Paramedics' Understandings of Managing Personal Reactions during Emergency Responses.

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Annabelle Ryburn

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ABSTRACT

The repeated exposure to potentially traumatic experiences is inherent within the field of emergency response work. Traditionally research focuses on *what* responders do to 'cope' with their reactions during emergency responses, and attempts to predict which 'personality types' may 'cope' better with this repeated exposure. This type of research leads to recommendations of 'best practice coping', which are often based on theoretical models of emotional processing and devoid of contextual relevance. This study investigated further than *what* responders do to manage reactions, and sought to understand *how* and *why*. It utilised individual interviews, focus groups and ambulance shift observation to explore how a group of St John paramedics constructed managing their reactions during and after emergency response situations. The study examined how reaction management is understood, and what options are perceived to be accessible when social, historical and cultural contexts are considered. The findings revealed that the paramedics' discursive constructions regarding reaction management related to four key areas of understanding. These areas corresponded to the chronological process of emergency responding. The paramedics' constructions started with conceptualisations of their job role and the expectations that came with it, then evolved through to incident response, post-incident reflection, and finally to support-seeking. The findings across these areas suggest that strategies described in previous research as 'negative' or 'risky' are oversimplifications. These individual strategies often exist as a component of a broader strategy to facilitate functioning in a response situation. It was concluded that the most important element of reaction management for the paramedics was ability to find acceptance for response incident outcomes. This understanding shifted the 'problem area' into the post-incident timeframe and onto issues of accessibility and acceptability of using peer and psychological support to facilitate acceptance. The implications of this research include understanding the necessity for tailored psycho-education regarding reaction management at St John which is both functionally and contextually relevant. Additionally, the research highlights the need to address the 'social risks' attached to support-seeking at the St John organisation.

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"We are what we think. All that we are arises with our thoughts. With our thoughts we make the world". Buddha Dharmapada sutra

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CHAPTER 1

Introduction

Disasters and emergency response situations have been growing in frequency and severity due to climate changes, environmental degradation, and growing world populations. The emergency responders who work in this busy field face repeated exposure to potentially traumatic circumstances, and are frequently in contact with severe injury and sudden death. The potential for the responders to experience trauma is proposed to exist within their own reactions to these events, as well as within their responses to the reactions of the people they assist (Alexander & Klein, 2001; Chang et al., 2003; Ursano, Carol, Vance, & Tzu-Cheg, 1999). The New Zealand St John paramedics are one of these groups of responders who face potential risk of trauma in their job. The job role of St John paramedics has evolved from initially only providing transportation to hospitals to now providing emergency medical treatment for patients both at a response scene, and during transportation to hospital (Hunt, 2009). The paramedics are often the first responders to arrive at an emergency scene, which may be fraught with confusion, multiple casualties, and the highly charged emotions of both bystanders and victims who have experienced serious injury, or just witnessed sudden death. The present study aimed to explore the understanding of St John paramedics about how they manage their own reactions during these highly charged emergency response situations. Additionally, the study aimed to understand the perceived utility of strategies they claimed to use, and to consider the short and long-term outcomes resulting from these choices.

The primary focus of much research on emergency responders has understandably been attempts to identify what factors may be more likely to lead to positive and negative outcomes for responders (Alexander & Klein, 2001; Chopko & Schwartz, 2009; Cicognani, Pietrantoni, Palestini, & Prati, 2009; DeValve & Adkinson, 2008; Stephens & Long, 1999). While the relationship between emergency responders and Post Traumatic Stress Disorder (PTSD) symptoms receives disproportionate academic research and media attention, there does also exist the possibility in emergency response work for positive outcomes (Paton, 2005). These potential positive outcomes are proposed to include enhanced future abilities to ‘cope’ during emergency responses, and improved resilience (Tedeschi & Calhoun, 2004). A large portion of the

previous research investigating positive outcome predictors for emergency responders has focused on personality types and traits (Fannin & Dabbs, 2003; Gohm, Baumann, & Sniezak, 2001; Lau, Hem, & Berg, 2006; Shakespear-Finch, Gow, & Smith, 2005; Wagner, Martin, & McFee, 2009). It is a common suggestion out of this research that a certain 'type' of person often chooses to be an emergency response worker. It is proposed that this type of individual self-selects into the emergency response field, due to their belief in their ability to cope in potentially difficult situations. Mitchell and Bray (1990) coined these self-selectors 'rescue personalities' and proposed that they possess a cluster of unique personality qualities, such as being 'inner-directed' and 'action-oriented'. Research has been undertaken to attempt to isolate these common personality traits, and evaluate similarities between different groups of emergency responders. Comparisons are often made by using popular personality trait identifiers such as the 16 Personality Factors model (16-PF: Cattell, Eber, & Tatsuoka, 1970) and the Five-Factor model (FFM: McCrae & John, 1992). However, studies attempting to uncover common traits for firefighters, ambulance officers, police, military rescue workers and volunteer emergency responders, fail to agree on common traits between different groups of emergency responders, and even within the same responder populations (Dougall, Hyman, Hayward, McFeeley, & Baum, 2001; Fannin & Dabbs, 2003; Gohm et al., 2001; Lau et al., 2006; Liao, Arvey, Butler, & Nutting, 2001; Marmar, Weiss, Metzler, & Delucchi, 1996; Regehr, Goldberg, & Hughs, 2002). These inconclusive results indicate that while a study may claim to have identified common traits for one specific group of emergency responders in one particular role, there may be limited utility in suggesting that there are common traits for the same responders elsewhere, or across the board for emergency responders in general. These types of personality tests lack the scope to encompass the unique experiential picture for different types of responders. The recorded responses will always be limited to the choices available within the questionnaires, which are presumed to provide a broad enough range to capture the experience of heterogeneous responder populations. Paton and Hannan (2004) suggest that contemplating the multiple phases experienced during just one emergency response can create an appreciation for the broad range of experiences undergone by emergency responders. Within the phases of a single response incident, the roles of individuals even within the same team can be extremely varied and heterogeneous. Despite the limited academic support for the concept of a 'rescue personality' (Wagner et al., 2009) the concept has been utilised to form the Critical Incident Stress Management model

(CISM: Mitchell & Everly, 1993). CISM is a model designed for formal debriefing of responders, and often the public, following emergency incidents. Despite CISM being widely utilised for emergency responses, its efficacy is very controversial (Barboza, 2005).

The 'personality type' concept has also resulted in the development of employee selection models in the emergency response field. These models are used to predict performance abilities for specific job tasks (Wagner et al., 2009). Emergency response employee selections based on these models are claimed to place the 'right' person for the job within the responder role, therefore potentially mitigate the chances of trauma outcomes (Sekiguchi, 2007). Paton and Hannon (2004), caution against this type of homogenisation of responders, claiming that similarities are often only being considered at the macro level of their job roles. Paton and Hannon's (2004) sentiments reiterate what the inconclusive results of the personality typing studies themselves suggest: that attempting to identify personality traits to mitigate trauma, may not be the most reliable line of investigation to follow.

Moving beyond proposed common personality traits, a seemingly more obvious common feature for emergency responders is the frequency with which they encounter severe injury and sudden death during their job. However, emergency responders interviewed in studies often claim that it is the inability to *make meaning* of anomalies that will give rise to stronger reactions in a response situation, not necessarily the most severe injuries, or sudden deaths of patients (Alexander & Klein, 2001). Studies that have attempted to identify what anomalies causes strong reactions for emergency responders list themes including child victims, known victims, particularly severe injuries, and instances of discrepancies between preparatory information and the actual state of the victims (Alexander & Klein, 2001; Regehr & Bober, 2005; Regehr et al., 2002). Emergency responders also report that events attended where a trauma victim could be contextualised, as in relationship with others, can cause strong reactions due to the empathy or sympathy felt (Regehr et al., 2002). Responders in various roles involving body-handling add that experiences of 'identification' with the victims, as in "it could have been me or someone I know", have caused them to experience more distressing or heightened reactions (Alexander & Wells, 1991; Ursano et al., 1999, p. 353). In a post-disaster interview, the New Zealand deputy police commissioner proposed that despite the frequency of these types of encounters, it is still normal for responders to want to ask questions and attempt to make meaning in these

circumstances (Stephenson, 2005). Constructionist-based psychological theory proposes that human beings are essentially ‘sense-making’ or ‘meaning-making’ creatures (Marcel, 2001). This is a concept that individuals attempt to make sense or meaning regarding what they encounter, in relation to notions they hold about themselves and the world (Willig, 2008). This ‘meaning-making’ concept can be used to consider why particular types of experiences are claimed to cause heightened reactions and distress. Western psychological theory proposes that anomalies and identification experiences may disturb an individual’s ability to make meaning. Experiences may be difficult to make meaning of, because they raise questions regarding an individual’s preconceived notions of ‘self’ and their understanding of their relationship to the world (Roese & Olson, 2007). Eastern, or Buddhist psychological theory also proposes this notion of a ‘self’ concept, that individuals are said to continually reinforce through cumulative experiences. Both theories allege that individuals may attempt to hold this ‘self’ concept rigid in order to create a sense of security, control and predictability in their lives (Welwood, 2000). Different Western psychological theories offer explanations for what is happening to this notion of self in a situation, that causes a heightened reaction or emotional distress. For example, emotion-focused theory proposes that heightened situations interrupt the functioning of an individual’s ‘emotional processing system’. This ‘system’ allegedly perceives, codes, and reasons regarding the information it receives in order to make meaning in relation to the ‘self’ concept held (Beck, 1993). A situation encountered that questions the ‘self’ concept and world-view is proposed to interrupt processing, and cause cognitive dissonance (Foa & Kozak, 1986; Greenberg & Safran, 1989). This type of explanation was born out of a popularised understanding of the human brain likened to a computer type ‘information-processing system’ (Herbert, 1967). This concept may seem sensible for cultures that use increasing amounts of technology to process external information, but is a less relevant way to understand emotional distress for many other cultures. Many indigenous cultural theoretical models for understanding mental health propose that trauma occurs when there is a lack of balance for an individual. The lack of balance could be for example, discord between the individual’s physical, spiritual, family and emotional spheres (Baxter, 2008; Jackson, 2006). Despite the obvious broad differences between the concepts of computer type ‘information-processing’ and ‘balance’, the indigenous models also conceptualise a notion of ‘self’ experienced in interdependence, or in relationship, to the environment and world. In a sense they also appear to support the concept that

disruption of some notion of 'self' in relation to the world, may cause distress. The commonality within the explanations is that a notion of 'self' may be being challenged when new, different, unexplainable or unimaginable information is encountered. The preconceived views or understandings that allow an individual to feel safe, in control, and to experience a sense of predictability about the world may be challenged. The resulting sense of lack of control or predictability may cause a heightened reaction or emotional distress.

These heightened reactions that might be *experienced*, and then somehow *managed*, are conceptualised to most likely be a complex interdependent functioning of emotion, cognition, behaviour and physiology (Corcoran, Farb, Anderson, & Segal, 2010; Koole, 2009). There are a multitude of psychological theories offered up for how this reaction process unfolds. Some psychological theorists claim it is important to understand how these interdependent components contribute to reactions, and in what order they occur in the reaction process. One school of thought is that attention, knowledge and physiological reactions are the emotion-generating systems (Koole, 2009). Conversely, emotions have been proposed to be responsible for generating the coordinated response of cognitions, behaviour and physiology in response to stimuli (Fredrickson, 2004). At the heart of this popular emotions-first concept is the work of theorists such as Lazarus (1991). Lazarus' (1991) original descriptions of a chain of events starting from exposure to stimuli, then leading to an emotional reaction, have generated a variety of step-by-step process models conceptualising emotional responding (Goh, Sawang, & Oei, 2010; John & Gross, 2004). Psychological theorist Pettinelli (2009) writes definitive opposing statements on this directional flow, stating categorically that emotions produce thoughts, and that the reverse flow is impossible. In reality, unpacking the discrete order in which this rapid-fire process occurs may be impossible, and of little or no benefit to conceptualising how or why individuals then go on to manage the reactions that have occurred. Trying to justify directional flow may simply be serving to reinforce culturally and socially accepted understandings of emotional reactivity. For example, proposing that a raw emotion is experienced first before a thought can be formed, may be useful to justify social acceptability of overtly displayed emotional expression, such as anger or distress.

The historical perspective on this reaction process is that it developed as part of human evolution. This explanation avoids giving precedence to either emotions or thoughts, by basing the reaction process in physiological functionality. The commonly

agreed upon historical perspective is that the human brain and biological systems developed to efficiently scan the environment for threats, and to then choose a path for immediate survival. Reactions such as fear and anger, are proposed to have developed as motivations for self-preservation, and adaptations to avoid predatory dangers (Nesse & Ellsworth, 2009). This physiological explanation is used to justify why individuals produce reactions quickly and automatically (Salters-Pedneault, Steenkamp, & Litz, 2010). Concepts such as 'fight or flight mode', a proposed automatic functioning of our nervous systems, have developed out of this historical biological perspective (Cannon, 1929). This concept is well publicised, and is socially accepted as a means to justify that the reactions individuals experience are beyond their sphere of control. While for many cultures there is no longer the same predatory threat to the physical self, these defensive emotional reactions could still be construed to relate to another form of self-preservation, the constructed notion of 'self'.

Rather than attempting to understand reactions in relation to the order in which the physiological, cognitive, behavioural and emotional components occur, it may be more useful to consider some broader commonalities people experience from reactions. Combining Eastern and Western psychological perspectives, the Dalai Lama and Ekman (2008) propose there are three commonly experienced characteristics of reactions. Firstly, reactions can be triggered automatically, within an imperceptible fraction of a second. Secondly, reactions can arise intuitively and without any deliberated consideration. Thirdly reactions can arise instinctively below the level of conscious awareness. They claim therefore, that reactions can potentially supersede an individual's conscious, rational, and 'mindful' thinking (Dalai Lama & Ekman, 2008). This focus on the common experiential features of reactions shifts attention away from the potentially unanswerable ordering arguments, and onto more useful questions. How does an individual understand their *experience* of this reaction process? What does a reaction feel like? Where does a person experience a reaction coming from? What do they do when it arrives? How and why is a reaction then managed?

Emotion regulation theorists Salters-Pedneault et al. (2010) propose that individuals develop strategies to manage or control reactions, as a response to having experienced them as instantaneous or automatic. This is especially so when an individual has experienced a reaction in a way that feels out of control, unhelpful, or in some way adverse. These processes by which people manage their reactions are commonly referred to as 'emotion regulation' strategies (Koole, 2009). The concept of

emotion regulation is proposed to serve a variety of functions, which fit with the notions of self-preservation. The preserving of the self may be to satisfy immediate hedonic needs, work toward long-term life goals, and to make meaning regarding the self in relation to others and the world (Koole, 2009). These conceptualised motivations for emotion regulation provide a proposition for why some emotional states or types of reactions come to be conceptualised as undesirable. A reaction itself is neither intrinsically 'good' nor 'bad'. However, when considered in light of self-preservation goals, some reactions may be value-judged as more or less desirable. This judgment concept has been termed 'meta-emotional' phenomenon by Salters-Pedneault et al. (2010). They propose that emotion regulation, and the strategies we choose to achieve this, are a response to how we have perceived, interpreted, judged and then reacted to our primary automatic reaction. These value judgments placed on reactions are proposed to be socially, historically and culturally informed.

Greenberg and Safran (1989) claim that the various strategies people employ when experiencing an unwanted reaction may cause 'interruptions' in emotional processing. They propose that psychological problems or trauma may occur because emotional experiences are interrupted before they can be understood, organised and 'filed' away. For example, a reaction to an event that causes an individual to question what they thought was a 'just and safe' world, may be 'suppressed' before there is an opportunity for meaning to be found, and the experience to be filed away with some understanding attached to it. Humanistic therapists construct a similar understanding, regarding trauma as being a result of emotional 'interruption'. Consequently, they propose that the most beneficial strategy to avoid trauma is to stay open to the emotional experience of a reaction. The proposed benefit of staying open is to be exposed to situations as they truly are, rather than potentially distorting them to fit pre-existing patterns and perspectives (Rogers, 1961). In this way new meaning can be found from experiences. This same benefit is also proposed in Buddhist psychology. They claim that if an individual can acknowledge their world *as it is*, and suspend value judgments, then they can learn to work with their immediate experiences more simply and directly, and ultimately experience less suffering (Kyabgon, 2005). Emotion focused therapists propose that reactions provide individuals with information that alerts them to their concerns and needs. Being able to stay open to adaptively receive and process these reactions with the messages they bring is constructed as important for healthy functioning (Goldman, Greenberg, & Pos, 2005). These psychological theories

construct sound arguments for staying open to reactions. However, as has previously been suggested, if an individual judges their instantaneous reaction to a situation as being unhelpful or unwanted they may choose to regulate it (Salters-Pedneault et al., 2010). This judgment occurs because "we do not observe nature, as much as we observe nature exposed to *our* [italics added] method of questioning" (Heisenberg, 1958, p. 58). Nin (1969) conceptualised this similarly, saying "we don't see things as they are, we see things as we are" (p. 124). How *we* are, or the position from which we judge our experience as desirable or undesirable, may be in relation to historical, social or cultural ideas, and in light of goals or self-preservation. While the regulatory strategies employed by individuals are intended to serve some functional purpose for the user, some strategies may nevertheless result in unintended negative consequences.

