociative detachment and compartmentalisation seemed to be necessary in order to cope with the job. Trauma based work that required more technical skills but no connection to the patient made this easier. Routine work which required more caring skills was more problematic. In this study paramedics bemoaned

routine work as boring and prized trauma work, although this was only a small percentage of their work load. Routine work required more 'emotional labour' (Hochschild 1983) in which actors have to follow display rules such as surface acting (outward emotional expression is inconsistent with feelings within) or deep acting (emotions felt are actively changed to fit situational or socialisation norms). Having to smile and be nice to people when their own emotional needs are not being met can lead to compassion fatigue, which can have implications for staff and patients. The paramedics' preference for trauma work could be because it requires less 'emotional labour'. This preference might also be linked to trauma work being more prized, public, valued and masculine. By contrast, routine caring work is undervalued, invisible and 'feminine'.

However, dissociation encourages paramedics to see patients as 'outsiders', alongside a belief that they are immune from ever becoming a patient themselves. This can lead to hostile or even cynical attitudes to distress, which can encourage detachment and a 'dehumanising' of the patient as a way a coping (Haque, and Waytz, 2012). Bennett's (1987) work on doctors identified similar traits. Bennett (1987) described the 'medical personality' as including an intolerance for distress, rejection of outsiders, rigid adherence to dominance hierarchies, less tolerance of uncertainty, driven persistence, compulsiveness, perfectionism and an exaggerated sense of responsibility alongside persistent self-doubt.

Although some detachment is necessary and desirable in professionals involved in distressing scenes, research into optimal stress management suggests that denial of negative feelings is a short term measure for extreme situations (Adshead

2010). This study found that negative feelings were best managed by acknowledging and articulating them, in combination with positive suggestions. Detachment is not the same as denial. It is possible to remain detached but if denial of feelings are encouraged, health care staff have no choice but to obliterate stress through the use of substances or the displacement of the distress onto others (Adshead 2010).

If paramedics feel ashamed of their distress they are denigrating their experience of being needy and vulnerable. It is crucial that this attitude should not be allowed to persist in health care. First because it is not possible to live a human life without feeling needy and vulnerable and second because health care workers come into contact with needy and vulnerable people every day. The number of complaints, about doctors' interactions with patients have increased by 23% (Sharma, 2012). 90% of communication is unconscious so most interchanges involve unacknowledged wishes, wants, fears and expectations (Adshead 2010). If staff are intolerant of their own or others distress this has huge implications for them as a profession (Stephens 2010).

5.13 Strengths of the study

One of the key strengths of this study was the use of free association narrative interviewing technique. This enabled a deeper analysis of the affective and often unconscious aspects of paramedics' lives including unconscious perceptions, desires and wishes. The unveiling of participants' biographies enabled a fuller picture to emerge of how paramedics 'survived' their work. The Psycho-social framework enabled an exploration of the complex inter-relationship between socio-

structural and psychological factors (Clarke 2008). Another strength was the emphasis on the co-construction of the data in which the emotional life of the researched and researcher were explored (Clarke 2008).

A further strength of the study was that five of the seven participants were ex-students of mine who had participated in a previous module I had taught. These students told me they volunteered for the study as they recognised my name on the advert requesting volunteers in the monthly bulletin. Some mentioned they 'wanted *to give something back*' as they had found my module useful especially the requirement to write reflective essays. This reflection enabled paramedics to process feelings about their work independent of their work organisation. The study recruited paramedics who wanted to explore their emotional lives, via the 'safe' medium of a research interview rather than access counselling. This may be unusual for the profession as a whole and the norm may be for paramedics to cope in other ways. For many participants the research '*opened things up*' and some went on to access counselling through their GP. The trusting relationship I had formed with many of them as students through discussing their reflective essays enabled participants to go deeper in the interviews than perhaps if I had not previously known them.

5.14 Limitations of the study

Psycho-social studies is a new and evolving area of research which challenges masculine notions of rationality structured in positivism and the social sciences in general. This was a difficult choice of theoretical position and method especially as its approach (narrative, psychoanalytic) contrasted with traditional requirements

for a doctorate in health and social care. This has meant that I have been unable to fully explore aspects of psycho-social research. I found it difficult to uncover unconscious transferences and counter transferences mainly because the research was done independently without access to a psychoanalytically trained team who could analyse the data from a group perspective. A background in psychoanalytical therapy alongside access to a team of researchers to explore the unconscious aspects of the data would have yielded more in depth results. However the insight gained from this perspective has been discussed in the previous reflexive account of the interviews.

A potential limitation of this study was the small number of participants recruited (seven), although this was intentional given the qualitative nature of the study. The study included only two males and predominantly older experienced paramedics, so it is not representative of the profession as a whole.

5.15 Reflection on the methodology and use of Free association narrative interviewing.

I chose to use the Psycho-social research method FANI because I wanted to test out a new and innovative way of conducting research which differed greatly to traditional methods of qualitative research techniques. The biographical nature of the interview process enabled a richer analysis of the resilience construct (Luthar et al, 2000; Ungar, 2004). It enabled participants to voice their own meanings of managing their resilience. It uncovered a range of strategies which assisted or hindered paramedics when dealing with negative situations within work. Alongside providing an understanding of why paramedics choose the work and use it to

continue to repair and enact previous life experiences. On reflection I feel the method remains an exciting and innovative move forward in qualitative research. However some of the tensions I experienced whilst conducting the research include first a concern about the sample. As mentioned previously, 5 out of the 7 participants who came forward were ex-students, although this was an advantage, I often wondered if the results would have been different had a more 'anonymous' sample come forward.

The tensions highlighted by Hollway and Jefferson (2013) in the recent edition of their book '*Doing Qualitative Research Differently'* were also evident in my research in particular the criticism of taking psychoanalysis outside the clinic into research (Frosh 2010). I found that I was constantly trying to use psychoanalytic concepts to 'analyse' the research e.g. transference, counter transference and projective identification. In a sense I was attempting to do too much without the psychoanalytic training, thinking that it was necessary for this type of research. I have been reassured by Hollway and Jefferson (2013) claim that the method is 'psycho-dynamically informed' and rather than exploring Oedipal dramas (which I was trying to do!) psycho social researchers can explore the kinds of defences of ordinary life, traces of which can be found in all human interactions and practices and are not exclusive to the clinic. The expression of repressed material, (although a bonus), was not the central aim of the use of free association in research interviewing. I did feel that the interviews were containing enough to enable the participants to relax their defences and 'think new thoughts' about painful or unbearable experiences previously defended against. This has been borne out by some of the post interview experiences participants have told me

(e.g. seeking counselling) as the interviews brought things to the surface. I was aware of the aspect of ‘wild analysis’ and hope I have avoided this.

Please note the last page 194 will be omitted from the thesis for the university library copy to ensure anonymity.

5.16 Conclusion

The study found that paramedics are exposed to stress due to the nature of their work. Some paramedics suffer from PTSD symptoms following critical incidents which in some cases are also triggered by their biographical experiences. The stress of the job seems to present a vulnerability to these staff. Paramedics choose the job to work through earlier aspects of their lives (the wounded healer and reparation). There is also the hidden toll of stress due to the recent restructuring in the ambulance service. This is mainly because this reorganisation (including the introduction of the ECA, single manned vehicles and use of standby points) has eroded more informal means of support that were previously available e.g. informal peer support through being teamed in pairs on the ambulances, time off road after witnessing distressing scenes and the return to the crew room at the station to enjoy the camaraderie of colleagues. One potential solution to this could be that Trusts implement access to peer support following the lead of the London Ambulance Service's LINK scheme in which peers are trained in active listening. Paramedics have the opportunity to phone and seek support 24 hours a day from trained peer supporters.

The introduction of technology has felt more impersonal and management's emphasis on operational work and meeting targets has led to a lack of support for staff on a day to day level. The study found that mangers need to be trained in methods of support including debriefing methods based around CISM or PD. The

study also found that paramedics wanted access to formal counselling via a confidential hotline without their manager's knowledge. Specific trauma focused therapy should also be made available where necessary. On a broader level the ambulance service needs a culture shift towards a more caring organisation which values and supports paramedics. This may include a review of training to include an acknowledgement of the role of psychological and sociological factors in work e.g. emotional labour, compassion fatigue, and seeking support as well as a focus on resilience training at all levels. The work culture needs to move away from shame and denial to an understanding and acceptance of the effects of the traumatic nature of the work. Future research is required to examine the long term effects of the work for psychological health.

I was asked to present this study's findings to the South West Ambulance Trust's senior management following my presentation at the Health Professionals College (HPC) conference held at UWE attended by the South West's Ambulances trusts head of education. The findings were very warmly received by senior managers. The head of well-being is planning to implement TRiM and conduct in depth management training; the only drawback seemed to be cost in light of the recent austerity drive. I am hopeful that further research into the issues raised in this study will continue to be thought about and acted upon for the benefit of the paramedic workforce. The concept of resilience is valuable for understanding how paramedics survive their work but only if it is relationally defined and organisationally contextualised as illustrated by the interviewees as they portray how they loose and find agency throughout their lives and work. Perhaps, so textured that there may yet be more to be uncovered.

The implications of this research for health professions practice includes the need to acknowledge the impact of the stress of their work and how work can present vulnerability, particularly for staff with unresolved aspects of their life history. Work can become a vehicle to manifest related defences from their biographies. To date very few studies have explored the specifics of occupational related stress (Lau et al, 2006) and even fewer from the paramedic profession's perspective (Bounds, 2006). This research has added to this body of work and is important because identifying the specific determinants of paramedics' resilience or vulnerability to critical incidents and daily occupational stress may lead to better individual health and in turn enhance patient care (Maunder et al, 2011).

5.17 **Recommendations for practice:**

1. Access to debriefing, this could include managers being trained in debriefing methods based around CISM or PD e.g. TRiM

2. Access to peer support; this could follow the lead of the London ambulance services LINK scheme in which peers are trained in active listening. Paramedics have the opportunity to phone and seek support 24 hours a day by trained peer supporters.