Current theory and recent studies on emotion regulation propose to have identified the various strategies individuals employ to manage their reactions. These constructed strategies can be clustered into three broad groups: 'avoidance' type styles; 'restructuring' type styles; and 'acceptance' type styles. The strategies have been clustered into these groups based on apparent similarities of how the individual deals with their reaction. The first emotional regulation style 'avoidance', has been constructed as an attempt to escape private psychological experiences. It is proposed that 'avoidance' offers a short-term benefit of reducing the immediate discomfort of a situation (Boulanger, Hayes, & Pistorello, 2010). The discomfort is proposed to be reduced by blocking or blunting an unwanted reaction. This strategy of 'avoidance' can be employed, not only within a current situation, but also toward an upcoming situation which is expected to elicit an unwanted emotional reaction (Koole, 2009). It has been proposed that 'avoidance' may be employed in this preemptive manner because an individual presumes they will not be able to control an upcoming situation. So instead, they will attempt to circumvent the pain they anticipate may accompany the reaction, by avoiding the reaction altogether (Boulanger et al., 2010). So, how is this 'avoidance' achieved? Derakshan, Eysenckn and Myers (2007) propose a two-phase technical process explanation for 'avoidance'. Firstly, an individual trains themselves to be hyper-vigilant toward any signs of a heightened reaction they might feel. Secondly, they employ avoidance and cognitive denial of any reaction they have felt.

Cultural and social norms may provide individuals with examples and support for the practice of controlling reactions. The 'avoidance' of an emotional reaction may allow someone to be seen as 'in control' of a situation. Being seen to be 'in control'

may be desirable because it has social or functional benefits, or it may even be experienced as an obligation of a particular role. However, if as some theorists propose, our reactions bring us messages, what happens when these messages are cut short, dismissed or not received at all due to 'avoidance'? Kabit-Zinn (2004) proposes that trying to avoid our reaction to an experience is essentially like trying to avoid a part of ourselves, and that the end result may be an intensification of the avoided emotions.

'Suppression' is another strategy that falls within the 'avoidance' type group. 'Suppression' has been constructed as an attempt to remove all the emotional components of a reaction from conscious experience (Richards & Gross, 2006). Similarly to 'avoidance', 'suppression' may result in short-term relief from stress, but has been associated with losing insight into recognising one's own emotional states in the long-term (Geraerts, Merckelbach, Jelicic, & Smeets, 2006). As with 'avoidance', it has also been proposed that 'suppression' of disturbing or traumatic material can later cause trauma by causing the return of an even stronger experience (Pennebaker, 1989). A recent review on 'avoidance' supports these claims, and reports consistent findings in emotion regulation research of correlations between experiential 'avoidance', and the fulfillment of criteria for depression and anxiety according to the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association [DSM-IV-TR], 2000), as well as relationships to PTSD, PTSD symptoms, self harm, and pain intolerance (Boulanger et al., 2010). Empirical trauma studies also consistently claim correlations between 'avoidance' reaction management styles and 'negative' life outcomes such as, reduced positive affect, lower appraisal of life satisfaction, lowered sense of meaning, lowered authenticity and connection to oneself (Alexander & Klein, 2001; Alexander & Wells, 1991; Fannin & Dabbs, 2003; Geraerts et al., 2006; John & Gross, 2004; Koole, 2009; Regehr et al., 2002; Ursano et al., 1999). Studies specifically on emergency response workers, who are repeatedly exposed to trauma type situations, claim reports from responders that they typically use 'avoidance' style strategies to cope with their reactions (Hayes et al., 2004; Regehr et al., 2002). The results of these studies suggest that the strategies the responders use most frequently, are also the most likely to result in trauma symptoms and negative outcomes. Would the responders choose to continue to use these strategies, if they knew this? Several studies on emergency response workers have asked this very question. In one study the responders claimed to knowingly use 'avoidance' strategies even though they had been made aware that this strategic style could lead to long-term negative

effects such as PTSD symptoms and emotional blunting (Regehr et al., 2002). In another study, eighty percent of emergency responders claimed to actively suppress their reactions, and also held that this strategy was unhealthy (Alexander & Klein, 2001). The majority of emergency response research is failing to then ask *why*? Why are 'avoidance' style strategies still employed when response workers are often acutely aware of the possible negative outcomes?

The second group of reaction management strategies include 'restructuring' style strategies. 'Restructuring' strategies are proposed by theorists to be attempts by an individual to manipulate or change how they think or feel in relation to a reaction. This manipulation may be attempted using strategies such as 'cognitive restructuring', 'attention shifting' or 'physical control', rather than complete avoidance or suppression of reactions (Salters-Pedneault et al., 2010). Studies of emergency responders attending to body-handling duties describe using an 'attention shifting' strategy to think about positive aspects of the task. They claim this can make a duty feel more meaningful and less arduous (Alexander & Wells, 1991). Goleman (1995) suggests that attention shifting can prevent individuals from becoming overwhelmed or hijacked by an emotional reaction. He additionally claims that restructuring provides opportunities to generate positive emotions, which may impact choices for behavioural responses, and then have positive knock-on social benefits. However, John and Gross (2004) suggest that, similarly to 'avoidance' strategies, 'restructuring' strategies may still result in an increased frequency and intensity of the original reaction. This is alleged to be a result of the active 'reality distortion' an individual alleged to be is engaged in, when restructuring. This active 'reality distortion' can range anywhere from choosing to trivialise information, inflate information, or selectively forget information (Roese & Olson, 2007). Therefore, 'restructuring' style strategies have been constructed as a defensive means to regulate unwanted emotional reactions. Defensive, because in the same manner as 'avoidance' and 'suppression', the emotional experience is being judged as unwanted. A major Italian study of 764 emergency responders in various roles investigated 'restructuring' as one of several strategies used by responders. They concluded that 'restructuring' was less likely than 'avoidance' to lead to negative outcomes such as PTSD symptoms (Cicognani et al., 2009). However, this is inconsistent with the findings of another emergency responder study by Chang et al. (2003) who found 'restructuring' styles were highly correlated to PTSD symptoms. Both studies used questionnaires with set categories for participants to express how they

cope with reactions in response situations. Both sets of authors offer in their discussion sections suggestions as to why these strategies may be used by emergency responders, and differing explanation as to why they do, or do not, lead to negative outcomes. These types of conflicting results may in part be occurring because of the inability of the types of questionnaires used, such as the Brief COPE (Carver, 1997) and the Ways of Coping Questionnaire (WCQ: Lazarus & Folkman, 1988) to fully extrapolate what is meant by 'restructuring'. The Brief COPE (Carver, 1997) has two sentences that are chosen between, to indicate 'restructuring' style strategies. 'Restructuring' in reality however, could be anything from shifting focus to a positive aspect of a task, to the complete trivialisation of a very important aspect of an event in order to lower feelings of anxiety. With such possible extremities, how can 'restructuring' be categorically labeled a negative or positive strategy to utilise? These types of questionnaires restrict participants' choices to a predetermined list of strategies, leaving room for a very large margin of difference in the individuals' interpretations of the available choices.

The third group of reaction management styles are 'acceptance' type strategies. It is proposed that during the use of 'acceptance' strategies no attempts are made to regulate the emotional experience by removing or manipulating it (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). 'Mindfulness' is a better-known type of 'acceptance' strategy. Mindfulness is an attempt by individuals to openly accept the presence of their emotions during an event, rather than to forcefully control them. It is conceptualised that being able to identify and acknowledge emotions, thoughts and sensations as mental events using mindfulness can help reduce literal identification with the content. This reduction of identification can create a buffer between the reaction, and the response to the reaction which may be causing distress (Corcoran et al., 2010). Understanding reactions as 'mental events' is proposed to create a sense of stability beneath fluctuating emotions, and reduce the urge to regulate the reactions. Using an 'acceptance' style strategy such as 'mindfulness', the reaction is acknowledged as it is, and not judged (Kyabgon, 2003). As a reaction management style, 'acceptance' could be seen as the antithesis of 'avoidance' and 'restructuring'. A recent study followed a group of American police recruits for a year to determine whether mindfulness techniques predicted positive mental health (Williams, Ciarrochi, & Deane, 2010). The recruits claimed that by using mindfulness they were able to stay with their moment-to-moment experience, better identify their feelings, and experienced better mental health overall, and lower levels of depression. There is a paucity of studies comparing the

utility of ‘acceptance’ style strategies with any other reaction management strategies. This may be because ‘acceptance’ style strategies do not even appear on the most commonly used surveys of coping strategies given to emergency responders, such as the Brief COPE (Carver, 1997) and the WCQ (Lazarus & Folkman, 1988). Although the word acceptance does appear in the WCQ (Lazarus & Folkman, 1988), it describes an action of accepting responsibility as the opposite strategy to blaming. In the Brief COPE (Carver, 1997) the word acceptance also appears, but is only used to describe acknowledgement that an event has indeed occurred. ‘Acceptance’ style strategies, in the sense of mindfulness, infers instead an acceptance of one’s reaction, without attempting to manipulate it.

‘Skills focused’ coping is another strategy constructed by responders, that does not fit neatly into any of the three reaction management style groups. A ‘skills focused’ strategy could be loosely conceptualised as a combination of ‘suppression’ and ‘restructuring’ type strategies. Paramedics in one study that claimed to use ‘skills focused’ coping conceptualised that this strategy is facilitated by focusing on the response incident at a technical level. Focusing on the technical level may mean for example, visualising a course of action for the patient’s treatment. This focus is then used to block their emotional responses, and manage their reactions (Regehr et al., 2002). The paramedics themselves suggested however that, while this strategy appears to be protective in the short-term, the emotional blocking component may have long-term negative consequences, such as emotional deficits, PTSD symptoms, substance use and depression (Regehr et al., 2002).

In summary, much of the research regarding the potential traumatisation of emergency responders in the last forty years, has investigated how they manage their reactions or cope during response situations. Personality traits have previously been conceptualised as important predictors for how responders might cope, yet the research findings are often contradictory. Most previous studies employ measures proposing to identify the reaction management strategies responders’ use, and then link these to predicted causal outcomes. These studies often claim that responders mainly use ‘avoidance’ and ‘restructuring’ strategy styles, which are usually linked to negative health outcomes. Recent studies which have evaluated the two most frequently used measures of coping, the Brief COPE (Carver, 1997) and the WCQ (Lazarus & Folkman, 1988), claim the measures are extremely valid and reliable. However, as is often the case with these types of evaluations, they have only tested the psychometric properties

of the *existing* items within the measures (Lundqvist & Ahlstrom, 2005; Yusoff, Low, & Yip, 2010). These recommended coping measures were both designed based on stress and cognitive appraisal models created in the 1980s by Lazarus and Folkman (1984). Among other factors, the business world, economics, gender issues, multi-culturalism, technology, globalisation, comparative religious understandings, the structure of a family unit, and the state of the environment have all shifted enormously since the 1980s, and even the 1990s. It is entirely possible that these coping models are no longer comprehensive enough or relevant to the present cultural and social environment. Without research that asks emergency responders to talk about what *they* understand they do to manage their reactions, rather than selecting from a predetermined list, how can we be sure we are capturing the range of strategies they are using in their current contexts? When the context is provided by the responders' own discursive constructions of reaction management, the social, historical and cultural factors affecting their understandings and choices are also able to be considered. Without this contextualisation only a small part of a whole picture regarding responding is ever seen, and conclusions may be dangerously misleading when used for policy and training recommendations. The conclusions from reaction management studies of emergency responders often summarise findings with variations of the following types of statements; "the mental health and emotional wellbeing of ambulance personnel appear to be compromised by emergence response work" (Alexander & Klein, 2001, p. 76), or "a coping strategies training program…needs to be established to strengthen positive ways of coping for workers" (Chang et al., 2003, p. 397). Research would better serve the emergency responders by attempting to understand the drivers of these strategy choices, rather than merely restating the problems, and proposing the need for alternate solutions. Therefore, in the present study it was considered important to contextualise the paramedics' understandings of reaction management. The study explores the paramedics' constructed understandings of managing their reactions, and the perceived utility of the strategies they use with regards to contexts they are used in. Additionally, the study investigates the paramedics' constructed understandings of the short and long-term consequences that arise from using these strategies. Concepts of 'self' and an individual's process of 'meaning-making' in relation to this self are also considered integral to understanding the paramedics' strategy choices. Together, these concepts provide insight into what some of the drivers might be behind the reaction management strategy choices. The research then provides a better understanding for the

experience of managing reactions during emergency responses, for St John ambulance paramedics.

CHAPTER 2

Methodology

Research Methodology

Qualitative research is proposed to be concerned with understanding how individuals experience events and phenomena, and how they make sense of the world (Willig, 2008). The present study was aimed at exploring paramedics' understandings of the phenomenon of managing their reactions during emergency responses. Using a qualitative research paradigm meant there were no hypotheses for the paramedics' understandings of reaction management, or predictions for causal outcomes from any strategies they might claim to use.

This research study utilised a design of individual interviews, follow-up focus group discussions, and ambulance shift observations. The research was conducted from a social constructionist epistemological stance. A social constructionist stance conceptualises that the phenomenon of reaction management is a process which is mediated historically, culturally, socially and linguistically for the paramedics (Andersen, 2003). The paramedics' personal experiences of this phenomenon do not take place devoid of context; using a social constructionist stance to inform the methodology allows consideration of these contexts. Additionally, investigating the social constructions of experience allows the research to explore multiple realities of the reaction management experience for the paramedics, rather than a positivist approach of attempting to confirm one single 'truth'.

The methodology chosen for this study was Foucauldian discourse analysis, due to its potential to achieve the depth of contextual exploration desired. Foucauldian discourse analysis procedures are intended to facilitate exploration of the relationships between spoken discourse, the subjectivity of thinking and feeling, the consideration of how actions are constructed and understood, and the conditions or contexts in which these take place (Willig, 2008). Language use is conceptualised to be the fundamental way in which people construct and agree upon knowledge. It is proposed that how an individual represents their 'reality' through the use of language, is influenced by, but also serves to maintain organisational and social practices. The way in which

individuals speak locates them in relation to people and situations within differing contexts. Discourse analysis explores how this positioning occurs. Particular ways of speaking, or discourses, may be more readily available within some cultural or social contexts. When using discourses individuals can create social 'positioning' for themselves. This 'positioning' may enable or constrain what is acceptable to say in a social context (Willig, 2008). What is said from the 'positioning' is then proposed to facilitate what type of actions are available for particular individuals to take within different contexts (Andersen, 2003). This is claimed to not only impact an individual's physical reality, but also shape their psychological understanding of what actions are available (Willig, 2008).

> "Reality is what we take to be true.
> What we take to be true is what we believe.
> What we believe is based upon our perceptions.
> What we perceive depends upon what we look for.
> What we look for depends upon what we think.
> What we think depends upon what we perceive.
> What we perceive determines what we believe.
> What we believe determines what we take to be true.
> What we take to be true is our reality" (Zukav, 1984, p. 310).

Foucauldian theory acknowledges the interdependent way in which an individual relates to their reality of the world. While an individual may relate to the world as somehow being predefined socially and culturally, equally their interactions are constructing that same world.

Foucauldian theorists assert that particular discourses, or ways of speaking about phenomenon, may be bound within an organisation's practices and workplace cultures. Discourses may be used to support commonsense acceptance of understandings regarding a phenomenon (Arribas-Ayllon & Walkerdine, 2008). The discourses used by paramedics may function to reinforce existing social structure and practices within the organisation they work for, St John. In an interdependent fashion, the organisation themselves may facilitate particular discourses as social norms and acceptable ways-of-being through policy and modeling of practices (Willig, 2008). Qualitative studies of various groups emergency response workers have used discourse analysis successfully to gain understanding of personal experience. A recent study of Australian police officers demonstrated the utility of discourse analysis to explore the taken-for-granted differing realities and power relationships that are entrenched within police institutions.

Discourse analysis highlighted how officers' decisions were affected by their workplace context. The study results were then used to work toward new leadership initiatives addressing these power relationships (Gordon, 2010). A recent study of hospital emergency department staff in America utilised discourse analysis to better understand the experiences for staff working with patients in critical condition. The resultant understandings contributed toward new integrative care models for the emergency department workers (McClosky, 2011). A study of ambulance paramedics in Australia revealed through discourse analysis how they were able to influence disaster preparedness of communities within rural areas. These understandings have contributed toward community preparedness, information design, and delivery (Stirling, Meara, Pedler, Tourle, & Walker, 2007). The successful use of discourse analysis with similar types of emergency responder populations supported the choice of methodology for this study.