3. Access to formal counselling via a confidential hotline. Paramedics should be able to access a counselling service independent of their manager's knowledge via accessing a telephone number in which appointments for assessment can be made. A formal counselling assessment should be made by trained professionals and referral on to appropriate therapy services ranging from 6 weeks to longer term if needs be. Also specific trauma focused therapy should be made available where necessary.

4. Management training – should be improved to include all managers to be trained in debriefing. Also the focus of management support should shift from operational to a more relational style seeking to meet individual needs of personnel.

5. Review of skill mix in particular the role of single use rapid response cars ensuring they are staffed by paramedics and not lesser qualified staff.

6. Improved back up to RRVs by double manned ambulances.

7. Less emphasis on performance targets and more on clinical outcomes for patients.

8. Review of the use of emergency care assistants. Paramedics prefer to work in pairs in order to support each other; if ECAs are used they need to be carefully monitored to ensure they are appropriate.

9. Review of training to include an acknowledgement of the role of psychological and sociological factors in work e.g. emotional labour, compassion fatigue, and seeking support.

10. Resilience training at all levels to enable a shift in culture away from shame and denial to an understanding and acceptance of the effects of the traumatic nature of the work.

11. A shift in culture to a more caring organisation in which paramedics are valued and viewed professionally and supported professionally.

07976187

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Inquiry

The Mid Staffordshire NHS Foundation Trust Inquiry: Independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust: January 2005 – March 2009, chaired by Robert Francis QC

Websites

NHS Choices Available from: http://www.politics.co.uk/reference/ambulance-service [Accessed 21.12.2011, 12.57]

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Television

Channel 4 News (19.12.11) England, Channel four television Corporation

Appendices

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Appendix A

Outcome of NHS ethics application approval returning information

Susan Clompus

Study title: **How useful is the concept of resilience in understanding how paramedics 'survive' their work.**

REC reference number: **10/H0102/1**

Thank you for considering my ethical application on 20/01/10. Further information as requested is discussed as follows.

1. Please find attached a copy of the email sent from GWAS and UWE. Yes I can confirm that the PIS and consent form will be sent as attachments to the email to staff asking for volunteers to take part in the study.

2. I can confirm that the first interview will take one hour and the second interview 45 minutes and I have ensured consistency regarding this in the information sheet and consent form.

3. Copies of the indemnity documents are enclosed.

4. Regarding data protection and laptop computer use. All files will be anonymised, password protected and stored on university computers on the H drive and S drive which are the most secure. If university laptops are used all files will be encrypted and password protected. Also personal identifiable information will not be held on the laptop but will be kept in hard form only within a locked filing cabinet, within the researchers locked office on UWE premises.

5. Changes to the participant information sheet and consent form have been amended as requested – please see attached with changes underlined as requested.

Appendix B – Advert for recruiting participants placed in Trusts monthly bulletin

Heath and Social Care Doctorate student at UWE requests Paramedics (all levels) to take part in study on:



How useful is the concept of 'resilience' in understanding how paramedics survive their work.

This consists of 2 interviews – the first is a biographical in depth interview (1hr), the second is a semi structured interview (45 mins).

All interviews can take place at Glenside campus.

If interested please contact Susan Clompus for further information (please leave a mobile telephone number)

Email: susan.clompus@uwe.ac.uk

Tel: 0117 3288918

Appendix C – information sheet for participants

How useful is the concept of 'resilience' in understanding how paramedics survive their work.

Participant Information Sheet

Thank you for showing an interest in this research study. I would like to invite you to take part. Before you decide I would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you have. This should take about 30 minutes and I will arrange an appointment with you to do this should you wish to participate.

Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study.
Please do ask me if there if there is anything that is not clear.

Part one

The title of this study is:
How useful is the concept of 'resilience' in understanding how paramedics survive their work.

This study is a final thesis research project for the Doctorate in Health and Social Care programme that I am currently attending at UWE. I am interested to discover your lived experience of being a paramedic and how you manage the stressful nature of your job. In particular I am interested in the role of resilience and strategies to engender this,

The research is qualitative in nature and will consist of each participant taking part in 2 interviews. The first interview will be an in depth interview of one hours duration. The second interview will be a semi structured interview which will be 45 minutes long. Both interviews will be audio recorded.

The first interview will include the need for biographical data and a storytelling approach. This is a different sort of interviewing which you may have encountered before as you will be asked to "tell me the story of your life". The second interview will follow up themes identified from the first interview

What is the purpose of the study?

The proposed qualitative primary data collection is interested in:

1. What strategies do paramedics currently use to manage the stressful nature of their work?

2. How effective are these strategies?

3. What interventions could moderate, minimise or eliminate some of the stressors for paramedics?

I am hoping that this research will extend the knowledge base in this area.

Why have I been invited

I aim to interview 6 to 8 participants across a range of ambulance service worker grade, experience, age, gender and ethnic background.

Do I have to take part?

It is up to you to decide to join the study. I will describe the study and go through this information sheet. If you agree to take part I will ask you to sign a consent form.

What will happen to me if I take part and what do I have to do?

You will need to take part in two in depth interviews. These will ideally take place at the university or a negotiated suitable location. This will take place outside of work time. The first interview will last 1 hour and the second follow up interview will take 45 minutes.

When I come to see you I will interview you about your experience of being a paramedic within the context of your biography, I will guide you through this process. The interviews will be audio recorded. I will also be making some notes about our conversation through my own reflection after the interview. Please note audio recordings will be destroyed after transcription.

I will give you copies of transcripts and analysis and if you wish to comment on this we can communicate via email or phone or arrange further meetings, this part of the research is entirely optional.

Expenses and payments

There are no expenses or payments available for participation. If travel to the University site is difficult. I can arrange for the interviews to take place at your home or another suitable location

What are the possible disadvantages or risks of taking part?

There are no serious risks involved. What you wish to disclose is your choice. However due to the personal nature of the interview, there is some risk that this may trigger some emotional distress which you need to be aware of. The interviewer will support you if this occurs and you are free to discontinue at any time. Please be reassured that the interview techniques involved include methods used in counselling so you will feel fully supported throughout. However I will provide you with a full list of counsellors from UKCP and BACP and information regarding services from Occupational health, should you wish to pursue further counselling as a result of the interviews. I will phone you one week after the interview to see how you are feeling. The study has been reviewed and approved by the NHS (Southmead research Ethics Committee) and UWE university ethics committee.

What are the possible benefits of taking part?

There will be no direct benefits to you personally for taking part in this study. You would be contributing to an interesting study, which may have benefits for understanding how paramedics manage the stressful nature of the work that they do. It may also give you insight into how you personally manage stress.

Will my taking part in this study be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. All audio recordings of the interviews will be destroyed after transcription. Further details are included in part 2.

Part 2

What will happen if I don't want to carry on with the study.

You are free to withdraw at any time, without giving a reason. Any information that you give including recordings and transcripts of conversations will be destroyed.

Complaints

If you have a concern about any aspect of this study, please speak to the researcher Susan Clompus telephone number 0117 3288918, who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this via the University complaints procedure. Details can be obtained from www.uwe.ac.uk

Harm

This research is covered by UWEs Public Liability insurance policy.

University of the West of England
BRISTOL

Will my taking part be kept confidential?

All information will be kept strictly confidential on a password protected computer; any information kept will have the names and addresses removed so there is no chance of discovering your identity. The tape along with my notes will be written up (transcribed) and used for to evaluate your experiences. This information will be kept in a locked filing cabinet to which only I will have access. Your name will be removed from this information so that the transcript and notes becomes anonymous.

All information will be destroyed after six years using the UWE guidelines. Any assessment of the study will be by UWE staff. They will not be at liberty to know your personal details.

What will happen to the results of the research study?

The results of the research will form the final thesis for the Doctorate in Health and Social Care. Your comments will be welcomed and will form part of the study. You will be made aware of all aspects of the study and will receive a final agreed copy of research findings. If you wish for any findings to be taken out at any point up to completion then this will be agreed and acted on. It is hoped that the results will be published. They may also be presented at conferences and through internal reports.

Who is organising the research?

The study group consists of myself and is supervised By Dr Elizabeth Frost from the social work school at UWE. Other supervisors are Nigel Williams who is a psychotherapist and senior lecturer from the Centre for Psycho-Social Studies at UWE. Also Jennie Naidoo, senior lecturer in Public Health at UWE.

Contact for Further Information

If you require any explanation or further information on any of the above points please feel free to contact myself or my supervisor:

Susan Clompus Email susan.clompus@uwe.ac.uk
Elizabeth Frost (Supervisor) Email Elizabeth.frost@uwe.ac.uk

You will be given a copy of this information sheet and the signed consent form to keep.

University of the West of England
BRISTOL

Appendix D – Consent form

Consent form to take part in a research study to explore:

How useful is the concept of 'resilience' in understanding how paramedics survive their work.

If you would like to take part in this research study please complete and return to Susan Clompus in the envelope provided. Your form should be returned within two weeks.
Please read the following information and sign to indicate your consent

I confirm that I have read and understood the information sheet dated 26.01.10. I have had an opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in this study is voluntary and I am free to withdraw at any time without giving a reason and without my medical or legal rights being affected	
I understand that the researcher (Susan Clompus) will contact me by telephone to arrange an appointment to meet with me to conduct 2 interviews. I understand that the researcher will interview me about my experiences and audio record our conversation. I understand that information I give will be anonomysed. Also all audio recordings of interviews will be destroyed after transcription.	
I understand that relevant sections of my data collected during the study may be looked at by individuals from regulatory authorities or from the NHS trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.	
I agree to take part in the above study	

Participant
Name…… Date……

Signature……

Name of Person Taking consent
Name…… Date……

Signature……

When completed: 1 for participant; 1 for researcher site file.

Appendix E – Information given to participants regarding how to access counselling.