Methods

Participants

This project was located within the Auckland area St John Ambulance organisation. All members of the current Auckland St John Ambulance paramedic staff were invited to participate in the study. The St John Health and Safety Advisor posted a brief notice in the internal staff weekly bulletin regarding the study, with instructions for any paramedics wishing to participate to contact him or the researcher directly. Posting the notice in the weekly bulletin ensured that all ambulance watch shifts received the message. Following their expression of interest in the study, the potential participants were emailed a participant information sheet by the researcher (see Appendix A). The recruitment criteria were an 'experiential requirement' of at least three years service as a paramedic with the St John organisation, and a currently held position that included 'on road' duties. For people who fulfilled the criteria, inclusion in the study was then based on expression of interest in participation, and availability to participate in both the individual interview and focus group discussions. Participants were advised on the information sheet that interviews and focus groups would take place outside of work hours. Participation requiring personal time sometime garners lower response. However, research has shown that this type of altruistic act from participants is often accompanied

by a willingness and enthusiasm to fully engage in the research process (The Hastings Centre, 2009; Grady, 2001).

This study utilised convenience sampling from the population of interest. The first eight individuals who responded and fulfilled the criteria were recruited as the sample group. The participants were between the ages of 26 to 58, with 'on road' paramedic job experience ranging from 4 to 25 years. The group consisted of four males and four females. One participant identified themselves as New Zealand Maori, and the other seven as Pakeha, or New Zealand European.

Sample sizes used for discourse analysis in qualitative research are typically small (Starks & Trinidad, 2007). These sample sizes are recommended due to the labour-intensive and time-consuming nature of transcription and data analysis of rich discourse (Wood & Kroger, 2000). The information collected from eight individual participant interviews, two focus group discussions, and shift observation, gave a wealth of data to draw upon and analyse.

Procedures

The individual interviews were scheduled at times and locations convenient to the participants. They took place in private rooms at participants' local stations, the Mt Wellington St John ambulance headquarters, and in participants' own homes. Interview data was collected using a digital recorder. Individual interviews lasted between 60 and 80 minutes. Memos were made during the interview by the researcher when salient issues were mentioned, to act as prompts for coding during the transcribing process, and as an aid to analysis.

Interviews were semi-structured, open-question style, and generated data relating to individual understandings of how reactions in emergency response situations were managed. To begin the interviews, participants were asked to reflect upon their first or strongest memory of paramedic emergency response work. They were encouraged to talk about any thoughts, feelings or sensations they remembered, and any recollections of how they responded to these. Requesting this reflection was intended to open up the interview and allow the researcher to ask questions solely relating to the participant's constructed recollection. This was an important consideration because social construction research acknowledges that interviews operate very differently than casual conversation between two people. A format of questions and responses can impose an unspoken set of conventions that relate to 'interviewer' and 'interviewee'

roles. With these roles may come an expectation from the participant that the researcher is seeking a particular type of response regarding the phenomenon under investigation (Abell & Myers, 2008). Therefore the opportunity was provided for participants to construct their understanding of what they *did* during a response incident, without initially being presented with psychologically loaded terms such as 'coping' or 'reaction management' to frame their understandings. However, it is also understood for the purposes of analysis that the usual narrative style of the participant may be altered, as conversation is being purposefully generated by the participant and the researcher to make the event of an interview for research take place. As such, during analysis the interview situation itself is considered to be a discursive context with social, cultural and linguistic factors that may affect the participant's discursive constructions (Abell & Myers, 2008).

During individual interviews 'shadowed data' (Morse, 2001) were also collected from individuals, by asking them to consider how their experience may resemble or differ from other members of the group. Participants may have directly commented on the experience of another paramedic, or used language to indicate they were expressing a group or organisational understanding of the phenomenon. When reflecting on the possible experience of other group members, participants are proposed to reveal some of their 'positioning' in relation to other members (Morse, 2001).

The researcher then accompanied two paramedics, one of whom was a study participant, on a ten-hour 'on road' ambulance shift in Auckland. The researcher made handwritten notes of observations regarding how the paramedics appeared to manage their own and patient reactions in response situations. Additionally, in between observations of ambulance call outs there were opportunities at the stations and at the hospital ambulance drop-off zones for informal discussions with paramedics. Handwritten notes were made by the researcher following these discussions.

Approximately one month after the individual interviews and the observation shift, two researcher-facilitated focus group discussions were held. One group discussion had four paramedics and the other three, due to the last minute unavailability of one participant. The participants self-selected into either discussion group, based on the suitability of the discussion group dates. Participants were unaware of who the other paramedics attending the discussion would be. Focus group discussions were held in private rooms at ambulance stations, and again recorded using a digital recorder. Discussions were approximately 90 minutes long.

To begin the focus group discussions the interviewer shared the themes that were emerging around the notion of reaction management from the individual interviews. Then topics for discussion were presented from salient issues and contradictions which had arisen in the individual interviews and the observation shift. Introducing these issues into focus group discussion was intended to provide clarification, and to explore any conflicts and contradictions within the discursive constructions from the individual interviews.

> **Example of a contradictory statement within a participant's individual interview**
> I was just so sick and tired of it. It was like I lost that empathy for them.
>
> ……
>
> I think they are probably easier now .. I give myself permission to be a bit more emotional…..
>
> **Discussion topic to address the contradiction introduced into focus group discussion**
> Some officers said that over time "you get cold or lose empathy"…. but at the same time these officers have also said that over time they are more accepting of occasionally getting emotional with patients and families as a human response, that they are OK with. Is this a contradiction?

The researcher aimed to keep the group discussions focused on the topics of investigation, to ensure areas requiring clarification would be covered. However, the researcher allowed the participants to direct the discussion themselves following the introduction of topics. This allowed participants to change the direction of discourse regarding specific topics, and to completely avoid some topics. These shifts in discursive direction were considered to be rich data in the same way spoken discourse was.

The three-step data collection process facilitated a more developed exploration of the phenomenon. This depth occurred because partial analysis was undertaken between each data collection step in order to generate discussion topics and questions for the subsequent steps. In this way the research questions were able to continue to emerge from the unfolding research process, and directly from the understandings being constructed by the paramedics.

Ethical Considerations

Ethical approval for the study was given by the Massey University Human Ethics Committee at Albany (see Appendix B). The researcher then presented a proposal for the study and a formal letter requesting participation in the study to the area management staff for the Auckland St John ambulance headquarters.

The ongoing construction of events occurring during the interview and discussion processes was anticipated to be potentially beneficial for research participants. However, there was also the possibility that recollection of response incidents during the research interviews may arouse strong emotion in some participants. Therefore, the provision of psychological support for the participants was arranged by the researcher. The direct contact details for the St John Organisation contract psychologist were provided on the information sheet given to the paramedics at recruitment, and again during interviews and discussion groups (see Appendices A & C). The options of peer support or a kaumatua were also offered to participants for the individual interviews (see Appendix A). None of the interviewees chose to request a peer support person or kaumatua to attend their interview.

The participants were offered the opportunity to review and edit the transcripts from their individual interviews (see Appendix D). Due to the interdependent nature of the focus group discussion data, an opportunity was not provided to review and edit the transcript from the discussion group. Instead the participants were advised that an opportunity would be available for the group after the discussion, to decide if there were any portions of the recorded data they would like to edit or omit. Participants were advised of this editing opportunity on the focus group information sheet (see Appendix C), and also verbally before the group discussion started. Following both the individual interviews and focus group discussions, no individual or group requested to edit their transcript or to omit any focus group discussion topics.

Participants were advised that while the Auckland St John ambulance unit would be identifiable, all personal information would be made anonymous in the final thesis. Additionally, before the focus group discussion commenced participants signed on their consent form that they would keep the discussion confidential (see Appendix E). As a further reassurance to each other the participants verbally swore to this agreement together before the discussion group commenced. A previous Massey University thesis on an emergency responder group reported officers' concerns regarding confidentiality

of the psychologically-based information collected about them remaining anonymous to their work organisation (Stephens, 1996). Based on these types of concerns, the past approach used for Massey University theses with emergency responder participants has been to conceal participants' identities and destroy recorded data once the thesis has been submitted. The present research used the same approach. From the interviews through to analysis the participants' identities were concealed using a coding system. For this final presentation of the thesis, in the instances of single quotes from paramedics no identifiers are used for the speaker. In the instances of group discussions randomly generated initials are used to identify the different speakers. These initials are used consistently to identify the same speakers between discourse excerpts.

A complete copy of this thesis has been given to the St John organisation as per their request. A briefer summary of findings will also be provided to the organisation and each of the study participants. This summary will differ in regards to the thesis, which addressed conflicts within discursive constructions regarding reaction management. The summary is instead intended to provide the paramedics with their consolidated understandings for the utility and outcomes of reaction management strategies they currently use. This may assist them with informal training they conduct with new recruits.

CHAPTER 3

Analysis Process

To begin the analysis process the audio from the individual interviews and group discussions, and the handwritten notes from the observation shift, were transcribed into electronic documents. All of the transcriptions were coded to create anonymity for the participants. Transcriptions were verbatim records of all speech, with symbols to indicate speech onset, pauses, overlaps, abrupt self-interruptions, changes in intonation, and instances of gesticulation used for emphasis or to demonstrate concepts. All of these transcription elements were considered to be valuable components for analysis. A pause mid-speech, for example may be indicative of a speaker considering the perceived social acceptability of a discursive construction within a particular context. Any memos made by the researcher during data collection, for example major shifts observed in body posture or facial expressions, were added as notes into the transcriptions, next to the appropriate speeches.

Example of verbatim transcription
Interviewer (I): Because .. you're more experienced .. do you mean?

I don't know.

I: Do you mean it's a sign of weakness-

-On my part I think! I am said to have this aura about me …. people are petrified to work with me.

Verbatim Transcription Symbol List

Transcription Symbol	Meaning
..	Short pause
….	Longer pause
-	Speech overlapping/interruption
" "	Quoting from their own thoughts or another individual's speech
italics	Emphasis given to a word

The chosen methodology of Foucauldian discourse analysis did not dictate a set approach for the analysis process of this study. Arribas-Ayllon and Walkerdine (2008) claim there is little benefit in over-formalising the Foucauldian analysis approach with too many set rules and procedures. This is rationalised with the claim that Foucauldian theory itself was originally intended to demonstrate a fluid, less defined, or formal

nature of the construction of reality. Foucault himself expressed a dislike for rigid analysis processes claiming "I take care not to dictate how things should be" (Foucault, 1994, p. 288). Instead Arribas-Ayllon and Walkerdine (2008) propose that three broad dimensions should be included when claiming to use a Foucauldian approach to analysis. These three dimensions are: discussion of mechanisms of power; issues of subjectification; and historical inquiry. Willig (2008) has provided researchers with six-step analysis process based on the theory of Foucauldian discourse analysis. Willig's (2008) six-step process was used as an initial guide to steer the analysis process in the present research. This six-step process provided the framework to address two of the three dimensions of Foucauldian discourse analysis: power mechanism and issues of subjectification. These initial six steps of analysis were: coding discourse by themes; identifying discursive structures; coding discourse by functions; identifying positionings; identifying the reality of practice; and analysing the consequences. Willig's (2008) process was then added to with analysis for "shadowed references" and "linguistic indicators" (Morse, 2001, p. 291). This analysis identified when participants were speaking specifically about themselves, or were more broadly referring to others. To address the dimension of historical inquiry the analysis was informed by contextual consideration of the historical St John organisation, and the broader culture of emergency responding in New Zealand and internationally. The discursive context created by a psychological research interview was also included in the contextual considerations.

The first step of the analysis process was to sort excerpts from the transcribed interviews and observation field notes into preliminary groupings. Groupings were based on the types of explanations and meanings given regarding phenomena. Willig (2008) terms this the first or 'descriptive' level of analysis. All references, both explicit and implicit, relating to the understanding of managing reactions were identified and categorised.

> **Example of explicit reference to 'support seeking' from people "like me" who understand the technicalities of the job**
> Um .. the right person to talk to I suspect for me is one of my colleagues here .. who I know .. even though they are not peer supporters. I can discuss a job and they can talk about what they would or wouldn't have done.

Indirect, implicit, or complete avoidance of reference to the phenomenon is proposed to reveal as much about how the experience is constructed, as an explicit reference (Willig,

2008).

> **Example of indirect reference to 'support seeking' from people "like me" who understand the technicalities of the job**
> I think I would go to a psychologist to talk about a nasty job. But I accept that they may not be able to help me in some ways that my colleagues could.

Additionally, indirect references may include instances where the surrounding discourse creates conditions of possibility for particular constructions of the phenomenon to occur, rather than making a blatant reference to the phenomenon (Arribas-Ayllon & Walkerdine, 2008).

> **Example of conditions of possibility reference to 'support seeking' from people "like me" who understand the technicalities of the job**
> It's also things that I guess people don't really understand what goes on in the job and they don't .. they are just looking at it from the excitement point of view. But they can't understand what we have gone through.

All other discourse that did not directly talk about the phenomenon of managing reactions, but appeared salient to the paramedics' understanding of themselves and their work was also identified and categorised. This initial process of creating descriptive level categories, started to reveal core themes within the discursive constructions.

The second step was to analyse these preliminary categories for similarities, differences and anomalies. At this stage the multiple ways in which the phenomenon is experienced and constructed could be seen. Then the types of 'discursive structures' the paramedics drew upon when they formed these varied constructions were considered.

> **Example of a discursive structure identified- A biomedical discourse**
> I: Right. And that waiting is stressful you said in part because you want to be able to distract yourself by using your skills and getting in there and doing it?
>
> It's not really *wanting* to distract myself. It's just that's what happens when I go and do .. I can focus on what I am doing rather than standing there and realising that I am shaking a bit. Which then makes me realise .. well that's the adrenaline coursing through my system .. which then makes you feel a little bit um .. sort of that process of feeling uncertain about things and then you realise you are shaking and you realise your stress levels are up and the adrenaline is coursing and all these things start coming in and you shake a little bit more. But then once you get yourself a task and start talking you forget that the adrenaline is coursing.

In the previous example, by using a biomedical discursive structure the paramedic could frame the experience of managing reactions from a biological understanding. This framing allows it to be seen as a physiological process with structures and properties

which are accepted and understood, therefore 'manageable'.

At the third step the data was sorted into higher-level categories relating to the 'functions' of the spoken discourse. This is considered to be the more analytical level of the data analysis process (Willig, 2008).

Examples of Lower Level Categories Grouped into Higher Level Categories

Lower Level - Descriptive Category	Higher Level - Functional Category
• Self talk • Focusing on tasks • Taking a step back • etc	Strategies to refocus attention to manage reactions during an incident response
• High patient emotion • Knowing the patient • Unpredictable situations • etc	Aspects of a response situation that affect the ability to manage reactions

To identify the function of the discourse, speech was explored for "action orientations" (Willig, 2008, p. 120). This is the notion that framing the phenomenon in a particular way serves some purpose for the speaker. The speaker's constructed understanding of what it is to experience and manage reactions, functions to conceptualise what sort of reaction or action then feels appropriate or available. In the following example a paramedic speaks about crying when a patient's newborn baby had died. The paramedic constructed the patient's reaction as "primordial", inferring it had an instinctive or automatic quality to it. Discursively constructing the patient's response in this way functions to construct the paramedic's own reaction of "tearing up" as an instinctive or automatic response and therefore acceptable.

Example of discourse function identification
Well when they said the baby had died .. you know she just let out this primordial sob .. you know?

I: And when you say "you lost it" what do you mean?

I just started tearing up. I didn't bawl or cry out loud or anything like that. And I think the staff were quite upset and that as well. All a bit emotional

As discussed in the Methodology chapter the themes identified using these first

three steps of analysis, and some initial indications of shadowed data, generated the topics and questions to be taken into the focus group discussions for clarification and expansion. Following the focus group discussions there was a return to the first three steps of analysis with this new data, and an opportunity to draw comparisons from the individual interviews. These comparisons demonstrated that individuals not only chose to solidify or evolve their constructions from their individual interview, but sometimes contradicted them in the group context. Shifts in construction can be interpreted as products of the social and cultural dynamics of the discursive context of the group discussion. It was then considered whether the group discussion dynamics may be indicative of work-place social dynamics.

Example of discourse regarding emotional expression in an individual interview
I: Also I guess I am asking .. did you feel OK about crying?

Oh yeah. I think that is normally human. I don't think you could .. I think if you tried to be anything other than yourself it would be a false impression

Example of discourse regarding emotional expression contradicted in a focus group discussion
…….. there was lots of tears and that sort of rubbish .. and than after that it sort of started to subside so .. All good!

Fourthly, data was explored for 'positioning'. 'Positioning' may demonstrate the dimension described earlier as mechanisms of power (Arribas-Ayllon & Walkerdine, 2008). Using a particular discursive construction regarding a phenomenon can create a positioning for a speaker within a discursive context. This positioning may allow certain rights for the speaker, but also may create certain expectations (Davies & Harre, 1999). In addition to providing a positioning for themselves, the paramedics' discourse may create a corresponding positioning for others. This corresponding positioning may support or reinforce their own positioning, as is seen in the following example.

Example of corresponding 'positioning' created by a discursive construction
ND: .... like I was saying to Annabelle before I try to encourage my .. when I am with junior staff to talk about stuff and be OK about talking about stuff if they are affected about things. And in that respect I have shared stuff with my junior partners before. Like what has upset me. So they have a good idea of what might .. what is OK to upset them in the future.

BL: See I wouldn't do that at all. I don't do that at all. I don't talk to junior staff about… Sign of weakness! As far as I am concerned.

The construction from the second speaker regarding the action of talking to junior staff

as a "sign of weakness", positions the previous speaker as 'weak' due to their claim to use this action, and positions the speaker themselves as 'strong' in contrast.

The fifth analysis step looked at the links between the discursive constructions identified, and the 'reality of practice' they create. The reality of practice may be that the discursive constructions of the paramedics' have legitimised and reinforced certain behaviours in the workplace. In the following example a paramedic reconstructs their first impressions of the job as a trainee. Here, the phenomenon of reaction management is constructed as something "you are *supposed*" to be able to do, therefore commands certain expectations of behaviour.

> **Example of phenomenological construction creating a 'reality of practice'**
> When you do a job like this it's like .. how do I put this .. you are kinda forced in a way that you have to cope…….It sort of seems like you are *supposed* to cope. When you go into these jobs in the emergency services .. that's kind of what you have to do. Well .. it is in my mind .. and to display being really upset by it or something just seems like it wouldn't be a cool thing.

In this example, the reality of practice occurs as a result of what reaction management choices feel accessible and acceptable from the positioning and action orientated by the construction of the phenomenon, as something "you are *supposed*" to be able to do.

The sixth step is the 'analysis of the consequences'. These are resulting consequences from the discursive constructions and their functions, the subsequent actions and positionings, and the reality of practices used. The culmination of these components creates consequences for each individual paramedic, and for the group. The consequences of these components may be that a particular strategy of reaction management is utilised because it becomes to be considered commonsense. In the following example a paramedic reflects back on the action orientated discourse they chose, the positioning and functionality it afforded them in one social context, and 'consequences' in another.

> **Example for the 'analysis of consequences'**
> ……..I am a lot harder now than I was [when I started out as a paramedic] and I know it's a coping mechanism. But I probably didn't know how hard I had become until I met my partner now and just the way I spoke .. and he's like "God you are a hard bitch" .. and that really threw me.

'Shadowed data' was also identified from individual interview and focus group discourse. The production of shadowed data was encouraged from participants during individual interviews by asking them to consider how their experience resembled or

differed from other members of the group. With a relatively small sample size, this process can be seen to add to the richness of the data, by increasing the references to phenomena (Morse, 2001). This information primarily added to conceptualisations of what the paramedics considered to be commonsense understandings of the phenomenon.

Example of 'shadowed data'
I: And what about healthy coping strategies of coworkers?

Um .. I think a lot of them are the same. We tend to exercise and laugh .. chat to people outside work. Catch up with people that aren't ambulance related.

Aside from when direct questions were asked of the participants regarding their opinions of other individuals or the group, there was also a more indirect type of shadowed data identified in the form of 'linguistic indicators' (Morse, 2001). The linguistic indicators found in analysis were instances within the participants' discourse that suggested their own understanding or behaviour was indicative of the group or organisational understanding. In the following example the paramedic says "*you* need to….". When saying "*you*" the speaker not only refers to themselves, but also to a generalised self. The use of "*you*", rather than "*I*", may function to imply a wider acceptance by the group or organisation of the construction they have proposed.

Example of 'linguistic indicator'
-*You* need to have a set of friends that are not ambulance related .. I mean a lot of my friends are ambulance friends .. but then a few of them I have been friends with outside of ambulance before we joined ambulance.

Then the paramedics' constructions were considered in light of the immediate and wider social and cultural contexts within which paramedics function. For example, how their understandings regarding the phenomenon may be informed by the history and cultures of the St John organisation, emergency responding, and New Zealand. Analysis of the historical dimension allows for consideration of the evolution of discursive structures over time (Foucault, 1972). In part, this dimension was analysed from direct references the paramedics made to social and cultural influences, and in part, from historical research and critical literature reviewing regarding emergency responding.

Example of a direct historical reference from a paramedic
Yeah. And I honestly think it's because that is how is was dealt with back then .. 15 .. 20

> years ago. And they were all boys back then. There were no women in the service and I guess it was a different generation 20 or 30 years ago.

Finally, the discursive context of the research interview itself was considered, and the impact the notion of an interview might have on the participants. My own positioning as a 33 year-old female psychology research student was a feature of each of the discursive contexts of data collection. In the analysis process it was considered how the paramedics related to this positioning and what corresponding positioning it may have created for them. In light of this, during transcription I attempted to identify instances of this influence, and discuss the potential impact on the paramedics' constructions. For example, where I used words that might be socially or psychologically loaded.

> **Example of the 'research interview' context and the impact of language**
> I: And what about 'negative coping strategies' that you see other people using?
>
> Eating badly .. ha ha ha .. Negative coping strategies um … I think .. I don't really know how people …….. I know you want me to say drinking or smoking drugs or something.

Foucauldian discourse analysis is proposed to be concerned with generating an *interpretation* of findings, not simply a description of findings (Willig, 2008). This interpretation is not an attempt to create definitive explanations, or to claim facts regarding the paramedics' experiences of managing their emotions. The interpretation is however intended to present an informed understanding of their experiences. The present study aimed to explore the understanding of St John paramedics for how they manage their reactions during emergency response situations. Additionally, the study aimed to understand the perceived utility and potential outcomes from these actions, and the choices they make. Following the analysis process the data was separated into four main areas of understandings, which the paramedics had spoken about in relation to reaction management. The four main areas were ordered into a chronological sequence following the paramedics' experiential process of reaction management. These four areas were: firstly, how they understood their role as a paramedic and the expectations they perceived came with it; secondly, how they understood the training or advice they received regarding reaction management, and subsequently how they manage their reactions during incidents; thirdly, the processes that occur post-incident with regards to managing reactions and finding acceptance for incident outcomes; and fourthly, how

they understand the short and long-term consequences of not managing reactions, and what support is available in this event. This chronological sequence enabled the study to address the aims thoroughly by gaining understanding of the paramedics' experiences of reaction management from their recruitment and training, through to the consequences of their present reaction management strategies. Each of the four areas was developed into a chapter addressing the conflicts and complexities that emerged in the paramedics' discursive constructions within the four areas of understanding. These constructed understandings by the paramedics often appeared to support conflicting positionings for themselves and others. Additionally, while their explicit constructions positioned particular actions as available, their more covert constructions often rendered the same actions unavailable. These conflicts were explored to reveal notions of 'power mechanisms' and 'subjectification' supported by the paramedics' discursive constructions. These conflicts are addressed within each of the following four chapters as follows: chapter one, wanting to be acknowledged as ordinary people who do an extraordinary job; chapter two, the balancing of being a technician and only human during incidents; chapter three, seeking the truth while needing to make meaning post-incident; chapter four, weighing up social risks against personal risks when support-seeking.

CHAPTER 4

Ordinary people doing an extraordinary job

This is the first of the four chapters exploring the areas of understanding that St John paramedics have for managing their reactions in emergency response situations. To elicit the paramedics' understanding of the phenomenon, they were asked to talk about incidents they had attended that had produced a heightened reaction, and which might have required management. In providing examples of heightened reactions, the paramedics constructed how they see themselves within their role as a responder. Two main constructions appeared. These constructions were, that firstly there is nothing special about *themselves inherently* as people that equip them to do the job, and secondly, there is nothing special about what *they do to manage their reactions* in a response situation. The constructions about their job role are addressed first, before presenting an analysis of how these may affect reaction management.

When asked to contemplate the notion that they might possess some inherent ability to fulfill their role functions, the paramedics completely refuted this notion. They claimed that anyone would be capable of fulfilling the job functions.

> I: Think about one of your friends that is non-ambulance. What makes you able to attend to someone with their foot hanging off that your friend…[couldn't]-
>
> -I think they probably could. If they were put in that situation .. they could. That's the thing. And I notice that with bystanders. Ninety nine percent of the time at really traumatic jobs people will just rise to the occasion and just do stuff .. and like I have seen a woman in her sixties who was holding the hand of a dead guy who has got his brain matter all over his head .. and she looked like she could have been the secretary at my mum's office. You know like completely different person to me .. yet she was dealing with the situation perfectly fine. I don't think that there is anything different. It's just I am put in the situation every day so I get to do it and they don't.
>
> ……
>
> A lot of people sort of say "Oh I couldn't do what you do" and I think "why not?" This could be your child somewhere else.

Thoughout emergency response literature the psychological construct of 'rescue personality' perpetuates the assumption that emergency responders possess some innate skills for the type of work they do. The 'rescue personality' construct proposes that responders have a personality 'type' which may provide them with pre-existing tools to cope in emergency situations (Mitchell & Bray, 1990). Despite a lack of consensus on this 'type', the concept is still frequently supported within emergency responder

research (Lau et al., 2006; Shakespear-Finch et al., 2005). As suggested by Paton and Hannon (2004), personality typing seems to be a convenient, and I would suggest somewhat limited assumption, that homogenises the responders. Furthermore, the paramedics construct themselves as being very heterogeneous.

> ….this week at uni we have just done our leadership assessments and they made us do that personality profiling stuff .. which I don't really believe in .. and I thought "surely if it takes a certain type of personality to do this job then everybody in the class should end up with the same profile?" .. Ha ha .. or one that's minimal variance of one. But nah .. everyone is really different .. according to that. But even just looking at the class. If you looked at the forty percent of the class that is really good at what they do they are still really different .. so I don't think there is something that makes….the ideal person for this job.

However, when rejecting the concept of a particular person or personality being inherently suited to the type of work, the paramedics have taken the concept a step further, and alleged that *anyone* could fulfill the job functions. In doing so they position themselves as the 'ordinary' element, and the response situation as the 'extraordinary' element in the equation. In the discursive construction above, one paramedic justifies "I don't think there is anything different. It's just that I am *put* in the situation every day….". This justification neglects to acknowledge one important fact. That as emergency responders, they have *chosen* to be in those situations every day. Acknowledging that there is an active choice to do the job every day, may be a key difference between themselves and non-ambulance people, and a very much less than 'ordinary' choice. The second claim, that there is nothing special about what *they do* in an emergency response situation, was justified with additional claims of not knowing what they do specifically to 'cope' in response situations.

> I didn't know if I was going to do the study because I read it and saw that it was about "coping strategies" and I thought "I don't know what I do to cope" … so .. ha ha
>
> I: Yeah. Every single one of you has said that to me.

This common claim of not knowing what they do to 'cope', or what might be considered 'coping', could perhaps be because 'coping' is a psychologically constructed term, that may be understood to indicate specific processes that can be learned or carried out. The participants will probably have been exposed to some media or literature regarding paramedics and other emergency responders, proposing to inform them about the stressors they are exposed to, and recommending coping strategies for someone in their role. They also live in culture where articles on such topics even

appear in supermarket magazines, and in the home and living sections of weekend newspapers. As suggested by Abell and Myers (2008), when asked to articulate with regards to these strategies, the participants will be aware of the discursive context as a research interview, and may present these known social constructions, which they consider to be appropriate to the context.

> Going to the gym. That's good. Going fishing .. that sort of stuff…..
>
> ……
>
> I: And what about negative coping strategies that you see other people using?
>
> Eating badly … ha ha ha .. Negative coping strategies um … I think .. I don't really know how people .. let's talk about "X" again .. people like him survive with families they go home to. After a night shift he will maybe get two hours sleep max and he has to spend the day with his family look after his kids or whatever then he will come in for another night shift and I'm just like .. I could not survive I don't know how he copes and I think long term it can't be very healthy at all .. um I guess it's not specific coping strategies um … I know you want me to say drinking or smoking drugs or something.

Their claims to use only socially and culturally sanctioned 'normal' coping strategies that anyone else might use, function to support the paramedics' self-constructions of ordinariness. However, while positioning themselves explicitly as 'ordinary', and claiming that anyone could do their job, a contradictory construction is dually presented. That is, a more implicit notion that they are in fact functioning extraordinarily. Regardless of having maintained to be unaware of using any explicit coping strategies, or to only be using the same types of ordinary strategies as non-ambulance people, these claims that they cope well repeatedly in high trauma situations function to covertly suggest that they do understand themselves to be more than ordinary.

> I: Is there anything that you think that we haven't talked about in terms of coping with emotional reactions or physical reactions or coping strategies? Anything that we haven't talked about that you kind of thought about before that you wanted to mention?
>
> No .. just that you talked about Christchurch [earthquakes] and what really um .. is significant to me is that I understand……. We have "Christchurch" in Auckland everyday .. you know? I .. like I said .. I have been to 4 deaths this set. You know. I have been to 3 status one patients in ONE NIGHT on Saturday night.

So, there is a tension emerging here within the discursive constructions of themselves that the paramedics have presented. That is, there is a mismatch between the overtly claimed constructions of the paramedic role as 'ordinary', and the covert propositions that they might consider what they do to actually be 'extraordinary'. These propositions

are also subtly constructed by the paramedics' voluntary participation in the research. One could argue that volunteering to participate in a study, which requests them to share their understandings of their reaction management, is in itself an acknowledgement by the paramedics, that on some level they do hold a conceptualisation of what they are doing to cope in a response situation. Additionally, the fact that the research aims to investigate what *paramedics* do to manage their reactions in emergency response, indicates to them that what they do is expected to be found different, and perhaps less ordinary than what a non-ambulance person does. Hence, the motivation for the research question. This proposition is supported by informal comments from paramedics on the observation shift, and from paramedics both before and after individual interviews and discussions. Outside of the formal data collection contexts, the paramedics expressed hopes that the information they were sharing regarding their reaction management would benefit trainees in future reaction management skill training.

Within the paramedics' discursive constructions regarding reaction management we will see this tension, or contradiction regarding their constructions of ordinariness. This appears in three main areas that are alleged to impact how they manage their reactions. Tension arises with regards to the paramedics' understandings of themselves in relation to what expectations the public have of them, what expectations the organisation has of them, and their own more covert self-expectations. So, what does this construction of themselves as being ordinary, which appears to be at such odds with the expectations of the role, afford the paramedics in this discursive context? Perhaps in part, constructing themselves as ordinary functions to place the paramedics in a protective position socially. Forming discursive constructions of themselves as ordinary may actually be an effort to moderate these expectations they claim are placed on them within the role. In other words, if the paramedics claimed to be something other than ordinary, this may open them up to more demands of being extraordinary, a risky proposition in a job where they deal with life and death situations, which they will not always be in control of. While not officially New Zealand's national ambulance service, in 2007, St John reported that they handled 86 percent of ambulance responses in New Zealand (Hunt, 2009). In an emergency New Zealanders expect to see St John ambulance paramedics, and expect to see them function in a particular way. The following discursive constructions the paramedics allege instances of added pressure in

the response situation, from public expectations of the paramedics' role function and capabilities, due to misinformation from media exposure.

> In the end we said "This isn't working. We are going to stop. There is nothing we can do for him". She is saying "Give him some more drugs .. haven't you got something else in that bag? Give him something else". The expectation was that we would be able to save him. And you often get that because people watch these TV shows where it's one zap and people stand up and they're fine.
>
> ……
>
> We have people watching reality shows and stuff like that .. 111 .. it's great for the profile of St Johns but I don't know if they have thought about a lot of things for the crews that are out there on a day-to-day basis. You know .. "why is there not an Advanced Paramedic here?" .. "There is always an AP on TV?" .. "When's the AP coming?" .. "When is the jeep coming?" .. "Well there is not" .. "Well why not? .. that's what happens on TV!" They say "Well .. is my Mum not sick enough? So they send highly trained paramedics to sick people. Well .. my Mum's sick .. Look! See she is sick!".. [there are] all these unjustified expectations that every ambulance is going to have an advanced paramedic on it. Cos that's all they see on TV. "When's the helicopter coming?" you know "Look the bone is sticking out of my Dad's leg .. they sent a helicopter last time to that guy on TV .. how come one is not coming today?" .. "Well cos it's not justified" .. "What do you mean it's NOT JUSTIFIED!" you know .. so you get all that pressure as well.

The public expectations of the paramedics to be extraordinary, and perhaps prevent a death, are constructed as unrealistic, and beyond their capabilities in these circumstances. These claims regarding the unrealistic nature of public expectations demonstrate to us the protective functionality of the paramedics' explicit self-constructions of ordinariness, in a situation where they are unable to prevent a death. While the pressure here to be extraordinary has been claimed to come from public expectations, in the following discourse we start to see the tension or contradiction in this construction, when we examine where this so-called pressure is coming from.