How to find a counsellor or psychotherapist

The following are accredited organisations and include options for finding therapist

British Association for Counselling and Psychotherapy

http://www.bacp.co.uk/

United Kingdom Council for Psychotherapy

http://www.psychotherapy.org.uk/

Appendix F – Second interview questions (all participants)

A2 – second interview questions – semi structured interview

1. How are you since we last met?

2. Tell me about your new ECP job.

3. You talked about safety, how do you feel about that now?

4. You mentioned feeling angry and militant; can you tell me more about that?

5. You talked about the lack of debriefing / time out and support, can you tell me more about that?

6. What kind of support are you getting now?

7. How do you manage difficult jobs?

8. What is it in 'jobs' that seem to affect you?

9. How do you feel about 'regulars'?

10. You talked about compassion fatigue can you say more about this?

11. How is your relationship with your partner?

12. How do you feel about conflict?

13. How do you feel about 'control' and your relationship with them?

B2 – second interview questions – semi structured interview

1. How are you since we last met?

2. During the first interview it seemed there were a lot of difficulties in your early life, bullying at school, moving house, dads job problems, XXXXX suicide and you mentioned you'd had depression a few times and after the last interview you said that you were thinking of having counselling again...I'm wondering what happened there?

2. In the first interview you talked a lot about using the coping mechanism 'dissociation' to keep a distance almost like watching yourself doing something, can you expand on that a bit more.

3. You also talked about how you didn't feel you got much support after that horrific RTC, but how you're talking to your crewmates help – can you talk about that a bit more?

4. You very much seem to recognise that being a paramedic is a stressful job as you said dealing with dead bodies, cardiac arrests, floppy babies and you said that you were working off road to 'give you a breathing space', how is that going?

5. You mentioned that you still have to do a couple a shifts a month out on the road and when on route to a RTC you felt physically sick and 'could have got out of the cab', do you still feel like that on jobs ?

6. You also discussed the difficulties on working with ECA's and being the only clinical person therefore holding all the responsibility, how do you feel about this?

7. Your plan for the future was to get the degree so you could work in a doctor's surgery, how is that going?

8. Lots of stress in your personal life recently in particular bereavements, your husband's dad died and your granddad died and how you felt as a health care professional everyone looked to you and how hard that was, how's things there?

9. How are you finding your job at the moment?

10. What do you think are your main coping mechanisms?

11. What does resilience mean to you in relation to your job?

C2 – second interview questions – semi structured interview

1. How are you since we last met?

2. During the first interview it seemed there were a lot of difficulties in your early life – sexual abuse, conflict, difficult relationships with men and I wondered whether some of those conflicts continue (albeit in a different form) to be played out in your job as a paramedic? It seems there is a pattern of replaying things from the past in your work; what do you think about this?

2. In the first interview you talked a lot about feeling the service didn't care about you, no debriefs, having to meet 8 min targets, can you expand on this.

3. Can you tell me more about how you feel the job affects your health?

4. You talked a lot about your colleagues, in particular feeling a) they were a liability and some don't care, b) a culture of moaning which you felt dragged down by. As a result you felt you wanted to be self-reliant. There also seemed a link between this notion of being self-reliant because no one was there to care for you in your early life and still this is continuing in your job?

5. Some of the coping methods you mentioned with difficult jobs (you mentioned no one ever helped me with the hangings) were dissociation, feeling stunned, numb and weary. What do you think are your main coping mechanisms?

6. You talked a lot about feeling unsafe, yet most of your childhood and your 20s you also felt unsafe. How do you feel regarding safety?

7. You talked a lot about feeling a lack of recognition from managers e.g. they were quick off the mark regarding any complaints or not meeting the 8 minute target but never seemed to thank you for your efforts.

8. You mentioned you felt very valued from the public – thank you cards etc and seemed to take good pride in your job e.g. making good clinical decisions and checking after if you'd got it right (which you often did do). How do you feel about the pride you take in your work?

9. You mentioned that you weren't 'lovey dovey' to patients – can you say more about this?

9. We also discussed the effect of poor kit and vehicles breaking down – can you say more about that?

10. You mentioned feeling weary and burnt out, but feeling better for a holiday and the relentlessness of the pressure of the job. You were trying to get another job – how's that going and how do you feel about this?

11. Finally how do you feel about your work now?

D2 – second interview questions – semi structured interview

1. How are you since we last met? (In particular you mentioned your uncle had been diagnosed with cancer).

2. During the first interview it seemed there were a lot of difficulties in your early life – first dad leaving, second dad a drinker, difficulties about making contact and ultimatums from your mum as a result you described yourself as a troubled teenager and yet you had strong influences from your dad and uncle who were in the ambulance service. Can you say more about how these male influences affected you in terms of your career?

2. In the first interview you talked a lot about 'tucking' things away and not wishing to put the thoughts about what you see in your job in other people's heads about jobs. You mentioned talking to colleagues, how is that going?

3. Can you tell me more about how you feel the job affects your health? (You mentioned that you were on Citalopram due to the link between work stress and

individual stress e.g. granddad dying and marital problems alongside the stress of the actual job).

4. What are your coping mechanisms – you mentioned you felt the need to cope as you need to be able to look after your mum, gran etc with the impact of your uncle's illness?

5. You mentioned the job is tough when you are tired and you felt going part time is your saviour, can you tell me more?

6. How are you finding it on the mentor vehicle?

7. Tell me about the parts of the job you find difficult?

8. You mentioned that you didn't like it when patients were rude to you, can you say more about that.

9. You seemed to get a lot of support from your husband who you said was a loyal family man always there for you, how do you feel this helps with your job.

10. What do you understand about resilience in relation to you and your work?

E2 – second interview questions – semi structured interview

1. How are you since we last met?

2. How do you feel about your confidence?

3. How are things with the complaint and the interventions with the training school?

4. How do you feel about cardiac arrests now?

5. You mentioned about the fear of getting things wrong and about the HPC being 'out to get you' how do you feel now?

6. You described one of the senior managers as a 'bully' how is that affecting you now?

7. What support are you getting now?

8. What kind of support would help you?

9. You mentioned that you liked the caring side of the job but felt it was devalued can you say more about this?

10. What do you think resilience means to you?

F2 – second interview questions – semi structured interview

1. You talked a lot about your previous life before becoming a paramedic, it seemed quite exciting you used the word “dodgy” a lot. How do you think it prepared you for the job?

2. Do you think being a paramedic mirrors your early life childhood and early 20s?

3. You talked about how people became disconnected and like the trauma type jobs because that way they didn’t need to “connect” with people, can you tell me more about that?

4. You talked about how you thought some paramedics were into trauma and seeing gory things yet you found it quite obscene, can you tell me more about that?

5. You mentioned you found it hard to be nice to people when you were going through your own stuff e.g. comment about the hypo, tell me more about how you felt at those times?

6. You did mention that you liked the excitement of the big jobs – can you tell me more about that?

7. Tell me more about when you felt most empathetic as a paramedic?

8. You seemed to be quite anti-establishment with management, tell me more about the management culture you worked in?

9. Boredom comes up a lot – tell me about that?

10. How do you think the job affected your health?

11. Have you ever felt unsafe?

12. What support mechanisms did you draw on?

13. What does resilience mean to you?

14. Anything else you want to add?

G2 – second interview questions – semi structured interview

1. How are you since we last met?

2. Any more thoughts on counselling (give copies of websites)

3. During the first interview it seemed there were some difficulties around confidence in your reading, how do you think that affected you?

4. In the first interview you talked about a lot of difficult jobs, what helped you to get through it?

5. How do you think the job affected your health?

6. What part of the job did you enjoy the most?

7. What do you think helped with your resilience?

8. How do you feel about safety in your job?

9. What support would you like to see the ambulance service provide?

10 How do you manage your emotions, what do you do when you recall traumatic memories e.g. the film love actually and the 17 year old?

Appendix G - Themes and Quotes for participant A1, A2

Initiation into the service

a. ferrying people around, that was the only way you had to join then you couldn't go straight into front line you had to start on PTS and kind of prove yourself and work your way up.

s. so you had to work up from transport service upwards then?, that was always the way in was it ?

a. at that point it was …it changed about a year after I joined when they started taking in direct entrants to technician at that level but no at the time it was you started on PTS you kind of proved yourself you became accepted by people and then if they thought that you could do front line work you then got taken on, so luckily within 5 months I was given a technician course (s right) so I went on quite quickly

Respondent A1

Childhood difficulties

but they didn't have a good relationship my parents didn't and their still together now but they didn't get on, mm they used to fight a lot they used to argue a lot …ummm it wasn't a happy a happy home my sister was a bit of a a bit of a nightmare (S. yeah) but this is this is… probably I don't know if the ambulance service seems to attract people who haven't had this smooth loving kind of…whether it attracts people who have got problems as such I don't know but I mean my dad he ran a business and he had a very outwardly very normal life but at home he was an alcoholic (s. right) umm he used to drink quite a lot at night and he was quite aggressive towards my mum and to us (s. uh huh) but …outwardly…to everyone outside of the house he was a normal man with a business and had a family you know (s. so you grew up with a bit of conflict in the family) yeah yeah yeah totally (sounds sad) (s. that's interesting isn't it) yeah yeah umm we came out very differently my sister went off the rails, she's older than me shes 37. She went off the rails completely and has only now just settled down she became an alcoholic (swallows) and she had lots and lots of problems and issues (s.ummm) and she's only just settled down and she's just finishing her degree

Respondent A1

Childhood difficulties, career and hardness

a. umm you find a lot of us we all went out on a works do a little while ago and had a few drinks and stuff and we were all talking about it there and there were so many of us that were in this group out who had had awful or what could be deemed as awful upbringings.

s. right in the ambulance service?

a. yeah

s. maybe it attracts you?

a. I think so I do honestly think so yeah (s. the conflict and the kind of …) hardness.

s. the hardness?