> ….And I sat there and thought to myself "that arm is white. I don't know if I want to go down there because if I touch it and it falls off .. I am going to scream and I didn't want that to happen .. you know I didn't want to look like I couldn't cope with it or something". It was just something I thought in my own head .. there was no way that I could show any sort of emotion or scream .. or something like that. So it's trying to keep hold of yourself .. together.
>
> ……
>
> I guess I don't know .. for me it does come down to that professionalism .. um to get all emotional and cry at a scene isn't really adding anything to the scene and in my opinion I think that people that call an ambulance want someone to turn up who is in control .. and that's .. they are all freaking out .. they want someone to turn up who is confident and in control……
>
> ……

> JW: In those situations I think that you have got anger inside .. but it's also you have got to keep .. you can't um .. you can't show judgment either-
>
> MH: -No ..-
>
> JW: -.. you can't .. you are in a professional role. You are wearing a uniform and you are there to help. Your job is to help the child. You know it's like in that sort of case .. or when you deal with someone who has been raped um .. you just .. that emotion is only natural I think that you want to-
>
> MH: -You want to continue to be their advocate don't you? You can't do that if you at odds with people-
>
> GA: -No no-
>
> MH: -So you have to take a kind of .. not a submissive role .. but you know a placating ..-
>
> JW: -Keep in intact don't you? You have to keep you emotions a little bit-
>
> MH: -Under wraps.

While the paramedics' overt self-constructions of ordinariness may be in conflict with the public's expectations for extraordinariness, their covert understandings and expectations of themselves to be extraordinary, are not. The discursive constructions above, regarding the expectations to manage their reactions, stay calm, be professional and impartial, are maintained in absolutes. For example "…you can't" and "…you have got to…", indicating that actions are constructed as constrained due to the expectations of their role. Despite the previous claims that it is the public who set these expectations, constructions such as "it has been in *my mind*… that you *have to* be seen to be the stronger person", suggest that these absolutes are self-expectations. These self-expectations of high functioning are in line with the paramedics' covert understandings of their potential and ability to be extraordinary. Conversely, these self-expectations are in contradiction to their overt constructions of being 'ordinary'. Some of the discursive constructions from the paramedics regarding public pressure, are more explicit in their claims of self-expectations. However, these claims still maintain that actions or ways to manage reactions are being chosen in response to public expectations. In this way, they can claim altruistic motivations for these self-expectations, which are framed as an attempt to live up to public expectations of extraordinariness, rather than their own.

> I think that sometimes the expectation of paramedics .. that we put that expectation on ourselves .. but also to protect the public … I don't know if you know one of our girls attended a job on the motorway where a young girl had been stabbed to death and she found her in the back of a car .. the north western motorway and it was televised of her .. her sitting there with her patient report form crying on the side of the motorway. And that had such a massive emotional response across New Zealand. Like they were just flooded with

> emails and texts like "the poor paramedic" and stuff like that. You know .. so I think we cry in private to protect the public as well as ..

So where do these covert self-expectations to be extraordinary originate from? Occupational health psychologists Demerouti, Mostert and Bakker (2010) suggest that attitudes and expectations of functioning can quickly become contagious and normalised in a team context. More specifically, individuals in the workplace are suggested to take cues from team norms demonstrated by their superiors (DeValve & Adkinson, 2009). Following the suggestions of this health psychology construct of normalisation we can easily identify constructions made by the paramedics maintaining these expectations are indeed rooted in the historical culture of the St John organisation, and within current professional expectations of their paramedic role.

> ….. it goes back to those guys with those 20 years service you know ……
> that we could handle anything and everything that we saw and that that was just how it was. That you didn't cry and stuff like that .. or you cried when you got home .. or you cried in private .. you know ….
>
> ……
>
> GA: -And you don't show emotion .. you either deal with it and forget about it-
>
> JW: -Yup-
>
> GA: -Or you leave the job. If you "can't cope" you don't do the job.
>
> ……
>
> And I know that a couple of times when we have been to really horrible stuff and said "Can we go back to station .. and have a cup of tea and a bikky or whatever" and then they send you on another job. You don't feel like you can ring up and say "Hang on a second .. I'm going to actually be capable of functioning…"-

However, there are two aspects I will argue are not taken into account by Demerouti et al. (2010) and DeValve and Adkinson (2009) in the normalisation construct used as an explanation for adopted organisational expectations for responders. Those are firstly, the prior knowledge of an organisation's culture an individual may have before they join the organisation, therefore secondly an individual's self-selection into this culture. The St John organisation was established in 1885, and has a history of providing support during war times. These historical foundations are cited in literature as the origination of the attitude of stoicism, within the organisation (Hunt, 2009). The types of organisational expectations claimed by the responders, particularly with regards to not showing heightened emotional expression, are very similar to the public expectations of

responders they claim. One might assume that at some stage, prior to being a paramedic, these individuals were once members of this public, therefore might have possessed prior knowledge of the public's expectations of responders. In light of this prior knowledge, and due to their voluntary self-selection for the role, we can surmise that the individuals probably knew there would be expectations to be 'extraordinary', and furthermore suspected they may be capable of this extraordinariness.

Within the paramedics' discursive constructions regarding the expectations for reaction management placed on them by the organisation, parallel notions of self-expectations are more explicitly acknowledged.

> How I look at it .. when you do a job like this it's like .. how do I put this .. you are kinda forced in a way that you have to cope……..It sort of seems like you are SUPPOSED to cope. When you go into these jobs in the emergency services .. that's kind of what you have to do. Well .. it is in *my* mind .. and to display being really upset by it [a response incident] or something just seems like it wouldn't be a cool thing.
>
> I: For yourself?
>
> Yeah .. and so you weren't going to look like an idiot or something .. and this is only in your own mind. Even if I did do something like that .. your colleague probably wouldn't think anything of it. They would probably laugh at you or something .. ha ha .. but you know? But you just didn't want to be seen in that light if you did something like that.
>
> ……
>
> I don't think I have been coping as well as I probably should .. or could.
>
> I: When you say "should or could" .. according to who?
>
> Um .. I guess according to the attitudes in the service .. but also according to me. It's what I was alluding to earlier. It's kind of the attitude that has been as I believe in the service for a long time and it's the attitude of "it's just a job. Get on with it" and "if you can't cope .. you need to leave" type attitude.

The presentation of their self-expectations, paralleled alongside claims of organisational expectations, functions to suggest that the organisational expectations are the impetus for the self-expectations. This paralleling serves to provide justification for discourse that might otherwise appear to merely be the protecting of their self-image. That is, the desire to live up to their own covert constructions of being extraordinary, and not "…..look like an idiot or something".

Regardless of where the expectations of their role are claimed to originate from, the paramedics maintain that there are several types of emergency response situations that affect their ability to manage their reactions, and jeopardise their ability to fulfill their role expectations. They claim that these types of scenarios raise their own emotion

levels and disrupt their thought processes, compromising their ability to technically function.

> ……. if you get too emotional .. if you get too emotional in a job it's going to affect your thought processes. It's going to affect everything. You may not do it to the best of your ability.

The response situations proposed as most likely to affect their ability to manage reactions are; when there is high emotion from patients and their family; when a situation becomes unpredictable and starts to feel out of control; and when a patient is known to them, so the job feels personal.

> **Situations with high family and patient emotion**
> …..The worst thing for me was that she was young and she was in SO much pain. And the GP didn't want to give her any more pain relief and she was trying to get up off the stretcher to throw herself out the back door. Just to run away. You know that fight or flight thing. And she just wanted to get away from this pain. And there was nothing I could do for her. I tried all the things I could do .. and there was nothing I could do for her. And she died in the back of the ambulance in horrendous pain .. and we carried on resuscitating her for a while .. and we tried to get help. But we were in the middle of no-where .. it just seemed to go from bad to worse…..

> **Unpredictable situations**
> I knew that [it had failed] after I had started it [a procedure] .. so yeah after I kind of jumped in and had gone that far I was like "Oh no!"-
>
> I: So when you are in the middle of that situation are there thoughts and emotions?-
>
> I guess after I had tried and failed I just yeah …….. I don't know how to explain it just feels like you've the worst thing ever and you don't know how to make it better .. and you also know all your colleagues also know that .. that you have completely messed it. I can't really explain it .. like you're not as good as you would be if you're not really there. Like when we where taking him to hospital I was like "OK what do I need to do .. what do I need to do?". I was almost at a mind blank because I was so worried about the fact that I had messed up so bad. So yeah you definitely not as good as you could be.

> **Situations that feel personal**
> I don't mind talking about it .. but I might have to get some tissues. My Dad has got [degenerative disease] and It's when I go to jobs that …… [starts to cry] It's really shit. So it's when I go to jobs .. and then I can see what he is going to be like…….. we went to an old fella. And he was old. He's allowed to have [degenerative disease]. 60 year olds aren't. And he's got heart problems and all sorts of other stuff as well.

The paramedics claim that these types of emergency response situations primarily affect their ability to manage their reactions because, instead of being able to focus on job tasks, they become distracted by external factors, such as the patient's situation. However, looking critically at the discourse, it appears to be the paramedics' own

judgments of *how they are reacting to the situation*, rather than the *situation* itself they find distressing. For example, the speaker commenting on 'unpredictable situations' said "….*I was so worried about the fact that I had messed up so bad*", and the speaker commenting on 'situational emotion' said "…..*I tried all the things I could do….there was nothing I could do for her*". These responses have previously been constructed as 'meta-emotions' (Salters-Pedneault et al., 2010). This is a proposition that paramedics have experienced a secondary emotional response to a situation, or a judgment of their own initial or automatic reaction to the situation. These secondary responses may be more accurately described here as 'meta-reactions', rather than 'meta-emotions', as we have considered that reactions are not only emotional, but the interdependent functioning of emotion, cognition, behaviour and physiology (Corcoran et al., 2010; Koole, 2009). While the paramedics discursively constructed the notion that heightened situational factors cause a drop in concentration, which then affects their confidence in their technical abilities, it may be the outcome of the 'meta-reaction' process, which is actually affecting their confidence levels. That is, when the paramedics' self-judgments or covert self-expectations to be extraordinary and able to manage their reactions under stress are shaken, their confidence in their technical ability drops. Revisiting the proposition that "we don't see things as they are, we see things as we are" (Nin, 1969, p. 124), we can understand that this sense of expectation from others will always be experienced from an individual's own perspective anyway. In this way, an individual's interpretation of the expectations of others can actually be considered a *self*-expectation.

Despite the paramedics' overt claims to ordinariness, opposition to this claim, and contradictory constructions of understanding themselves to be extraordinary arise from several sources. Contradictions appear via the paramedics' participation in this research study, in their self-selected choice to work for St John, and frequently in their own discursive constructions. Whether maintained to be historical, organisational or social expectations of their role function, the voice that expects extraordinary functioning, or that acknowledges the extraordinary aspect of the work they do, is claimed to be anyone's but their own. In the following quote a voice of authority is borrowed from a colleague, to construct themselves as extraordinary, while dually constructing their role as ordinary.

> …… what we see in our job other people never experience in their life time .. you have just got to find that way. Like I said to you .. "X" who is ex-army who was in [war zone] .. like I said to you in our interview is that ***I*** just see us as coming to work .. driving round in a

> little ice cream truck doing our job. Just going from one job to another. And "X" quoted himself one day and ***he*** said to me "the only time you will see more suffering is if you go to war".

Justifying the necessity to behave in particular ways and manage your reactions due to organisational and public expectations, functions for the paramedics as valid, commonsense and even admirable rationalisation for these choices. Ultimately these expectations, claimed to be impacting their actions, are experienced from an individual's own perspective, so attempting to separate them into *self* and *others* expectations is, in a sense, a redundant exercise. However, within their discursive constructions of themselves as a paramedic, without these separations, the paramedics may risk appearing as though they are simply prioritising themselves, or the protection of their own self-image. This is a position that does not align with the frequently cited altruistic motivations claimed by emergency responders (Howe-Willis, 2002). Possibly more importantly, without the voice of *others*, they risk acknowledging that despite what they claim, they too expect themselves to be just as extraordinary as the organisation or the public do, thus risking the protective cover of their claim to ordinariness.

CHAPTER 5

Balancing being a 'technician' and 'only human'

This second chapter will progress the chronological exploration of reaction management from the paramedics' role construction onto the actual functioning within the role. The chapter investigates how these functions come to be defined and taught, and how this subsequently informs paramedics' management of reactions during incidents.

When recalling incidents and constructing understandings about the functions performed within their role, the paramedics conceptualise the actions of their role as very methodical and technically based.

> Our job is tactile. It's tactile……. At the end of the day it's a tactile job. We have to do this .. put this into here stick a needle in here .. do different bits and pieces .. we are very much using our hands all the time.
>
> ……
>
> We have something to fall back on even when there is nobody else around. That's ingrained. You learn those protocols and procedures .. and that is what you do.

A core conceptualisation is constructed that being a 'technician' is their principle job function. During informal discussions with paramedics, in the hospital ambulance bay, some paramedics claimed to literally remind themselves while they are working, that "I am a technician". The paramedics maintained that this helps them accept the reality of what is possible, and to not blame themselves if a job falls very wide of the parameters of the available resources and skills. This understanding of themselves as a technician, is claimed to be rooted in the historical culture of St John, and is maintained to still be reiterated to new St John trainees.

> I worked with very experienced officers…….. and they said to me there are three things you need to understand about a paramedic. He goes .. "As soon as you come to terms with the fact that not everyone you go to is going to live .. that's just life .. you know .. age-wise whatever. Not everyone you go to is going to survive". The second thing he said to me was .. "as long as you go to a job and you do your very best and you can stand back and can say .. I gave it my best crack .. then you will be fine". The third thing he said to me was "What's the difference between God and a paramedic?" He said .. "God doesn't believe he is a paramedic .. so no paramedic should believe he is God". And I still relate that to my trainees now and that's helped me.

To discursively construct themselves as 'technicians' appears in some senses hold the same benefits as constructing themselves as 'ordinary'. The construction functions to impose inherent limitations on a response situation, and facilitate an acceptance with regards to the paramedics' scope of practice, limitations of available actions to reduce pain, and the impossibility to prevent loss of life for all patients. While the construction of being a technician is conceptualised as being protective, with regards to setting realistic self-expectations, it also seems to create a double-bind for the paramedics. On one hand, understanding yourself to be a technician who has specific "protocols and procedures" to follow, which naturally impose realistic limits and predictable outcomes, is protective. On the other hand, specific "protocols and procedures" could also understandably create expectations for failsafe actions and outcomes from the paramedics, given that the guidelines are apparently so clear. However, it is maintained that in reality, that this is not always the case.

> ……..at the end of the day [my ambulance partner] did the right thing anyway. He still had to treat what he was seeing .. but yeah it was really hard because we .. we have just killed this woman .. we have been instrumental in her death.
>
> ……
>
> …….we are only human and we will make mistakes and I don't think that anyone wants to be in that situation where the mistake that they make is responsible for making someone…. for someone becoming worse than what you had. But it has happened .. it's gonna happen and it will continue to happen.

So, a second core conceptualisation of themselves is presented here, a notion that while they understand themselves as a technician, they hold an equal understanding of themselves as 'only human'. This proposal to be 'only human' is constructed as a knowing and acceptance of themselves as fallible and emotional.

> For me I know that we are human and we stuff up. And there are times that even when I go through in my own head there will be times when I think "Shit .. could I have done that better?" And this person has died. In most cases you know that .. in most cases the outcome was going to be the same.
>
> ……
>
> ….from an emotional point of view .. pediatric deaths and that .. I have learned to cry. You know .. there is times to be ten foot tall and bullet proof and there are times just to be humble and realise that you are really human.

This second construction, to be 'only human', appears to almost be an antidote to the potentially unrealistic, failsafe expectations that might be expected of a 'technician'.

These two constructions of being a 'technician' and 'only human' are claimed to be held concurrently.

> -And I think at the end of the day when we go to a job like that we try to do our level best .. to the best of our ability we do the job. And as "X" says "we are only human and we can make mistakes". But at the end of the day we try .. we bust our arse to do the best job that we can.

While being a helpful antidote to the expectations of being a technician, in some ways being only human appears to be a contradictory position to claim, and to hold concurrently. However, when analysing them together, both constructions, to be a technician who "will try to do their level best", and to be only human and "make mistakes" or "cry" are similarly protective for the paramedics. This is because the conceptualisation of being 'only human', like being a technician, also borrows from the protective construction of 'ordinariness' in terms of its function to moderate expectations. In other words they will do their best, but in the end are only human like anyone. All bases appear to be covered by these two constructions. The paramedics can claim to be a person who functions within the technical limitations of a role, so are protected by these inherent limitations should the *technicalities* of a situation limit their ability to prevent an unfavourable outcome. At the same time they claim to be only human like anyone else who is inherently fallible. They are therefore equally protected by the 'human' construction, should their *own mistake* in a situation cause an unfavourable outcome, or should their outward expressions indicate that they feel overwhelmed by a reaction that they are experiencing. An additional benefit of this 'human' construction is that it fits their self-views of being naturally altruistic people who will do their best, but who are constrained by the same limitations of reality and emotions that non-ambulance people are.