A yes because were quite hard probably not underneath (s. yeah) but exterior this kind of you know go to things and you think 'you take me on them' (laughs) (s. right) you know the hardness and maybe I think that's why I feel very vulnerable working on my own now it's the safety side of things that scares me (s. yeah) and it didn't really scare me before maybe that's the thing that's put me out of my comfort zone (s. right) and ive realised that actually I'm not that hard (s.arrrr) maybe

Childhood difficulties and a caring career?

a1. I wanted to DO something where I felt ..I had a social worker in my teens (s.ummm) because my dad used to be quite aggressive towards us (s. yes) and I was placed on the at risk register when I was 14 (s.uh huh) and I had a social worker for those last 2 years at school and I don't know whether it was from that I didn't want to be a social worker because I thought she was a pain in the bum to be honest laughs (s. yeah) but I wanted to <u>do</u> something …that, not help people that sounds a bit…(s. yeah) do you know what I mean (s. I know what you mean) that sounds a bit fairyish doesn't it not that I wanted to do something …in that kind of caring sort of (s,umm) and then I went to do the pre nursing course , the diploma and I thought emm I don't know whether I want to stay on ward and actually I fancied the ambulance service (s. that was your BTEC wasn't it) yeahhhh.

Respondent A1

Wanting to escape childhood difficulties

a. I always worked I was very independent even through my childhood I was very independent I never counted on my parents for anything (s. right) never ever wanted anything I used to have this ambition when I was young that I was going to London I was going to run away to London (laughs) I remember being about 12

and thinking that's where im going to go im going to go to London (speaks quietly) laughs ha ha I don't know why ha ha I don't know why I couldn't imagine anything worse that living in London now but that was my I don't know if it was an escapism thing I don't know (s.ummm) I don't know but …..

Respondent A1

Gender

s. Allright then, oh that's interesting in a kind of very (A, macho) macho blokey way, yeah but we do have to be quite macho and in a certain sense when I said to you earlier this is how they looked for something in females as much as we can look very girly and we can turn on the girly charm and everything else we are actually quite boisterous and quite macho (s, right) you can stick most of us in a room with a few pints with the lads and we can be one of the lads and it seemed to be this was the kind of females I don't know what you call us geezer birds or something like that I don't know there was kind of this this macho ness about us even though most of us are quite slight and everything else were not big muscley things but it seemed to be that that was they way (s.oohhh) they didn't take on soft women that were softly spoken and do you know what I mean (s. oh they took on sort of ……?) more boisterous girls then is the only way I can describe it weve all talked about it amongst ourselves quite a lot of us that will sit and watch the football and stuff like that and kind of be one of the lads and it was almost like that was the kind of females that they were integrating into the service when they started taking females on.

s. that's interesting umm just wondering eh going back to your kind of life story maybe if you could tell me a bit about kind growing up and the family that you grew up in then cos that might link in I don't know dunno if it does

a . well I was a bit of a tomboy I suppose my

s. you were a bit of a tomboy

a. yeah my dad had a garage when he was working he had a motor spares place and a mot station and stuff and I used to used to work down there a lot with him so I was quite tomboyish but they always wanted a boy. They made it clear because ive got an older sister they made it very clear that they wanted a boy and they were a little bit disappointed when another girl came along. Laughs (s. oh really!) yeah (s. and you felt that growing up?) oh yeah we were told it growing up (s. you were told!) laughs yeah yeah my dad used to call me XXXXbecause he wanted a boy and they wanted to call him XXXX you see so laughs they used to call me XXXXX when I was growing up, he used to dress me in overalls and take me to

work with him and things (s.did he??) yeah desperately trying to make me as boyish as I could possibly be (S. its fascinating isn't it) it is yeah (s. well there's a link isn't there)

respondent no 1

Attitudes to women early on in the service

a. well most of them had been in ohh 30 years 20 or 30 years and they'd em they didn't like women in the ambulance service because obviously when they joined it was just men (s. yes I remember that) yeah women couldn't lift and women couldn't do this and women couldn't do that and you kind of had to really prove yourself to them emm some of them accepted you some of them didn't there were some and you'd go in for a shift and think 'oh nooo im not working with them oh god' laughs (s. yeah)

ECP role

a. well there not umm in XXXXX they cant spare us they don't have enough resources to spare us from off the road from doing emergencies and doing cat As to doing crew referrals and trying to keep people at home which is what were supposed to be doing…(S. yeah) so they've now decided that we ..they literally keep us on standby in our cars 24/7 and were just doing cat As and dealing with drunks and things like that and I didn't ever do the ECP role to do that on my own …(S. no) if id been told that that was what I was going to be doing on my own I wouldn't have done it.

s. so you'd rather be in a double manned ambulance to do that

a. yeah yeah emergency stuff yes..its just not safe

s. so in a way you are doing the work of a double manned ambulance but on your own in the car. A- yeah.

Respondent A1

a.Yeah I think (sighs) I wouldn't if I had the choice between working on a ambulance or working in a car as a paramedic id choose an ambulance every day emm but the ECP role the way we were told it was going to work and the way its working in XXXXX is completely different I mean it works in XXXX differently to us the guys in XXXX are used differently to us if I …that role itself is a fantastic role, all those extra skills we took on I mean the extra training and everything it is a brilliant role, you know being able to go and treat people at home you know prescribe and you know even if they've got a lack and you go and suture it and then go back a few days later and go and check on them what a brilliant role its like community nursing isn't it

s. it is isn't it

a. and referring them ..directly …to places

a. yeah its such a fantastic role and I think that's why I don't want to go backwards to.

s. yes cos you've got more skills

Respondent A1

8 minute target fudging the figures

A2: yeah, you can still wait half an hour but that's not as bad as over there where you would wait an hour and a half with somebody who's dying, you know, it's

Safety

a. its quite scary (s is it?) yeah I feel really unsafe…umm its worse I umm people think oh surely if you are called to drunk and they are in the street that's quite scary but not as much as pulling up outside someone's house and not knowing what's going on inside the house else down a dark street somewhere we don't get many details were not told many details of the calls so sometimes you pull up you don't know what's going on and your expected to venture into the house and find out (S.umm) umm and I just don't think its very safe ive got a (child) and I want to be able to go home to XXXX after a shift and so (s.yeah yeah)

Respondent A1

A yes because were quite hard probably not underneath (s. yeah) but exterior this kind of you know go to things and you think 'you take me on them' (laughs) (s. right) you know the hardness and maybe I think that's why I feel very vulnerable working on my own now it's the safety side of things that scares me (s. yeah) and it didn't really scare me before maybe that's the thing that's put me out of my comfort zone (s. right) and ive realised that actually I'm not that hard (s.arrrr) maybe

Respondent A1

a. yeah sometimes you'll just get a line on your screen that says 25 year old male drunk (s.ummm) and you think what do they want me to do? Laughs. Why are you sending me a single female to a 25 year old male whose drunk, what on earth do

you want me to do he’s on a third floor flat on his own why has he called an ambulance you don’t get any of these details and when you ask for more details your told oh we haven’t got any.

Respondent A1

I think so there were another couple of things that have happened like with safety aspects and my friend was assaulted who works on a car as well he was assaulted quite badly and there was a whole catalogue of errors that led to him being assaulted he shouldn’t had been sent to this job he was sent to and they didn’t tell him the patient was aggressive and everything else and he (swallows) got got almost strangled really so (S. did he) and he was hitting his emergency button for help and control ignored it control just completely ignored it and emm that was another one where I thought …oh gosh you kind of think your protected even when your going into these jobs but actually your not at all so yeah I think 2 years ago if somebody had said to me then cor would you ever leave XXXX I would have said no no ill be here until I retire but these things there’s a catalogue of things I suppose but these were the things the only things I can pinpoint that have made me say no actually I need to get out now. I need to move

Respondent A1

A2: Still the same. I had a discussion with my partner we went out last Friday and he doesn't really understand it and I was trying to explain it to him. And it's worse now because. It's better that I don't work nights. But It's always worse in the winter. When it gets dark, the job changes. It completely changes. I mean, you can go to a house that in the daytime, you'd pull up outside and think wow, what a beautiful house, this is going to be quite nice, it's going to be a pleasant job. You can just tell or they're going to be pleasant people. You pull up at the same house in the dark and you immediately think, oh that looks a bit spooky. And I want to get out. I always drive around with the doors locked. There's little things – I'll walk up to houses and I'll keep the key sticking out so if somebody jumps out to attack me, I can jab them with the key. Isn't it funny, you know

Sue: you're on your own aren't you? That's why.

A2: I feel very vulnerable

A2: Yeah in the middle of the daytime about 8 weeks ago probably, no maybe longer because it was warmer. I just got called to a man in his 50s. He was fitting, no but he wasn't fitting. When I got there, I got out of the car and it was a fruit picking place with a lot of Latvian workers. They said, 'oh he's around there. He's going crazy.' I thought maybe they meant because he's fitting. I went behind the

building and he just ran at me, pushed me out of the way and started punching my car. He's completely naked, completely naked. Nothing on at all. Something had gone wrong with him, I don't know. They still don't know what it was. We've since been called back to him with the same thing again.

A2: well I started having students out with me now because I feel it makes me feel a bit safer as most of them are about 19 years old and about 6 stone, (laughs) it probably wouldn't... You just feel you've got that backup don't you. Two pairs of eyes are always better than one. Um so yeah that's not on every shift but I think that helps a little bit. But yeah I don't know, I did think a few weeks ago actually I don't want to be on the car any more. Is it worth it for keeping band 6 just to you know being on the car just to keep band 6 and everything else or should I just drop back to band 5 and go back on the ambulance?