> I think ….. this job does attract people.. who have .. who normally have a caring nature who want to help people…… in general terms I think it's .. we are a service that wants to help people and to look after people. And …um I suppose we try and …… try to employ people who we think are going to cope.

These human and technician understandings of themselves are claimed to both be present during an emergency response situation. It is maintained that the understandings can be harmoniously balanced, to allow access to the benefits and action orientations available from both modes of functioning; in a sense a type of dual functioning. There are two main types of justifications for how the utilisation of the dual

functioning is managed. These are proposals that the dual modes of functioning are monitored and balanced, or that they can be switched between, with a sense of voluntary control.

> I: …Can you concurrently manage those emotions of your own in your head and do your [technical] job?
>
> Yup. If I don't think I will be overwhelmed by it .. I mean I am a really compassionate person and that is why I love my job so much .. and I quite often .. there is definitely a line you don't want to step over .. but I am definitely always very involved with the family of the patient and make sure that they feel a connection with me as well because it's important that they feel like the person is getting the best care and that the person looking after them does actually care. So I will often just let myself .. as long as I don't think I am going to burst into tears or be overly affected by it then yeah .. that is usually how I operate.
>
> ……
>
> ND: I think it lets you get on with doing what you should be doing .. for me it is specifically during cardiac arrests .. and it's probably because we practice cardiac arrests on mannequins .. but it also allows me to completely disassociate myself from the fact that this is a person and let myself think of all the technicalities of what I am supposed to be doing……. if I am worried about the fact that this is a person who has a family .. who has parents .. children .. brothers sisters .. then perhaps I can't focus exactly on what I need to be doing as well as I could be .. and it's like a switch .. as soon as the cardiac arrest is over then I can turn it off and the person becomes a person again .. and I will treat the with the absolute utmost respect especially if they have died .. they are not just a mannequin anymore ..
>
> I: So that literally is just for something like cardiac arrests?
>
> ND: For me it is.
>
> I: It doesn't flow through to-
>
> ND: -It happens if someone has some real traumatic injuries as well .. when you are just dealing with the absolute nitty gritty of what's happening in front of you .. and as soon as I have stopped having to think at a real kind of high functioning level to make sure that I am going to do everything that I can and should be doing .. then I can just turn it off. I don't know if it's a good thing .. but that's what I do.
>
> BL: Yeah .. what she said.
>
> DK: Yeah

Already in the claims regarding dual use of these functional modes, we can see issues begin to arise. Firstly, there is a disclaimer regarding the conditions under which these modes can be balanced. That is, "…*if* I don't think I will be overwhelmed by it...". This claim indicates that the balancing of a human reaction, while being a technician, may actually come with some risks attached to it. The inference regarding the risk of becoming "overwhelmed", is that the paramedic could potentially cease to be able to access their technical actions. Secondly, a caveat is claimed in the group construction

that the dual functioning is "…like a switch…." and "….I can turn it off…" *after* finishing operating as a technician. These issues suggest, that while being human has been constructed as an acceptable action or reaction to an emergency response, that there are perhaps some more implicit understandings regarding this acceptability.

When going on to further analyse the paramedics' discursive constructions regarding their own reaction management, and that of others, we will see that conflicting constructions and difficulties arise. Conflicts arise not only regarding the claims to be able to balance the constructions of being a technician and human, but also regarding the acceptability of this human reacting. These conflicts arise in four identifiable areas: with regards to organisational expectations and learning of reaction management skills; the types of reaction management strategies they claim to find most effective; the anomalies within their claims to accept human reactions from themselves and from others; and with regards to changes in their emotional functioning over time.

In the previous discursive constructions, regarding dual utilisation of the functional modes of technician and human, the speakers alleged that there are potential functional risks, if the balance is not maintained. As we start to explore these four major conflicts, we will see this notion of balancing the dual functions is not as simple as it was initially constructed. The first conflict appears in the following constructions about where the paramedics learned reaction management. In addition to potential functional risks, social or cultural risks are also claimed as repercussions for not sustaining this dual functioning successfully. These risks are proposed to be, appearing unprofessional and losing the respect of colleagues.

> Um .. I think it is. At the time it wasn't I was told .. I was told I needed to move away and sort of .. I'm not sure I was *told* to pull myself together .. but that was the implication. I needed to……. I don't know what the rationale was. My way of thinking was that .. what I though of at the time was .. you are in uniform .. you are supposed to be professional and ambulance people don't cry .. so that was what I took from it. But I never asked the person what their issue was.
>
> ……
>
> Goes back to those guys with those 20 years service you know …… It was a process where you talk about professionalism and stuff like that. And apparently being professional was being emotionless. You know .. that we were professionals and that we could handle anything and everything that we saw and that that was just how it was. That you didn't cry and stuff like that ..

While tight knit cultures are suggested to create a sense of loyalty and belonging, they may also foster complex implicit expectations of group members

(Alexander & Wells, 1991). In organisational psychology literature the concept of an unspoken 'psychological contract' has been constructed. A psychological contract describes a sense of what the group member may feel is expected of them, over and above their job description and technical functions (Pilbeam & Corbridge, 2006). These perceived behavioural expectations for reaction management, or the psychological contract, may come from the expectations of the organisational culture as it is interpreted from the behaviour of peers and management. The paramedics' experiences as new recruits start to form this unwritten psychological contract. This contract suggests that it actually may *not* be that acceptable to conceptualise yourself as 'only human', or display this human response. These constructions around examples of reaction management start to form a justification which alleges that the lack of acceptability is rooted in the cultural history of the St John organisation. However, if we look more closely at the discursive constructions, and who they are formed by, we can see another source appear. Claims such as "….. that was what *I* took from it" and "*apparently* being professional was being emotionless" sound more like individual perceptions of cultural expectations, than explicit instructions.

So, firstly they have claimed to have been exposed to expectations of what were *not* acceptable ways to manage their reactions. Secondly, they go on to claim to have received no actual training or instruction for how to manage their reactions. There are two main claims made in the following discursive constructions, regarding the learning of skills for reaction management. Those are, that there was *nothing taught* to them with regards to reaction management, and that there is *nothing that could be taught* to prepare a paramedic for the job.

> I: So there is no training around "here are some coping mechanisms….?"-
>
> -Nope. Never had any training on coping mechanisms. No one has ever been told about coping mechanisms. You learn them on the job……. Certainly there are no coping mechanisms. For what we see I don't believe there is any coping mechanisms.
>
> ……
>
> JW: ……You can't train somebody to situations because you just can't do that until you are faced with them .. you can simulate them. But a simulation is never the same as what you see in real life.
>
> MH: No
>
> JW: And so people don't know how they are going to handle a situation until they are confronted with it.

MH: That's right.

For the paramedics, discursively constructing reaction management skills as un-teachable and un-taught appears to serve two main functions. Firstly, the understanding that training is futile and that you will need to figure out how to cope by yourself, perhaps reinforces a sense of achievement, self-reliance and efficacy for having achieved this, and having become a proficient technician in all aspects of the job. Secondly, it positions eventually possessing the ability to manage your reactions as having navigated a 'rite of passage'. Consequently this earns respect and positioning within the hierarchy that is claimed to be ingrained within the organisation.

> I just did what I was told. In those days it was probably more hierarchical .. sort of. You had people that were um .. these people .. the person that came to us was basically. They were considered to be like the 'God Squad' .. they didn't walk on water. They walked above the water so they didn't get their feet wet. Um .. so if one of them said "this is what you are going to do" .. then basically that is what you did.
>
> ……
>
> You are talking about a rite of passage right? Well this is how pathetic it is…… it's an unwritten rule of thumb that the senior person "clinically" drives first. On the first job [of the day] the most clinically highly trained person gets to drive the ambulance first.

Both this sense of achievement, and the 'rite of passage', can also be considered evidence or justification for their previously constructed covert understandings of themselves as 'extraordinary'. Now we can start to interpret some logic for the contradictions regarding the acceptability of displaying thier human side. Having worked so hard to secure this position of hierarchy within the organisation, perhaps by proving that you can manage your emotions and not showing your human side, it becomes apparent that there are social risks at stake for being seen to *not* be managing your reactions.

The second main conflict arises with regards to the types of actions or strategies the paramedics undertake to manage their reactions, and claim to find effective. Their claims do not support their original proposal to use dual modes of functioning. Although the paramedics claimed to balance or switch between human and technical responding, when discursively constructing what they do to manage their reactions, the majority of actions they claim work effectively, are framed from an understanding of themselves as needing to operate as a technician, rather than framed from their human construction. The actions they claim to use to manage reactions, can be split into two

sequential steps and viewed as strategies. The initial step of reaction management is claimed to facilitate calming and refocusing for themselves, when encountering a heightened situation. The second step of reaction management is conceptualised to facilitate a separation of themselves from the patient.

The first step of reaction management is alleged to be utilised by the paramedics to re-orientate their attention. They present several conceptualisations of how this is facilitated. These concepts are, pausing to refocus themselves, instructive self-talk to calm their reactions, and deliberate focus on tactile activities.

> **Strategy of pausing to refocus**
> You just do I suppose. Um .. for me I try with any patient that if I feel myself getting worked up about things I try and mentally .. if not physically take a wee step back and just take a couple of deep breaths to calm everything down and then go back in. Um .. and that seems to work OK. You can't always do it .. it obviously depends on how sick the patient is and stuff but generally it's sort of at least a mental step back .. a couple of physical deep breaths and back into it to just try and calm that stress and stuff down.

> **Strategy of instructive self-talk**
> Well .. probably like .. "get yourself together" .. "sort your shit out" you know .. ha ha "Pull yourself together and sort your shit out". And it's going through your head. "Can't do it .. can't do it .. can't show any sort of .. gotta focus". And it's going through your head "I have to focus and this is what I have to do".

> **Strategy of tactile focus**
> If I do feel like I am going to be overwhelmed by it than I will usually try and become task focused and distract myself with a job .. and stop talking.

Emergency response literature usually constructs these type of actions as 'restructuring' style strategies, and proposes they are employed to redirect attention away from threatening situations in order to regulate unwanted emotions (Roese & Olson, 2007). John and Gross (2004) argue that this re-orientation style of strategy is a manipulation of the responders 'true' emotional experience, and a distortion of reality with potentially negative outcomes. These types of explanations fall short of considering the functionality of these strategies. As Salters-Pedneault et al. (2010) suggest, having just experienced an instantaneous reaction process, or what John and Gross (2004) call 'true' emotional experiences, people develop strategies to manage these reactions. So, the functionality of strategies that redirect attention can be understood as having been learned by the paramedics as a way to prevent becoming overwhelmed by their self-orientated emotional experience, which may be perceived as a risk to their technical functioning. When constructing how these types of strategies are facilitated the

paramedics propose that they place their own human response to one side, and focus solely on their technical responding. This contradicts their previous claims of being able to, either balance and/or switch between these modes.

The second step of reaction management is proposed to facilitate a separation between the paramedic and the patient. The paramedics construct the use of several strategies to achieve this: creating emotional distance for themselves from the patient and their family; depersonalising the patient; and facilitating emotional detachment from the response situation. This emotional separation is justified as necessary, for the paramedic to focus on the technical response tasks.

> **Strategy of emotional distance from the patient and family**
> ….. so you might be working on a cardiac arrest and if you start thinking too much about what you are doing working on a person or their background with family and stuff I guess it can get quite emotional .. where as you can't really let yourself. In my opinion really you can't let yourself get too emotional because it then starts to affect what you are doing.

> **Strategy of depersonalising the patient**
> You divorce yourself of the emotional person. The person no longer .. does not remain a living entity. They become a something that you are observing. Like you would observe a book or a film on anatomy. You can look and say "gosh .. is that what brains look like' so you can use it as a point of interest I suppose.
>
> I: And why is that helpful?
>
> I guess it enables you to function in the task at hand. When your emotions get high your thought processes drop off. So to me .. the higher the emotion .. the higher the stress .. the less you function at.

> **Strategy of emotional detachment**
> ……I remember thinking at the time "this is really weird .. it's like it is a mannequin". I had NO attachment to the kid at all. I remember feeling really overwhelmed by what was going on around me. But I had no overwhelming feelings about what I was touching or seeing with the kid. I was completely detached from it……. And I don't even know how you do it. How you become so detached from them .. but then you talk to paramedics and they say "well it's necessary. If you can't be detached from them then you can't think clearly".

These types of strategies used to create distance are often constructed as avoidance and suppression in emergency response literature, and alleged to be an attempt to escape private psychological experiences (Boulanger et al., 2010). However, the inability to be able to take control and manage their own reactions in a heightened situation, is also constructed in emergency response literature as dangerous for emergency responders, and detrimental to their technical performance (Jennifer, 2001). So clearly a heightened reaction needs to be managed in some strategic manner. In the paramedics' discursive

constructions regarding the use of emotional separation strategies, they propose that allowing the situation to become self-oriented or to let themselves "….get too emotional…." and human risks making technical functioning inaccessible. The strategies of creating distance and separation are constructed to facilitate technical control in a response situation via the deliberate removal of emotion.

So, both steps of reaction management, the reorientation of their attention and the separation created between themselves and the patient, contradict their original claims of holding and balancing both functional modes, of being technician and human. Both steps of reaction management seem to only work in an 'either/or' fashion, with a clear preference for the functional benefits of the technical mode. So, why discursively construct the type of functioning that alleges ability to balance both, to begin with? The following discourse, in which the paramedics attempt to extrapolate the construct of emotional separation further for the researcher, provides some answers.

> .. it's really hard to explain. It's like while you are doing chest compressions on something .. it's not a real person .. it's just a mannequin .. like we train on all the time.
>
> ……
>
> For me I seem to be able to do in most cases ..and it is only most cases .. not all of them .. you disassociate with it. So it's like someone you don't know .. and um .. you are just treating what you see. Does that make sense? It's kind of like-
>
> I: Try and explain it to me.
>
> Um .. so you know .. they are a person .. and you understand that .. but I think for the fact that most of the time you don't know them. So there is not an emotional level of actually knowing them.
>
> ……
>
> I: OK and how do you do the "distancing" you mentioned?
>
> I don't really think about it I'm just .. that's them .. this is me like .. ha ha ….. it makes me sound cruel and mean…….. If it's my family member then absolutely .. but if it's not somebody I know then it's not .. I don't even really think about it … it's not my pain.

The paramedics claim "…it's really hard to explain" and "…does that make sense?" and "...it makes me sound cruel…", with pauses and hesitancy. They appear to be alleging that emotional separation strategies may not be understood by non-paramedics. All of a sudden the paramedics are risking their constructed image of being 'human' and 'ordinary' like non-ambulance people. They are constructing the use of a strategy that sounds impersonal and cold, and possibly not aligned with their assumptions of the

public's expectations of them to provide caring treatment to their loved ones. Perhaps this is why it was important for the paramedics to construct their ability to balance both modes of functioning. These constructions may have been to reassure the researcher of their altruistic human nature, or perhaps even to reassure themselves.

> I: And is that a coping mechanism in itself? Why do you think it happens .. the whole "robotic thing"?
>
> [sigh] um ….. oh … I'm not 100 percent sure. I'm not sure if it's just that staff are …. I'm not really sure …it's just … you know are we becoming that disassociated that it just doesn't matter anymore? Because we have seen that much death that it just doesn't matter anymore?
>
> ……
>
> I've probably told hundreds of family members that their spouse has died. Um .. so it becomes easy for me um .. so I suppose with that experience .. I started to think .. do I find it easy because I have the experience? But when I am doing it I have …. I am showing empathy .. um am I actually feeling it? Or am I showing what I think they need to see?

Is the real utility of constructing a dual functioning mode that it helps them maintain their *own* self-view, that this is how they still function? Perhaps claiming to use this style of functioning justifies to themselves that they have not lost the ability to be human in their responding.

The flipside to this fear of losing their human side of responding, are the types of situations alluded to earlier, where their human nature could be in danger of "overwhelming" them, and affecting their technical functioning. In corroboration with what is frequently reported in literature to cause more heightened reactions in responders (Alexander & Wells, 1991; Ursano et al., 1999), the paramedics claim that when they 'identify' with the patient, heightened reactions often occur.

> Well for me it was .. incidences in my memory that have stayed with me the most of things that affected me .. perhaps it was the recognition of relating it to something in your own personal life that it seemed to play on your mind a little bit more.

Here, the paramedics sidestep their previous claims to balance and monitor their human reaction, so they will not become overwhelmed by it. Instead they justify that they allow themselves this outward emotional expression of their reactions.

> So I ended up crying with the wife and I actually think it was appropriate.
>
> I: Yeah?
>
> So she could just see that we were normal people.

> ……
>
> I just let some tears come down. I thought that was OK .. I thought "we are all human" .. and I thought "if her Mum had been there that's what would have happened".

The responses here are justified as being human, and are alleged to be understood as acceptable by themselves and the public, or colleagues. While these responses are claimed to be in keeping with the dual constructions of being "….normal people…" and human. These human responses are not maintained to function in the way they were originally constructed. In reality, these responses cannot always be monitored, controlled, and switched on or off.

> They put it [her dead baby] in a towel and brought it over and said to her "do you want to cuddle your baby" and she kind of recoiled. And I said to her "you sure you don't want to hold your beautiful boy….. and that's when I ….. I kind of lost it a little bit……..
>
> I: And when you say "you lost it" what do you mean?
>
> I just started tearing up. I didn't bawl or cry out loud or anything like that. And I think the staff were quite upset and that as well.
>
> ……
>
> Sometimes things do actually catch you unaware. You do .. for me you try to keep a lid on it. I mean there is always stuff that is going to…….. and you think "well I can't .. I have got to keep a lid on this" but you do get that exposure to something that for some reason it catches you unawares and you can't keep a lid on it.

This brings into question, if this type of human response is not fully within their control and is in danger of affecting their functionality, then why are they justifying it as acceptable and "normal"? This post-incident justification may be a response to a 'meta-reaction' they have experienced with regards to being seen to be not coping. Justifying that the response was acceptable may not only abate their own self-judgment, but also fears of functional or social risks that their reaction potentially exposed them to. Claiming self-acceptance may not only alleviate any dissonance they felt about how they reacted, but also any self-judgments about their own ability to live up to their expectations of being a capable technician.

The third area of conflict with the paramedics' claims to accept and balance human reacting is seen in their constructions of colleagues. Despite their continual claims to accept human emotional expression, contradictions can be found between their

constructions about emotional expression from themselves, and emotional expression from others.

> **Participant construction regarding their own emotional reaction to an incident**
> The issue was when we went and spoke to his mother. And said "I am sorry" we couldn't save her son. She asked if she could be with him. And we said "of course you can". So she went down onto the driveway with him .. where we had dragged him out of the garage. Got on her knees. Put his head on her lap and started brushing his hair and talking to him.
>
> I: Mmm. So it was her and her-
>
> -Yeah it was her emotions that upset me .. and I can still feel a little emotion now while I am talking about it.
>
> I: And what did you do with the emotion at the time .. you know-
>
> -I cried.

> **Participant's construction regarding emotional reactions from others**
> I: What do you think the culture is now around getting or showing an expression of being emotionally affected by something?
>
> Um …… I tell crews it is OK and it is a normal reaction to stress .. um so I feel that crying is OK…….. But I still believe .. personally .. that they still have a task to do and um .. they have to be able to function…….

The contradiction is that emotional reacting from themselves is human and acceptable, but from their colleague is risky, therefore implicitly unacceptable. The justification claimed here, for this lack of acceptance of emotional reacting from colleagues, is that it poses risks to technical functioning. This contradiction raises an interesting question. Is the construction of their colleague's response as risky and unacceptable, actually indicative of a covert judgment of their own emotional reacting? If so, this could be further evidence that their own so-called self-acceptance is simply functioning to remove dissonance regarding having had these reactions. To investigate this notion of acceptability further, we can examine the difference between the discursive constructions from a paramedic regarding human responses, when conceptualised in different discursive contexts. In the following example taken from an individual interview, when constructing emotional reacting for the researcher, the notion is constructed to be human and acceptable. When constructing the same incident for colleagues in the group discussion, the paramedic reconstructs the human response as "rubbish". The speaker's changes between contexts may indicate a covert acknowledgement that human reacting may not be so culturally accepted by the group.

Discourse regarding emotional expression in individual interview
I: Also I guess I am asking .. did you feel OK about crying?

Oh yeah. I think that is normally human. I don't think you could .. I think if you tried to be anything other than yourself it would be a false impression.

Discourse regarding emotional expression in focus group discussion
…….. there was lots of tears and that sort of rubbish .. and than after that it sort of started to subside so .. All good!

The change in their construction functions to mitigate social risks attached to being seen to not be coping. This brings us back to the notion of a 'rite of passage' and positioning, within the organisation, for having learned to manage their reactions. Once having secured this position, by being seen to cope, there may be social risks attached not only to displaying this human side, but also to be being seen to condone it. It is safer instead to construct human responding as unacceptable in front of the group. So, a cycle of reinforcing the condemning of this type of reaction subtly continues within the organisation.

The contradictions that have arisen between their overt claims to utilise a dual mode of functioning, and then what they actually construct to be culturally, socially and technically appropriate in some ways appears to be a split of what is desirable, and what is functional. It is a split between the way they want to construct their functioning for their own self-image, and the reality of how they do function because it is appropriate or acceptable in the emergency response context. This tension regarding their change in functioning over time, is the fourth area of conflict with the acceptability of human reacting.

JW: …..So in this last year I have realised what I had actually *become* out there on the road. And it wasn't something .. like you said .. it wasn't something I particularly liked. But it was something that when I came into the job .. being naïve as I was back then and I worked with someone who was a very 'strong' female .. and I thought that's how you had to be to get on around here. So over the years that I worked with her .. that person .. that's sort of some of the role that I took on. And it wasn't till I .. one .. probably met my partner and probably saw from his perspective .. and he just pointed out a few things .. ha ha .. and I was sitting there going "hmmm .. OK". And yet on the inside I knew what I was portraying wasn't the person that I was on the inside. But it was how to get that person on the inside out again-

GA: -Mmm-

JW: -Without .. without .. I wouldn't say "not coping" because .. I've always pretty much coped .. but yeah .. that probably doesn't make sense? But a struggle that you have with yourself…-

I: Between? …

> JW: I think there is an element of "who you *have* to be at work".

Here, technical functioning, or being seen to be coping and managing your reactions is constructed as necessary and desirable in front of the group, reflected by the claim "….I've always pretty much coped….". Yet in other ways, it is constructed as not completely desirable, because it is not "….the person I was on the inside" and instead someone "….who you *have* to be at work". This conflict is maintained to be a struggle between their internal understandings of themselves, and the external expectations of response behaviour, once again claimed to have come from the organisation. There is a disclaimer here by the speaker that this is not the true me, that this is a façade that was learned within the organisation, and is endorsed by the organisation. The technician is perhaps the version of *me,* required by the organisation, and the human *me* is the true *me* underneath, as I know myself.

> Yup. Um .. I think …. In the job allowing yourself to be a little more .. vulnerable I suppose just .. it probably comes back to this thing about being this hard *bitch* cos if I look at myself. If I look right underneath that's not who I am. I am a big softie. So I think this is an outer thing that I have been portraying and it's kind of like .. that's probably not such a good idea. Not that you should be completely vulnerable that you lose it all the time but just allow yourself .. I don't know to maybe feel the emotions rather than bottling it all up and going hiding somewhere and having a cry where no one sees you or going home and being angry about it or something.

This conceptualisation of 'true' self and 'portrayed' self, raises issues regarding the notion of truth, and the construction of self. As previously discussed, there seems to be a general agreement between Eastern and Western psychological understandings of self. Both psychologies construct a notion of self-concept, which is reinforced through our experiences. Individuals are suggested to attempt to hold these self-concepts rigid, in order to create a sense of control and predictability regarding their lives, and their world views (Welwood, 2000). However, despite the attempts to hold these self-concepts static, as living individuals we are a continually evolving constructions of ourselves. So, these self constructions at any time in their evolution can be considered to be truth, in as much as that they are constructed in relation to the social, historical, cultural, experiential impacts on our lives at that time. So when referring to previous knowing of themselves as the true self, in contrast to present knowing of themselves, perhaps it is not so much the true self that they desire, but more the preferred or self-acceptable self that they are referring to. The self that is both human, and a capable technician.

This notion of preferred self can help us make sense of the motivation for the initial claims of dual functioning. Perhaps these claims would have more realistically been constructed as the preferred idealistic view of functioning. That is, the way in which they want to know themselves to be functioning. However, as demonstrated by their discursive contradictions regarding human reactions, in relative terms this dual functioning may be unacceptable to the paramedics due to the risks it presents. A more technical mode of functioning has been favoured both historically and presently by the paramedics. Despite their claims to balance both modes of functioning, the necessity to operate solely as a technician is repeatedly used as the justification claimed for reaction management strategy choices.

While the paramedics claim to be moving on from a hierarchical culture where human expressing is not acceptable, their attitudes toward others, and perhaps also more covertly toward themselves are perpetuating this culture. The human reaction, is constructed as functionally risky in an emergency response, socially risky in terms of organisational positioning, and indicative to others of not coping.

> I: And is there any standard piece of advice that you feel is important that you impart on them as new trainees?
>
> Um .. I have always said to them .. that if I know we have gone to something in particular that I can see has affected them then I'm always .. it's what you usually do .. you ask if they are OK. But sort of more so now I say to them .. if you are not coping with it then it's OK. You can say .. no one is going to think any less of you.
>
> I: Do you think they believe you?
>
> Don't think so .. because there is still that staunch as culture out there……. So whether that is changing it I don't know.

While they blame the culture of the organisation for this lack of acceptability, the fact that their own constructions regarding reaction management are complicit with this way of being, may actually indicate there is a commonsense in the functionality claims of being a technician, which they recognise. This notion of dual functioning while responding, is more covertly constructed to be less feasible than desired. Instead, it may be more reflective of a preferred view of functioning, and preferred view of self. That is, the true me, a person who has human reactions to situations, who is caring and altruistic, yet dually is a highly functioning technician. 'Ordinary', yet 'extraordinary' at the same time.

CHAPTER 6

Seeking the 'truth' or making meaning?

The third chapter in the chronological exploration of understanding reaction management explores the processes that occur post-incident with regard to managing reactions and finding acceptance for incident outcomes. As discussed in the previous chapter, to facilitate technical functioning *during* an emergency response incident, the paramedics claimed to put their personal reactions aside using attention refocusing style strategies.

> Um… I don't know whether it was just self talk again or something that sometimes you say "gotta deal with that one later .. right now I have to concentrate on doing my job".

The paramedics maintain that time directly *following* a response incident is the most likely time to naturally process what has happened during the incident. It is then that they attend to their own reactions, and consider what their role was in relation to the incident. All paramedics interviewed constructed the use of similar types of strategies to return to their reactions and process them. These types of strategies are understood as processes of 'self-reflection'.

> I: You said "deal with that later" .. what does that look like? What do you do?
>
> Usually I just repeat it over and over again in my head and work out whether I could have done things differently to process the information.
>
> I: Ok .. and so that is important is it .. to know?
>
> Yes it's important for me to know whether I could have or should have done something better.
>
> ……
>
> I: What do you do in a situation .. so you have attended to someone .. you have dropped them off at hospital and you are hopping back in your ambulance. What's your thought process about ….?
>
> Oh especially if they are really sick .. critical like status one. I will constantly go over the job in my head. I will reassess and reevaluate every decision that I made in my head.

The benefit of 'reflection' is alleged by both Eastern and Western psychologists to be in preventing conflicting emotions or cognitive dissonance, and in promoting growth and new understandings following an experience (Welwood, 2000). The cognitive-based

theory that the Western psychological explanation is rooted in proposes an 'information processing' system analogy for the mind. This information processing system is conceptualised to become interrupted during a heightened situation (Beck, 1993). This concept of interrupted information processing appears to be an acceptable explanation for why the paramedics' claim the self-reflective process is so important. They claim that this reflection allows them to return to their reactions, to reconsider their technical response decisions during the incident, and to give honest self-appraisal to their actions.

> But when you actually think about it afterwards that's when you are able to say "there is a medical reason for this". You are able to rationalise with the condition that they were in .. and what they didn't do before they called you .. and all this…..
>
> I: Have you ever had a situation that you have attended where you haven't been able to have that rationalisation and why?
>
> Um…..
>
> I: When it was perhaps more difficult to let go of and accept because it just didn't make sense?
>
> No. I have never had that. There has usually been a reason.

The analogy of interrupted information processing during an incident, followed by post-incident processing and filing away of information, is a tidy explanation for the self-reflective process. However, it neglects two important questions that arise when analysing the claim by the paramedic in the previous quote that, during self-reflection, an incident response reaction will usually be able to be "rationalised". The two unanswered questions arising out of this claim are, *why* was the information unable to be filed away without applying some layer of rationalisation to it, and *how* does the information become acceptable and able to be filed away? Paton, Taylor, and McFarlane (2004) claim that teams and individual responders may experience what is termed 'responsibility trauma' after events, which can potentially adversely affect their future performances, if unresolved. Given the paramedics' previous claims of expectations about their role, we can consider the responsibility theory of Paton et al. (2004) as a commonsense functional reasoning for using a self-reflection process. This is a possible explanation for *why* some information may initially be unable to be 'filed' away. The paramedics themselves allege that during the self-reflective appraisal process they essentially want to answer two questions honestly; did I do the *right* thing, and did I do *everything* that I could in the response situation?

> I: And that questioning of whether or not you could have done more .. or that thought of wanting to do more .. does that linger?
>
> Yes .. for a while until you come to terms with the fact that there wasn't anything else that you could have done. And there is an acceptance there. You um .. work your way towards that. And I think that's the same with most of the horrible things. You rationalise what was actually going on. At the time you are not able to so much because you are doing stuff.
>
> ……
>
> If it's a traumatic type incident you are always thinking .. "could you have done anything different .. could you have done anything better..?"

We can return to the information processing analogy to consider the answer to the second question of, *how* the information becomes able to be 'filed' away. *How*, is claimed to be when the paramedics know they have answered those two questions honestly for themselves. That they did the *right* thing, and that they did *everything* they could. Having answered these questions, the self-reflection process is maintained to facilitate 'acceptance' for the outcome of a response situation, and allow the paramedics to find resolution and to move on.

> I: And how did you .. what happened that eventually allowed you to let go and move on?
>
> ….I knew that regardless of what .. I didn't get done as soon as I could have .. the outcome would never have changed……
>
> I: Yeah? And is that quite important?
>
> Yeah it is. Because if it had come back any other way .. that what I did or didn't do was the cause of why that person died .. I mean it would take a huge amount to get over that.
>
> ……
>
> ….I mean there is nothing that we could have done for her. So even if we had tried something I very much doubt .. I could almost be one hundred percent sure that it wouldn't have done anything anyway.
>
> I: And how do you come to that one hundred percent? What are you doing to know that that is true?
>
> I guess just knowing that she would have lost pretty much her whole blood volume before she was brought up to us and that she had no pulse .. so her heart wasn't beating and that the breathing that she was doing were the breaths that people do just before they die …….. So it is just really a matter of processing and using the knowledge that I have to work my way through it and realise that there was actually nothing [more we could have done for her] ….

Claiming the function of the reflective process is to appraise technical decisions, performance, and outcomes allows the paramedics to talk from a medical discursive

position. In this position they can utilise the protective construct of being a technician, who works within inherent functional limitations. Although this reflection on whether they did the *right* thing and *everything* they could is positioned with regards to the patient outcome, at the end of the day it is their own self-judgment that is inescapable. This is expressed in the discursive construction above, in the claim, if "…..what *I* did or didn't do was *the cause* of why that person died .. I mean it would take a huge amount to get over that". This sense of trauma responsibility (Paton et al., 2004) can be understood as experienced by a paramedic in terms of their individual perception of the response incident. That is, the perception or 'sense of self' that has been constructed through our previous experiences may function to moderate how this present sense of responsibility is experienced (Welwood, 2000). Protecting or maintaining this sense of self may be the motivation for undertaking the process of self-reflection. This notion that their sense of self is being protected using the self-reflective process is interpreted from the risk claimed by the paramedics. The risk is that, if questions of responsibility are unable to be rationalised and the paramedics were found to be at fault, then the alteration to their sense of self with regards to the incident would take "…a huge amount…" to recover from. So what happens, if upon reflection and honest self-appraisal, a paramedic concludes that they did not do the *right* thing, and perhaps did make a mistake during the incident response that meant they were at fault for the outcome?

> I actually did put my hand up and say it didn't go well for me that job it was a huge learning curve in the responsibility that you have when you are single crewed. It was such an awakening call that you have to be on top of your game when there is just you. ….....yeah it played on me a while .. and I just vowed to myself that it would never ever happen again. That I would always have my shit together.
>
> ……
>
> I had an officer yesterday .. a senior officer who put up their hand and said "look I forgot to give aspirin to a patient who was having an infarct" and it was the one thing that could have actually helped the patient. Look at the end of the day they were really close to hospital .. they got the patient to the hospital and before they had even left the hospital the patient was upstairs getting a catheterisation .. um would the aspirin have made a difference? .. maybe .. um and I just said to him .. I said you know "there is no point in me .. you know .. it's happened .. I can't recommend remedial training for you because there is no point. You know your job. You are a good officer. You have just had one of those human times when you have forgotten".