Lack of support following traumatic jobs

a. yeah yeah it is all about times, last year this was probably the turning point for me after I decided its just no good last year I went to a suicide and emm it was somebody who jumped out in front of a train and I'd been to him the day before as well he was a very disturbed young man he'd cut his own finger off the day before and he'd been taken in he'd been arrested on the scene actually because he'd got quite aggressive with the police he was arrested he got taken to hospital emm and then the next day he discharged himself from hospital and jumped out in front of a train ..obviously he was dead but I went to that and I asked for a crew to come and back me up now I knew that I didn't need a crew to help me do anything to him because he was going to be dead… you know people don't survive jumping out in front of a trains very often (S, no no) em so I asked for a crew got questioned why I wanted one I said I need them for support because I didn't want to go to that on my own I wanted a crew with me to support me really because if there's body parts all over the track you just want somebody it's not a nice job you want somebody with you so eventually they did decide to send somebody, after the job the crew got taken off the road for an extended break so they could talk through the job and debrief each other I got put cos I'm in a car straight back on standby on my own so I had no debrief no one to talk to after the job it was just literally the crew ..you go and have a cup of tea and a bit of a chat about it and when I went clear they said if you can go straight back to where you were on your standby point.

Respondent A1

Impact on mental health

a. yeah yeah its was kind of diverting away from umm but umm I was ….for that ummm…… 6 months to a year I was scared of the dark, I woudn't walk the dog in the dark, wouldn't sleep without the light on (s. right) didn't like closing my eyes in the shower, that's how bad that had got from these jobs (s. right) and even now 13

years on I could still tell you what each one of them was wearing (s. yeah) and you know it's all those things that they don't go away but you don't have the same feelings when you think about them it's almost like you numb off to it somehow.

Respondent A1

Impact on mental health – Dreams PTSD

a. I didn't …for 3 nights afterwards I dreamt about it which is unusual because I don't usually but because id dealt with the guy the day before

sue shuts the window as noise outside

Note following a difficult job in which children died talking about a colleague

Sue: so he was involved in such a traumatic job. How has it affected him?

A2: um I mean he's been in so long that he's very much, well he's sane. He seems to manage very well with things but actually (laughs) that's probably not true because he tried to hang himself about 2 years ago. So it's probably not true actually. (laughs)

Forming an attachment with a patient seems to impact more

it was completely different (yeah window shuts) there was a bit more of an attachment I didn't know it was him when we walked up the track we got there were little bits obviously I don't want to go into it too graphically there were little bits and then I looked at the jacket and thought ohhh is it and then we saw his hand further off down the track and the bandage had come off his hand and his little finger was missing so that's how I realised it was the guy id been to the day before cos obviously everything else was smashed to bits (S. yeah) so there was just this jacket and his finger was missing and the police that were there was the same police that had arrested him the day before so I said that's the guy !! from yesterday (s.ummmm) and they said it is and then they found further down the track his hospital band with his name on. So yeah so that's

Forming an attachment affects emotions

a. isn't it funny how you can do that with something that's really awful you can go to something that's really awful or you can have something really awful going on in your private life and you can shut off to it and carry on the outside world you know you may feel like your completely dying inside but to the outside world you can put on this complete front cant you you know everything's fine but something very little will make you feel very emotional I had a little old couple who sat in the back of the ambulance and they were in the 80s shed broken her hip and we were taking her into hospital they'd never been apart since they got married (s.right) they'd never

spent a night apart and they held hands all the way in, in the back of the ambulance and he cried and he said ive never spent a night with out her (s.ahhhh) exactly it made me well up (s, I know …I felt tearful!).

a. isn't that funny I can go to somebody whose died and the whole family are crying and I can shut off to that completely (s yeah) but …this little old couple that had never been separated made me well up the same as its just done (to me!) isn't its funny

I felt quite tearful here ? projective identification

Respondent A1

Need for debriefing of some sort

a.it was I mean these things its not so much its not so much seeing it I think we kind of..you kind of expect this when you join the job you it's the things like that that don't bother you so much its …….i think it was just this complete ……lack of having anyone to talk to ..about it (s. ummm) the oh you just go back on standby then and I sat and I thought ummm so im just going to sit here on my own and think about it now and that's that was just the way it was so I went home and you know you try to switch off and push it to the back of your mind and I dreamt about it and the next morning it was the first thing I thought about when I woke up and then when you go to bed it's the last thing you think that went on only for about 3 days (s.ummm) but its still the first job that comes into my mind if someone says oh name something really horrible you've been to recently …that would be the first one. I mean that was over a year ago now so . (S. umm) and its bizarre that that's you know I think if I'd gone back with the crew and chatted to the crew had a little bit of banter and a little bit of er it's not a laugh at someone else's expense but something else comes out other that the morbid bit of it (s. yeah) then you remember that rather than the job itself (S.yeah yeah), if you know what I mean so yeah I think that was the turning point for me last year where I thought I don't know if I can do this now on my own in a car without any support its very difficult and to be actually questioned why you're asking for support on a job well you sort of think oohh because it's going to be a really nasty job and I'd rather have somebody else with me, than go and do this on my own and you know the police are there and network rail and everyone is there but it's still not the same they are not your colleagues (S. no….i think that must be really hard to have…so that was the turning point that made you think right) I think so yeah (s. you've had enough now)

Support from colleagues

I'm just interested cos the other guys had some support then what kind of support did they have?

a. they just chatted between themselves they didn't have a debrief no official debrief (s.ahh right) yes this was the thing that made me do my dissertation on debriefing because I thought that's really interesting emm they sat together emm on station they went back to station there were a few other people there they had a bit of a chat and a bit of a laugh and everything else. And I think this is the the peer support debrief seems to be better than anything else than going and sitting with somebody else who doesn't do your job and tells you that you know (s. no, the peer supports really really helpful) yeah totally totally (s. a bit of time off road they have time off road) yeah yeah (s. and you didn't) no they got I think they were due a 30 minute meal break and they got taken off the road for an hour (s. right) emm so they could (s. only and hour?) Yes laughs only an hour but that's quite a long time in laughs in ambulance service terms you know so yeah so they had an hour of just kind of sitting down and having a chat and err (s.ummm) …but they were due for a break anyway but they just left them alone for an hour but um yeah (s, interrupts do you know if that helped them?) yeah yeah I did speak to one of them cos she backed me up the day before with him as well so it was quite bizarre that there were 3 of us that had been to him the day before and umm I did speak to her afterwards and she said she was a little bit shaken by it ..but em she seemed to be a lot better (s. yeah) than I was but then you don't really delve very deep we never delve deeply into each other unless they are very good friends (s.yeah) we don't really say "oh you know were you affected by it and stuff because it just seems to be one of those things we just don't do (s. you don't talk about anything) no no not unless it's a very good friend and I think in the whole service you can probably have very close friends on one hand cant you the same as life in general umm and I know a couple of people if they went to a bad job id quite easily ring them up and say are you alright? (s.uhhh) are you feeling alright about that? Have you dreamt about it or anything but on the whole we don't we just kind of say oh that was horrible wasn't it ok (s. that was it) laughs yeah (s.ummm) I think that pretty much what we how we do it – strange maybe it will come back to bite us on the bums one day I don't know (laughs)

Respndent A1

Mangers responses to support

a. yeah yeah definitely I mean we have, they send officers out sometimes but there not trained in debriefing or anything (s no) they just send them out they turn up, stand outside the hospital have a cigarette and say "Allright then!" laughs (s. what is that is that your experience then of it then that and it kind of "alright then" rather than a kind of "How are you feeling?" or or and does that help..or) No no not at all, no most of the time you want them to go away laughs (s. you want them to go away because?) because there our officers, there management and we feel that there just there to hurry us up to get back on the road really (s.right) because

if you've had something that's nasty and your cleaning up the ambulance and things like that cos quite often on the cars well go in with the back of the ambulance with someone whose poorly and quite often we just get the impression that thy are just down there to gee us up because control want us back on the road laughs (s. oh right rather than a real support) yeah (S. oh that's a shame isn't it) it is yeah yeah and they kind of my friend went to a cot death not long ago and they carried the baby in and one of the officers turned up there and he said to one of the girls that was at the job "Oh you didn't touch the baby, then you didn't handle the baby and she said no and he said oh right ok so who did then and he was only interested in people who had handled the baby and it was kind of but she saw it as well, you know she was there she was present she saw it as well (s. yeah)

s. and what did he do when he did find the person

a. "ALLRIGHT THEN ! " LAUGHS ALLRIGHT THEN ALLRIGHT THEN ! LAUGHS AND MINICS VOICE.

Respondent A1

Managers response

a. I've got friends who work over there em….it ….huh…I think all ambulance service there all under the same pressure to meet unrealistic targets the same as every hospital is under the same pressure emm I think as far as debriefing goes I don't think it's any better anywhere (s.noo) I think if you get a bad job I think it's pretty much the same everywhere but it very much depends on your manager as well (s.yeah) whether your manager will say oh your off the road for an hour go and sit down cos that's all you need you don't need to have much more than that

s. But they don't do any formal debriefing?

a. no you can go if you choose to you can go to the work counsellors if you choose to (s. ok) but there's no ……most people preferred peer support to formal debriefing.

s. yeah that's what I've find as well actually, but the counselling is that open ended or is it only so many sessions

a. I think it depends what you're going to them with (s. right they'll make a decision) yeah I think one of our girls left a couple of years a go she had some stress issues and they said they couldn't deal with her it was just too much for them so they sent her on to someone else but she then had to pay for that (s. right) she ended up leaving in the end she couldn't deal with it (s. ok yeah) but emm.

s. so they're there, so you've got that and you've got an hour of the road and emm.

a. if you're lucky!

s. and the 'you allright?

a. if you're very lucky

s. if you're lucky

a. yeah

s. yeah

Respondent A1

One traumatic job to the next !

a. I got pulled away from a hanging once because there was a cardiac arrest down the road a 42 year old cardiac arrest down the road so they just said 'are you doing anything at the hanging' I said 'No' so can you go to the cardiac arrest instead you kind of get pulled away from one horrible job straight in to another horrible job, you know…

Respondent A1

Boredom

s. how do you find that then when you sat in your car for hours on end?

A bored!

s. really

a. bored stupid! Absolutely bored stupid and there is nothing that makes me more angry than boredom! (laughs) its bizarre isn't it that's the emotion I get with boredom I get angry (s yeah) it's a funny emotion to have with boredom but

s. I wonder if its cos you've got time to think and it's coming out

a. maybe

Respondent A1

Anger and projection onto others

s. you know maybe the other stuff is too big and and that's why you shut down really. So if there's this kind of shutting down of the big stuff, do you think it comes out any where else or ?

a. ummm. A couple of years a go I would have said no I would have said oh no were completely normal and yet the stss stsss, what we do now id say a couple of years on id say that it manifests itself as anger, I think because I've noticed in the last couple of years that I just get really angry (s. uh huh) about really irrelevant silly little things and even sometimes my partner will say to me "why are you letting that wind you up?" you know it really doesn't affect you why are you letting that wind you up (s yeah), just because it does and then I think actually he's right its completely irrational the way I'm behaving about that its completely irrational (s. yeah yeah) and I think this is what made me think well ok I need to leave and go somewhere else. Whether it's because it's because of the things that are going on in XXXX or whether it's just because that's how it manifests itself in you I don't know, I don't know you kind of em take that emotion I suppose, shut off to it and then you direct it at something or someone else maybe (s, ummm) don't know.

s. so what kind of little things would get you angry then?

a. ohhhh…….im trying to think of something recently but …. We have a student whose doing some placements with us at the moment and she's, she's got a bit of, a bit of an attitude type of thing (s. umm) I know this I know that she's only done one module at XXXX So far and she was sent on placements to us and there are a few of us that have been really really wound up by her (s. yeah) can't put your finger on anything in particular that's shes shes done she kind of picks out things the older technicians are doing and says 'Oh your doing that wrong, your doing this wrong' and (s.umm) exactly that makes me really angry because I think how dare you tell my colleagues that have been doing this job 15 years that there doing it wrong, you've only done one module you know and that got me really wound up and she's on some bodies facebook site or something and shed put something about 'is going out for another 12 hours of saving lives' and thaaaat wound me up to a point that its really silly isn't it I'd kinda directed this anger at her, - How dare she she's not saving lives she's shes not doing this we don't go out for 12 hours saving lives and drr drr drr shes just showing off to people (s, yeah yeah) and in the end my partner had to say why is that affecting you, why is that bothering you? (s yeah yeah) and I thought well it just is – were fiercely protective over what we do blah blah blah and then I thought actually he's right it doesn't affect me why is it bothering me (laughs)

Respondent A1

NOTE EG OF PROJECTION

Anger, militancy and change

a little bit militant against …well you start fighting against things instead of just accepting change and going with the flow, when you start getting angry by change …maybe its stress reaction I don't know but it's when I'm going home and I'm feeling so wound up …because I can see that things are being done so wrong

(s.umm) then to me it means I need to ..perhaps …change, I need you know I can't fight these things I'm not going to be able to make any difference to the decisions that are made by the powers that be and everything else so I think therefore it's when I get something…I can remember when I first joined I worked with as I said with a lot of old the old boys we used to call them and they were very militant and they were very much ' uhhh I don't like change now we've got these new stretchers which were brilliant because they helped us with our backs but they wanted the old ones that they've always been used to you know (s. laughs) and I can remember saying then gosh if I ever get that bitter and twisted it's time to go and over the last couple of years you can FEEL it creeping up on you, you don't really notice it but you kind of feel oh couldn't you you hear yourself sometimes .you think I've turned into one of those old boys you know (s. yeah..) whose kind of moaning and everything else (s.yeah) and I don't feel that ..I'm not getting any job satisfaction anymore

Labelling patients – a young persons view?

a. yeah yeah I think so yeah, because I do hear with this student paramedic programme where people come in directly as paramedics now and I do hear a lot of them are very young and I do hear a lot of them talking about things and calling them 'oh I've been to a domestic scrotes' and things like that and actually you know they're not they might be very nice people it's just unfortunate that they are in that situation (laughs)

s. they call them domestic scrotes? (a. umm) Oh so their kinda labelling the job as being a bit yuk (a.ummm that's because they don't have this kind of experience, they haven't been through these things themselves. I'm sure a lot of people have (sighs) but I don't know but maybe I felt that way when I was younger when I joined I don't know, I had a lot of suicides when I first joined (s. yeah) laughs we seem to attract certain jobs certain people seem to attract certain jobs yeah my first few weeks on the road I had a lot of suicides and that really messed me up for about a year I nearly left in my first year because I couldn't – they were all young people and they were all hangings and I just could not understand why even after everything id been through in my life why anyone would want to take their life (s. yeah) whereas now after a lot more experiences (s. uh huh) and looking back and speaking to more people and everything I sort of think well actually no I could see why people could get to that situation where they feel there's no other way out now but at 21 I couldn't understand that.

respondent A1

Denial

a. yeah yeah its was kind of diverting away from umm but umm I was ….for that ummm…… 6 months to a year I was scared of the dark, I woudn't walk the dog in the dark, wouldn't sleep without the light on (s. right) didn't like closing my eyes in the shower, that's how bad that had got from these jobs (s. right) and even now 13 years on I could still tell you what each one of them was wearing (s. yeah) and you know it's all those things that they don't go away but you don't have the same feelings when you think about them it's almost like you numb off to it somehow.

s. You you numb off? What what do you mean by that ?

a. yeah yeah you just you we have this amazing ability that if you haven't got it when you join the service you very quickly pick it up I'd say within a year you can make yourself do this and I think anyone could probably make themselves do it – don't know how we do it but everybody in the ambulance service does the same but all the people that I speak to at work about it is that you become an complete emotional shutdown and not just to the jobs you go to but to everything in your own personal life as well, you can completely shut off to anything that affects you in life

s. what emotionally?

a. yeah yeah (s, right) I don't know how we do it nobody can say you know there's a lot of us when we sit in the truck and were on standby and were bored and we have these chats about things and we say you know if something happens to you outside work that upsets you what do you do – just shut off push it away don't like it

shutting down

a and there's quite a lot of us that have been through divorces and relationship break up s and stuff and we just have this amazing ability just to shut down, completely shut down.

s. so shut off to the feelings?

Respondent A1

Type of counselling received from occupational health

s. how did you cope with that then?

a. umm I don't think I did actually at the time – I think em I think in time it just numbs and it goes away anyway I think (s. umm) they say oh times oh healer don't they, I had …….pause we had a mentor err we were assigned a mentor when we first started and he was pretty good he was a laid back sort of chap and he was quite good fun to work with and somebody had said to him oh XXXXX had quite a few quite a few bad jobs, he hadn't picked up on it and I hadn't told him someone had told him and he sent me to the works counsellors 6 months into my first year

on the road umm I (quietly spoken) don't know whether it helped or not really I can't really say whether it helped they you know we have the occupational health people had some counsellors there (s. uhh) they gave me a packet of red dots and told me to stick them on everything and every time I thought about the nasty job I had to take a deep breath uhh it's kind of an avoidance technique I suppose where you you've got red dots on everything you stick it on the microwave the fridge the mirror everything you look at the steering wheel of your car everything and every time you see a red dot you take a deep breath in through your nose out through your mouth and it is quite relaxing and I suppose it does work to a certain extent so you stop thinking about the horrible thing and you start thinking about breathing instead (s, umm ummm)

a. the only thing I can say now is that I think it's an avoidance technique and you're not actually (laughs) dealing with what's gone on….i don't know..

s, I suppose it's that kind of umm …kind of stress they're kind of trying to stop the panic.

a.maybe

respondent A1

Attitudes to vulnerable patients

but em yeah …they did they used to get very angry if they were given a job they'd get very angry, they'd get angry at the patients, they'd get angry at everybody really and the patients I've lost a lot of my compassion (s. have you?) whether this is compassion fatigue or what have you, if I go to somebody whose truly ill and worthy of compassion (s yeah yeah) then they get it you know and I'll spend all the time in the world looking after them, all the time I can looking after them. Other people whereas I used to go in and have a bit of a laugh with them and say 'ohh what have you called us for this time' (s. yeah) now I'm angry straight away with them (s. are you) your wasting our time don't you realise this is this this is this (s yeah) you know and I don't know whether that's a bad thing or not but….

s. so what kind of patients would they be then?

a. oh our regular patients (laughs)

s. your regulars.

a. laughing – our regular patients that call us for absolutely nothing – you know recently one of our regular patients called because she wanted to know if there was anyone in next door (s, right) laughs

s. so you get people who ring and ring and ring constantly

a. yeah oh yeah 10 times a day sometimes

a. for some reason the ambulance service thinks they have to send an ambulance every time I don't know if there's a legal loophole to say to go or not to go or not you know (s. yeah yeah) yeah that used to make me laugh and I used to go out and have a bit of a banter with them a bit of a laugh with them you know (s yeah yeah) I can remember going to this particular regular a couple of years ago and doing her washing up for her just saying 'oh look at the state of your kitchen, hang on I'll give your cups a wash for you' laughs whereas now I don't enter over the doorway " what have you called" for as soon as they say what they've called for its duddle duddle drrr and off I go laughs (s right) so I seem to have lost my patience there completely, completely and drunk people who you know just won't take responsibility for themselves as such that they used to not get wound up about but I do now.

s. so drunk people regulars any others

a. emm we have the usual calls where people have just called 999 instead of their doctor because they don't have credit on their phone and things like that emmm no I think that's really the ones that really wind me up or people who are doing it for attention or sympathy (s. umm) you know I've taken and overdose I've taken 10 paracetamol and I want to die that sort of thing (s.ummm) but you can't say that they don't feel absolutely dreadful at the time and it is a cry for help isn't it. But sometimes I find it hard to muster the patience (laughs) (s. yeahh) I wouldn't say I'm angry with them its more the people that get drunk and lie in the street and just won't get up and I think 'oh for goodness sake' emm (s. right) and it's because we know that their using resources that they don't need to use you know, that makes me quite angry.

s. so that's been a change then has it since the beginning

a. yeah yeah definitely

s bits of compassion fatigue towards maybe certain groups of people.

a.Yeah yeah

s. it's interesting the overdoses even though they've only had 10 paracetomol….. cos you….im just trying to think …your sort of .. you know, you went to a lot of suicides didn't you?

a. that's probably why I get angry with the ones who aren't doing it properly (laughs) I don't mean that I want them to do it properly (s no) but that's probably why I feel 'oh for goodness sake' because in my experience now is that people who want to go and do it don't tell anyone (s, nooo) they go and they take themselves off into the woods and they hang themselves or they'll wait till everybody goes out and then they'll do something (s. umm) emm not the ones that take tablets and 5 minutes later there on the phone to their best friends saying 'ohh I've just taken an overdose' and you know that sort of thing.

a. apparently in sweden or somewhere Sweden or Norway they actually give them leaflets on how to commit suicide and their suicide rate is really low (laughs).

s. what in sweden?

a. somewhere in Sweden or Norway or somewhere they actually given them little leaflets on this how you commit suicide and their suicide rate is really low because they just won't tolerate this you know I've taken a very small overdose that's really not going to do me much harm to yeah (laughs) it would be great wouldn't it if we could hand out that leaflet saying right if you want to overdose you need to take these (laughs / chuckles)

s. that's amazing isn't it that they do that?

A, yeah

s. ummm are there any other groups that you find particularly ……annoying

.a. no I don't think so

S so what would you classify as a kind of patient that's kind of worthy if you like then (weve got 15 minutes)

a.Someone's whose ill

s. do you get many of those jobs? The really sick people

a. yeah there not as …..yeah yeah we do

s. yeah

a. 60 / 40 very ill if they took the time wasters as they are labelled – fairly or unfairly as some of them genuinely think they need an ambulance, if they took that part of our job away we'd be relatively quiet.

a. the booze related incidents and the regulars calling for no reason or because they want their TV switched off and stuff like that then yeah…we wouldn't be very busy

Respondent A1

Relationships with control staff

a. yeah so this this kind of makes me angry as well you know you ring up for back up and you say I need a priority one back up you've got someone whose very ill emm an example of a recent one of a 36 year old with a dissecting aneurysm he just collapsed coming out the bathroom he was very very poorly and because control aren't clinicians they kind of laugh at you down the phone and they said 'oh your 4th in the queue you'll be lucky' and I said if you don't get an ambulance to me this man is going to be dead by the time they come you know he's 36 he's got 4

children here I need to get him to hospital and very quickly I can ‘t do that in my car (laughs) we need an ambulance very quickly but this kind of ‘huh you’ll be lucky’ it’s awful isn’t it and I had to wait an hour and a half for an ambulance

s. for a dissecting aneurysm!!

a. yeah

s. did he live

a. yeah so lucky he lived yeah he did

s. so that a hell of a long time so in a way they’ve fudged the figures haven’t they

a. yeah totally

s. cos you’ve arrived within 8 minutes but you can’t actually do anything and then he had to wait an hour and a half

a. an a hour and an half and he just kept saying he was completely grey. Had no radial pulse couldn’t get a line in cos he was completely shut down and he just kept saying over and over again ‘I think I’m going to die, I think I’m going to die’ I was thinking ‘oh you probably are’

s. and you were sat there for an hour and a half?

a. on my own yep yep

s. so that’s a real misuse isn’t it of the ECP role

a, yeah yeah

s. it’s kinda just to fudge the government figures

a. it is totally it’s just to hit that 8 minute response yeah and they would deem that as a success because I got there in 6 minutes so to them that was a successful job, to me it was horrendous, absolutely horrendous, but we and it was near because it was quite the way out it was out the other side of XXXXXX (s. yeah) emm they we were near the XXXXXX border and I just kept ringing back and saying if you’ve not got an ambulance to send can you not ask XXXXXXXX for some help see if they’ve got one over the border that they could send you know you’re trying to stress to them ’this guy’s gonna die’ (s. yeah) you know we need to get him in and …

s. so the people on the control are not the clinicians?

a. no

s. in the past did they used to be?

s. yeah

s. so do you not think they don't have the understanding of what's

a. no it's a real power struggle between us and them (s, really) yeah huge power struggle

s. are they just general admin type people

a. yeah they are call takers yeah

s. their call takers have they got any training

a. they are trained to use the computer system to dispatch jobs that's it so they look a screen for the red dots for where the ambulances that are clear are

s. so they woudn't know what a dissecting aneurysm was and the seriousness of it

a. no no

s. that must be really difficult

a. its frustrating really frustrating

s. so in the past you could talk to control and they would be..

a. in the past we had paramedics that were coming off the road that had done all these years and wanted to come off the road and kind of like wind down sort of thing and it was always the done thing that you could go into control towards the end of your career

s. oh right

a and I think we've got one person whose retiring in august who he was off the road but even that he hasn't been on the road since I've been in service, he's been off the road a long time but none of the others are ..it's such a power struggle

s. did you find them more supportive then in the past

a. ummm yeah totally oh totally yeah completely different you always then in the past if you had a bad job you always were rung up and say oh do you want to go and grab a cup of tea or ..are you alright now – we don't get any of that now

s. so you don't have that personal relationship

a. no no

s. oh dear

a. they kind of just think that they're in charge of us because they move the vehicles around really…..oh there's people that have got so militant at work now

that they say ‘were not calling them control anymore were calling them dispatch ummm you hear people over the radio calling them dispatch because they just will not call them control (laughs) cos they in control of us!

s. right that’s sense that they are called control but they feel like they are in control of you and you feel there in control of you

a. yeah there’s such a power struggle

s. yeah sounds it

a, and that doesn’t help towards anger as well cos when you get a bad job you then direct your anger at them

s, yeah

a, and it’s not their fault really they are just doing a job that they’re paid to do aren’t they but there

s. can you get quite angry with them then when they are saying on your 4th in the queue ?

a. yeah we’ve had some horrendous stack ups with them over the phone

s. do you

a. yeah it’s pretty much it’s not their fault they haven’t got any ambulances available but we will really shout at them about it

s. uhhhh

a. you do feel a bit bad afterwards and sometimes you do ring back and say sorry some I don’t ring back and say sorry as some of them do it on purpose as a bit of a laugh they’ll send a vehicle off on an urgent pick up to transfer between hospitals instead of sending them to you and stuff

s. so they do the wrong the wrong kind of job really

a they don’t have any qualifications or anything else they’re 19 year olds that have been plucked off the street to do a job

s. that must feel really quite difficult actually must it.

a. ummm it’s frustrating

Respondent A1

The impact of doing academic studies

A2: yeah. You get the bug don't you? You do. And it's nice now. There's so many people in the ambulance service now who wouldn't have dreamt of doing academic studies before and they're, there really is this big thing now where people are saying, do you know I read this paper the other day on so and so and so and so. It's so nice to hear.

Type of debriefing that they want

A2:…….. Do we want debriefing after jobs or do we just want to sit around in a group and chat amongst ourselves? I think on the whole, most people would say, actually I just want to sit with the colleagues I like, the funny ones that would just make me laugh for half an hour and then I'll be all right again. If that is what works, I don't know or do people want debriefing where they go and sit with somebody who hasn't seen what they've seen? You know? It's very difficult to weigh up and I know there's for's and against's with both but I think that most ambulance staff would say, especially people who work on cars. After my child I just got sent on standby to XXXXXX. I thought uh okay, I'll just go and sit in a little building in XXXXXX on my own then, you know, but I got another job on the way so it didn't ever get to the standby point. It's um (pause) it would have been nice if they'd just said, do you want to go and have a cup of tea and see someone or, anything really. A gesture goes a long way, doesn't it? Just a little bit

A2: nothing at all. Because it's more important to have us out on the road than it is to look after our psychological welfare which is what they're not doing really. They're, you know, they're not ensuring that psychologically we're looked after. I know that traumatic jobs are very few and far between really. We don't, people say, oh I couldn't do your job. They could because most of our days are spent picking old people up off the floor or you know. (laughs) the normal, our bread and butter stuff but every so often you get something that you really really sticks in your throat and you just think mmm I would really like to have

Drug errors – support from husband (who works as a health care professional)

A2: a nice cushy job. Yeah (laughs) Oh I wish I'd tried harder at school. (laughs) So yeah. So he doesn't really understand the whole. I did, when I got home, I did say to him that I'd had this job with a child and there's a lot more to it, there's stuff going on. It was actually in a minor injuries unit and they'd sent me around because it came through as a Cat A. They don't have a doctor in the minor injuries unit. They have a nurse practitioner though but she'd given an adult dose of diazepam. (lowers voice)

Sue: oh right that's why it was a bit flat then.

A2: yeah yeah. So I was quite angry about that as well.

Sue: did that get followed up?

A2: I don't know. It probably will do. Yeah. She'd given 20mg.

Sue: Did she realise what she'd done?

A2: No. I don't think so. (Sue: dear God) No I don't think so. But I feel angry with myself. Because I thought why didn't I say something to her? Because when I got there, she said she's had twenty. The child was fitting, came in as febrile convulsions. But she'd been fitting for about half an hour. So she was really going for it. And when I got there, she said “I gave her 10mg diazepam PR 10 minutes ago and she hasn't stopped fitting so I'm just going to give her another 10.” And I'd just walked in and you know, I thought, wow you give her a lot more than we do. And I didn't think to say to her, it's too much. I just assumed that they give more than we do because I don't know what their drug protocols are. But then I felt really angry with myself about that because I thought ooh, why didn't I, if I was thinking it, why didn't I say it? Cause I'm usually so dadadada.

Sue: probably, her assertiveness probably confused you. I've done this. I'm going to do this.

A2: It's their domain as well. Isn't it?

Sue: It's their domain as well. So I wouldn't beat yourself up about it.

A2: I did feel quite cross with myself. I did go home and I spoke to XXXX about it. He just said, oh don't worry about it. The diazepam will wear off. It's more

important to get on top of the fit. And blah blah blah and I thought that's actually true.

Sue: so having a XXX for a partner is quite supportive then isn't it?

A2: it can be.

A2: yeah yeah sometimes I do go home and say would you have done that? Did I do the right thing? And he's quite good actually. He's very blunt. He's a XXXXX He's very blunt so he's very kind of, (puts on XXXXX accent, deep voice) “oh no I wouldn't have done that. I wouldn't have sent him in.” (laughs) that type of thing. He's very good for talking those things through with but he's not very good at talking about feelings. He doesn't understand if I say, “that really upset me. That wasn't very nice. That wasn't a very nice job.” He doesn't really get it and I don't know why. Because he's done A&E. He's been an XXXXXX He's done lots of stuff. None of it seems to bother him. Maybe it's because he's a bloke. I don't know. (laugh)

Effect of the first interview – feeling emotional

A2: No. No. but last time, I came and spoke to you, I felt like I'd had a really in depth counselling session.

Sue: just with the interview?

A2: yeah. Yeah because I'd talked about all these things, about my family and past. If you don't bring it to the surface, it doesn't ever come out. Does it? It kind of stays in there. And because we'd talked about it, I felt really quite emotional when I left. I felt really kind of oof, almost drained. You know gosh and then I really and then you kind of have this guilt that you'd talked about things. Why on earth would anybody want to know about all these things that you just ooh they're just ooh things that you shouldn't talk about.

Fed up with the job wanting to leave

A2: yeah, the main reason is that I've outgrown it and I want something more. I want something better. I want uh. See I say I don't want shift work anymore but then I don't really want to work 9 to 5 Monday to Friday either so there is, it's kind of. I've never really worked 9 to 5. I think that would drive me mad as well. So I

can't really put my finger on exactly why I want to leave. I just feel that I'm not feeling it with the job any more. I still have good days. I still go home certain days and think I can do this, and I quite enjoy this, I had a really good day today but on the whole I don't get those days any more. I feel no excitement about jobs that come through. I used to, I used to get that kind of adrenaline rush and think, “Oh Brilliant,Going to a cardiac arrest. Yeah yeah brilliant” Now I just think oh, can't think of anything worse. It's awful isn't it really. Because we turn up for people, they look to you to do so much, wave your fairy dust in the air. It's all right, the paramedics are here now and inside you're just thinking, “it's not.” (laughs) It's not all right because I don't want to be here. It's awful

Appendix H - Themes occurring across all respondents

A to G = respondent identity, numbers = page numbers

Theme	A	B	C	D	E	F	G
Initiation into the service	1						
Why choose this career? Childhood difficulties Childhood difficulties – reading Left police force because of an aggressive sergeant Struggled being a mum difficult relationship with own mother	1	1-2	yes	1 4	1		 1 1
Childhood difficulties, career and hardness	2						
Childhood difficulties and a caring career? Why wanted to go into the job Being noble to make up for a difficult childhood Thanks from the public Why choose this career to ? resolve old hurts? Edgy early life – edgy jobs, unpredictability	2	 1	 3 6		 1	 5	
Wanting to escape childhood difficulties Not fitting in similar to early life – on the margins Why did you go into the ambulance service? Linked to early life Burying things – but parents split up at 16 !	3					 2 8 9	

Gender **Attitudes to women early on in the service** **Strong male role models for ambulance service** **Mother as a role model (mother studied late in life)** **Hard working role models** **Doesn't feel paramedics get good emotional care compared with police and fire service**	**4**			**1** **7** **8**			**8**
ECP role **ECP role** **Misuse use of ECP role** **ECP role meeting targets – Not doing ECP role** **Boredom in ECP role** **ECP role didn't feel confident**	**5**	**9**				**2/3** **15**	**2**
Performance targets **8 minute target fudging the figures** **Performance targets** **Feeling uncared for (push buttons)** **One traumatic job to the next** **From job to job no time in between** **Performance targets rather than emotional needs** **Performance targets gets in the way of providing emotional care**	**6** **15**		**5** **7-8**	**9**	**8**		**5** **8**

Because of the performance targets managers can't treat people as individuals							**9**
Impact on health **Impact on mental health** **Impact on mental health – Dreams** **PTSD** **Mental health following ambulance stolen at work** **Dissociation** **Emotionally detached but good clinician** **PTSD** **Tucking it away** **Tucking away doesn't work long term** **Went to pieces after cardiac arrest when got home** **PTSD symptoms following that job**	 **9** **10**	**3**	 **1** **2** **5** **10**	**3** **2** **7**	**3** **6**		 **4**
Unhealthy Job **Found job stressful** **Not coping/feeling emotional /crying** **Effect on health – physical and mental** **Difficult jobs impacting**		 **4**				**17**	 **2** **6** **7**
Forming an attachment with a patient seems to impact more **Forming an attachment affects emotions** **Flashbacks and forming empathic relationships means they can't shut it away**	**11**	 **5**					

Not wanting to get emotionally involved **What upsets – making a connection** **Jobs impact more if there is an emotional connection i.e. had a child same age**			**3**			**5**	**3**
Debriefing **Need for debriefing of some sort** **Difficult jobs impacting** **Lack of support following traumatic jobs** **Debriefing** **Type of debriefing they want**	**11** **9** **28**	 **4**	**2**			**5**	
No support no debriefing		**5**					
Support from colleagues **Talking to crewmates a helpful support** **Prefers to be in pairs and not working alone** **Where does she get support from – crewmates and good line manager** **Lack of support at home as wife grieving**	**12**	**8**		**2**	**3 7** **8**		**7**
Mangers responses to support **Supportive manager** **Good help from management** **Support from management and attachment figure (as has young children)** **Fear of cardiac arrests linked to lack**	**12-14**	**10**	**4** **1**	 **7**			

of support **Bullying management** **Not supported** **Weak management** **Where does she get support from – crewmates and good line manager** **Spending a long time working with someone for 12 hours** Management culture **Changing cultures** **Management culture / targets treating you like a kid** **Mangers needing to meet their targets changes their mindset** **Having different values than the managers** **Difficulty with the management role** **Tough management approach**					**4** **6 7** **6** **7** **8**	**9** **1** **1** **13** **14** **14**	**1** **8**
Boredom	**15**						
Anger and projection onto others	**16**						
Anger, militancy and change **Moaning and burnt out** **Hates rudeness** **Public being rude and abusive**	**18**		**11**	**4** **10**			
Caring and uncaring **Labelling patients – a young persons view?** **Attitudes to vulnerable patients** **Compassion towards patients with**	**18** **21**	**2**					

mental health problems as a result of early experiences. Caring attitude to vulnerable people Annoyed with falls Good at some things cannulation and caring 2 types of paramedics Has other skills that others lack Giving empathy Doesn't like injustice – caring important			3	4	4 5 5 7	12	7
Dissociation as a coping mechanism Denial shutting down Using distraction to cope Connecting with people very briefly Good at burying things The short term nature of connection compared with looking after people long term Non-committal Being hard as a way of coping	19 20	6-7 9				9 10 12 12	9
Not sure whether it's a good or bad thing (detachment)						20	
Type of counselling received from occupational health	20						

Counselling and HR **Counselling helped** **Experience of occupational health** **Fear of medical records** **Need for structured counselling not just lip service**			**10**	 **7**	 **2**		 **4** **5** **8**
Relationships with control staff	**21**						
The impact of doing academic studies **Improvement with paramedics being taught in higher education** **Doing a degree made up for previous academic problems**	**28**		 **9**				 **6**
Support from family **Drug errors – support from husband** **Support from mum and dad** **Supportive partner who was in the services** **Supportive husband** **Close friends in ambulance service provide support**	**29**	**4**	 **10**	 **4 10**		**18**	
Effects of interviews **Effect of the first interview – feeling emotional** **Interview may bring things up** **Interview brought up a long standing depression**	**31**			 **7**	 **6**		 **7**
Fed up with the job wanting to leave	**31**						

What helps **Coming off road for a break**		**9**					
Changes unpaid meal breaks		**9**					
Resilience summary **Personal background giving resilience** **Part time work being a saviour** **What makes you resilient – compartmentalising**		**10-11**	**10**	**10** **4**	**9**	**19**	
Kit missing **Lack of equipment**			**6**	**9**			
Use of alcohol **Guilt not talking and alcohol**			**7**				**5**
Organisational issues: **Feeling uncared for** **Not feeling cared for by the organisation** **Use of ECAs** **Changes to shift patterns** **Meeting response times with changes to shift patterns – Taylorism time and motion !** **Distress of the changes and not feeling attached to the organisation** **Projection onto the organisation of hurts – no support** **Old way could learn when not so rushed** **Pride in the job blanket folding**			**7-8** **8**	**8** **8** **8**	**2** **8** **8**		**6**

NHS uncaring profit making Changes in technology affects the attachment processes McDonaldisation							6 16 16
Home stuff impacts on job Depression and counselling – antidepressants (linked to biography) Emotional labour How external factors impinge on the job – break up of a relationship Finding it difficult to empathise when own stuff going on				3 4	1	5	
Shame over talking about emotive stuff Shame and hiding feelings Shame and link to mentor vehicle Not speaking about difficult jobs			8	3 6			5
Fear of getting it wrong and fear of cardiac arrests					2-3		
Trauma and Voyeurism – double murder Loving the big jobs Doing the am dram stuff avoids emotion						3 3/4	3

Not having to connect with people because of the trauma **Voyeurism over the trauma** **Some paramedics get off on seeing trauma** **Being detached allows you to do the trauma** **God like and theatrical** **Not enough trauma in the job** **Trauma means you don't have to do empathy** **Car crash – family imploding**						**5** **5** **10** **11** **11** **11** **11**	**5**
Safety – feels unsafe driving but safe due to gender **Feels ok about safety**						**18**	**8**