Here, the paramedics return to the protective construction of being only human when making mistakes. The claim here is, that putting your "hand up" is condoned and

respected when you believe you have made a mistake responding. This is because essentially, albeit post-event, they are still being honest and doing the *right* thing. This construction of honest self-appraisal when reflecting, positions the paramedics as a people of integrity, which fulfills the social and cultural expectations they have previously constructed, with regards to their role. These constructed expectations of being honest and doing the right thing, are further justified in the group discussion with claims of disdain for paramedics who make mistakes but do not do the right thing and put their hand up.

> PF: There is the other option of course that .. like if your are driving and you have banged into another car and no-one has seen you .. and nobody knows .. you could drive away and no-one will ever find out. So .. there could be that as well. There will be people out there who will have given a drug or done something and adversely affected a patient and nobody will ever find out.
>
> BL: Cos they won't write it down.
>
> PF: And then I guess they are just keeping that inside themselves.
>
> I: What's that going to do to you?
>
> ND: Probably leave-
>
> I: What do you mean by "leave"?
>
> ND: They'll leave-
>
> BL: -Yeah-
>
> ND: -Eventually. Because they will be so stressed I would imagine. I couldn't imagine staying if that was me .. ha ha ..
>
> BL: Also people who do that have got no real conscience .. have they
>
> All: No exactly .. mmm .. yeah …
>
> BL: They don't deserve to do the job anyway .. just quietly .. if they can't put their hand up if they have cocked up like that .. they pretty much have no scruples .. a bit like Addidas .. ha ha
>
> All: [laughter]

The concept of being honest with yourself and others, and knowing that you did the *right* thing and *everything* you could in the response situation, is clearly constructed as very important to the paramedics. However, constructed with equal importance is the need to find acceptance with the outcome of a situation and to move on from their reactions. The interdependent nature of the relationship of these two constructs creates some tension. This is because, while self-reflection is constructed as an honest 'truth-

seeking' process, the outcome they require from the process is very specific and non-negotiable. That is, the outcome from self-reflection must facilitate acceptance for the paramedic. Therefore, in order for the self-reflective strategy to facilitate the function of acceptance and moving on, this means the self-appraisal process will always end with a result of the paramedic knowing they did the *right* thing and *everything* they could.

> ……I will reassess and reevaluate every decision that I made in my head. And I think it's just like .. it's almost self fulfilling. You sort of try and get yourself back to the same decision that you made at time so that you know that you made the right decision.

In casual conversations during the observation shift, I sought to validate these interpretations, with paramedics in a hospital ambulance bay, through 'member checking' (Abell & Myers, 2008). An experienced officer spoken to regarding the use of self-reflective strategies to relieve dissonance, claimed to have never experienced a case that he had not been able to find internal resolution for. He maintained, that reaching this state is achieved very deliberately and justifiably. This justification is rationalised due to the additional claim, that the process of achieving resolution is essential for their mental health. He alleged, that one way or another, he will consciously find a way let go of residual thoughts and emotions attached to an incident. This then begs the question, is their self-reflective strategy a truth-seeking appraisal exercise, or more of a 'meaning-making' exercise? Mismatches or counter claims to the concept of honest appraisal and truth-seeking, appear in three areas of the paramedics' discursive constructions. These are: claims to actively reconstruct meaning regarding the outcome for patients and their families; to selectively seek the opinions of others regarding outcomes; and claims that reaching acceptance and moving on can be a conscious choice, rather than a natural outcome. Having constructed the importance of reaching acceptance and moving on following the self-reflection strategy, we can see how each of the mismatches potentially works in order to fulfill this goal.

The first of the contradictions arises with paramedics' discursive construction of a 'meaning-making' process they utilise post-incident. Although the paramedics have constructed their principle strategy of self-reflection as a truth-seeking exercise, they then claim to actively construct their own version of the reality regarding a patient's life when reflecting, to find acceptance.

> And I feel in my mind and my heart now that she lost that baby because it was not going to be viable .. and it was never going to be viable and mother nature knows that. You know? And that is how it [my reaction] is dealt with. That is how I rationalise it.
>
> ……
>
> The way I personally cope with that [my reaction] is that I look at someone and say .. 75 years old .. got photos of grandchildren on the walls. He's got veteran's medals from when he was at war and stuff like that. So this is obviously a guy that has had a good life. He has lived. He has had a family. His wife was there you know .. in all schemes of things .. not too bad .. you know? And that makes it .. I'm not saying it's right .. but it's easier to let them go knowing that he has had .. from what you can see .. a life that was fulfilled.

Discursive constructions of, "that is how I rationalise it" and, that is "….the way I personally cope…" are identified as covert claims to a conscious awareness of story creation during this meaning-making process. These stories, or meanings, are claimed to be knowingly reconstructed from their own perspective to assist them with their reaction management. The mismatch between what might be truth for the family regarding the patient outcome, and their reconstruction to facilitate acceptance, is claimed to be recognised.

> I: So you do a bit of self-talk in your head about it?
>
> Yup. We went to a sudden death the other day. It was a 21 year old child …….He was severely disabled both mentally and physically. He had Down's Syndrome, Muscular Dystrophy and it's not normal that you get those two associated with one and other .. so he was extensively disabled .. and he was last seen alive by the afternoon caregivers when they put him to bed at 8 o'clock. His night shift caregiver looked in and saw what he thought was a child still sound asleep in bed and went to wake him because his brother normally .. who is exactly the same cos they are twins .. he was in the next room he woke at six thirty .. they went to wake him and he was dead in his bed…….To let him go .. for me .. and probably wrong .. is that I felt that um .. he wouldn't be suffering anymore but .. is it right for me to make a decision for him? .. because I don't know how happy he was like he was……..And I sort of think that .. is my thought process of him dying .. him being better off? Well who am I to make that decision? .. does that makes sense? .. you know what I mean?
>
> I: Are you saying that you use that mechanism to help you …… but you don't necessarily need to know that this is true for his parents .. that it's possibly not true for his parents?
>
> Yeah. But it works for me. And I am not saying it will work for you .. but it seems to me that ninety nine percent of the cases is that you take the information that is placed in front of you .. process it and you come up with a decision of um .. yeah "I am happy with that" .. you know.

The claim to awareness during the meaning-making process, which is at odds with their constructions of truth-seeking, functions as a disclaimer for the action. This disclaimer works in the same way that making the *right* decision, to own up to a mistake after a response event, becomes the next most honourable thing to do if a mistake was made,

and the *right* decision was not made during the response incident. Somehow being honest about the fact that they are constructing a story, overrides the reality that they are deliberately reconstructing meaning regarding the situation, to facilitate acceptance for themselves.

Emergency response theorists have constructed this type of meaning-making strategy as 'cognitive restructuring' and describe the process when used by emergency responders, as an attempt to control and manipulate how they are thinking in relation to their emotional reactions (Salters-Pedneault et al., 2010). Criticism is expressed for this strategy (Roese & Olson, 2007) because it is conceptualised to be an active distortion of reality, due to what is alleged to be trivialising of information, inflation of information, and deliberate selection of information to forget. This strategy is also constructed by Western psychological theorists and researchers to be interfering with processing the 'truth' of a situation, thereby risking or leading to PTSD symptoms (Chang et al., 2003; John & Gross, 2004; Roese & Olson, 2007). These views neglect to consider the possible protective function this type of strategy might serve for the paramedics. What is this 'truth' of a situation, where is it to be found, and who owns the patent on it anyway? If we understand that truth is only ever constructed from an individual's own perspective anyway, then we could propose that at any time during an individual's day-to-day information processing, they are engaged in a degree of what is alleged to be reality distortion, selective inflation, trivialisation and forgetting of information to facilitate a positive level of functioning.

Eastern psychological ideas of mindfulness at first glance might also appear unsupportive of this meaning-making strategy used by the paramedics. Reconstructing and making-meaning initially appear to be at odds with the mindfulness concepts of finding equanimity with an experience, and relinquishing attempts to control experiences (Mace, 2008). However, a more expansive explanation on mindfulness proposes that when recalling an event we should be mindful of how we are experiencing this recollection, and that mindfulness should be coupled with 'awareness' (Kyabgon, 2003). This 'awareness' is an appreciation that we will have interpreted an experience from the past in a particular way, based on our sense of self and our history. Knowing this means that we can examine the idea of how events are remembered, and see that individuals may actually focus more attention on what was personally unpleasant or difficult for them about a situation. Buddhist psychology proposes that recalling and reinterpreting an experience, should ideally entail looking at the whole event, and

shifting one's attention deliberately to what is beneficial to remember (Kyabgon, 2003). Using this concept as a framework for interpretation we can consider that individuals can change the way that they are feeling or relating to a past experience by *reinterpreting* it when they are meaning-making: this does not mean they are falsifying the actual event elements. Additionally we can see that while the meaning-making strategy used by the responders is at odds with their claims to be truth-seeking, due to their active restructuring, the notion of definitive truth to begin with was possibly a fallacy. It reiterates that recollection will always be inseparable from sense of self, so meaning-making can only ever reflect an individual's own story.

The paramedics maintain that sometimes their attempts at skillful self-reflection fail to assist them with reaction management. In these circumstances they claim to seek out and enlist the help of a colleague, or medical professional, to assist the acceptance process. This assistance is to enable the paramedics to reach an understanding that they did do the right thing, and everything that could have been done.

> If I had phoned through and asked for a helicopter at that time I think they would have said "No. I don't think so". Ha ha … so I was .. I think I made the decision at the time and thought that was OK……. Yeah .. I don't know. I guess there is always that question yeah. But since .. I have spoken to people since and they have said "Yeah I don't think it would have made any difference. In fact it could have made the situation worse."
>
> ……
>
> I: So why is your colleague the best person to talk to after a job?
>
> I suppose for some of my colleagues here if it was a clinical issue .. and they have a great deal of experience .. so they will know whether I have made a mistake or not.
>
> ……
>
> I: Yeah? How important is it to have that conversation .. or to have someone say that [you did the right thing]?
>
> Oh it's huge…….. it is massive .. I mean we all do this job because we care. And you want to know that you did the right thing.

The utility of speaking to a colleague is constructed as beneficial, due to their knowledge of the paramedic role, and the possibilities and limitations within it for patient treatment and outcomes. Receiving advice from someone who can speak from a medical discourse, with a recognised authority of knowledge on the topic, is constructed as assisting with the process of knowing you did the right thing, by accepting the inherent limitations within the response situation.

> I know [my ambulance partner] thought about it for ages and he was in tears at the hospital .. because it was pretty apparent fairly quickly that we had killed her but we .. the next day we went in together and had a chat to the [hospital] consultant that was on .. and that was really good .. and he pretty much put [my ambulance partner] and my concerns aside and said "look she pretty much probably would have died anyway .. you were stuck between a rock and a hard place" .. and I guess that pretty much makes you feel better straight away as soon as you are absolved of that feeling of guilt.

However, we can see caveats emerging for the process of seeking collateral opinions. These caveats become the second contradiction, to the truth-seeking claim, of the self-reflection process. The caveats are, firstly that the opinion should come from a paramedic colleague: this is justified because they are someone who can speak from a medical discourse and therefore know "….whether I have made a mistake or not.…" and "….did the right thing….". Secondly, as rationalised in the following group discourse, this opinion will only be sought from someone whom they trust. We can see, the criteria for who will give them a 'truthful' opinion, is very specific.

> GA: ……..there are some people out there who you would trust to the ends of the earth to give you an honest opinion. And then there is others that who may say and use the exact same words as the person you trust would use .. but you just kind of have that feeling that they are judging you quite highly .. well judging you quite a lot on what you did. And rather than them thinking that you know .. you have made this mistake and this is the way that I would have done it and this would have been the more acceptable way .. they are kind of going "Well you really screwed up"-
>
> JW: -"And I can't wait to go and tell someone else about it."-
>
> MH: -Yeah .. "Did you hear about…"-
>
> JW: -"Did you know…." .. and that is exactly right .. there is that …. some that you would trust to have that conversation with and others you just wouldn't even bother to go there because you know that it would come back and get you stabbed in the back for it somewhere along the line…….. you would be picking who you spoke to.

The allegation that a person whom they do not trust "….could use the exact same words…." as another person who they do trust, gives a clue as to what is being constructed here as the idea of 'trust', and clues to what is really being gained from the collateral opinion. Here, trust is interpreted to mean a person they trust to understand how important the need is to find acceptance, therefore be complicit and possibly selective in the way that they give their opinion, in order to facilitate the acceptance process. This very deliberate criteria begs the question then: are they really seeking the truth or are they seeking out someone who will assist them with meaning-making for what they did do, to help them relieve dissonance, find acceptance, and move on?

Reflecting back to Heisenberg's (1958) construction of how people interact with their world, that "we do not observe nature, as much as we observe nature exposed to our method of questioning" (p. 58), we can understand that the appraisal of whether a paramedic did the *right* thing, from a colleague, will be no more free from perspective, biases and individual world-views, than the paramedic's own opinion. So although the retrieval of selective collateral opinions may not support the construct of reflective truth-seeking, a certain commonsense can be understood in the notion of seeking the collateral opinion of someone who is likely to make meaning the same way they are themselves, and support their acceptance process.

The third contradictory construction, to the claims to use self-reflection as truth-seeking to facilitate acceptance, is a claim that acceptance and 'letting go' can simply be a conscious choice.

> At the end of the day we can only do what we can do. Not point in beating yourself up be saying "I should have done that .. or I had done that". It's not going to prove anything. You have done what you have done. You can't change that.
>
> ……
>
> Ordinarily .. I think ……..I have done my job efficiently and well and afterwards I might have had a think and have thought "Could I have done something different? ….. I think the outcome would have been the same. I did all I could".

Claims such as "….you have done what you have done…." and "….I did all I could." suggest that rather than always fulfilling the admirable position they claimed, of reaching an understanding that they did the right thing, instead they might reach an understanding that they did the best that they could with the available information, skills and resources in the situation. These claims speak from their discursive construction of themselves as a technician, and utilise the justifications of the inherent limits of that position, to construct a rationalisation that the *right* thing, or that being able to do *everything*, will have been constrained by contextual factors.

> DK: …..Not every patient we go to is going to live. What you said "X" that as long as we do our very best .. you know..
>
> PF: We try our hardest .. and if the patient dies that's just the ways it is.
>
> BL: Yup yup.
>
> DK: Um .. that once you become comfortable with the fact that people do die .. it will make you a better officer and that God doesn't think he is a paramedic .. so no paramedic should

> think he is God .. because not every patient he goes to will he be able to save. And that has done me. And I have passed that on to many a person-
>
> BL: -It works though!-
>
> DK: -Yeah yeah .. and as soon as we become comfortable with the fact that you know .. people are going to die ..
>
> BL: -At the end of the day it doesn't matter what we do .. people are going to die. Because .. people die. Obviously you give your best and at the end of the day I am going to do my level best for that patient .. and if it doesn't work ..I'm sorry .. but I tried!

These claims rationalise that acceptance is actually more about constructing a meaning regarding the choices made and the outcomes, than about seeking the truth. In this sense, rather than appraising if the right decision was made, the process appears to be more about appraising if the right decision was made with regards to how the contextual factors were being understood at the time.

> We got to the hospital. My Advanced Paramedic was beside himself thinking "I have killed the patient. I shouldn't have done that .. maybe I should have just sat and waited". And then the [hospital] consultant said "Well you have got to treat what you can treat .. you have got to do something". At the end of the day .. so we were able to kind of justify that-
>
> ……
>
> I have had it myself where I have .. I am not sure I have felt horribly responsible .. but I have had occasions where I have done things that have made patients worse…….. so I have to rationalise with myself .. have I done harm? .. you know .. have I actually stuffed things up and made things worse? So I guess I don't dwell on it too much um .. I have to treat what I see I think ..

Constructing "….you have to treat what you can treat…." and "….I have to treat what I see…." are possibly covert claims that they are aware they may have made the wrong decision for the patient, but rationalise that they were decisions made based on contextual factors. In this sense they were *right*, at the time. We can see in these constructions, that the justification to accept and let go then becomes a conscious decision. This contradicts their claims to need to reach a conclusion from the self-reflective process and to know definitively the *right* thing was done.

Without considering that this conscious acceptance strategy may only be employed occasionally, amongst many other self-reflective processes in the life of the paramedic, there is frequently a psychological interpretation or accusation that this strategy is a form of 'avoidance' (Boulanger et al., 2010). However, if we consider the functionality of this strategy for a paramedic who may attend four or more heightened incidences to reflect upon that week or that day, this conscious decision to accept and let

go could be interpreted as commonsense functioning. It is commonsense to aim to reach a point of acceptance in order to enable continued functioning. It is commonsense and beneficial for the paramedics to consider the whole incident context, rather than focus on a single perspective of whether they felt they definitively did the *right* thing. Which, as claimed previously, may only be a meaning-making exercise in itself anyway.

> But I don't know that that is because I have always made the right decision. Because I doubt that I have. But it's that feeling like .. like I say it's self fulfilling. You create that ability to do that in your head.

The paramedics constructed understanding of what they did with their personal reactions, in order to continue to function effectively in an emergency response situation, was to put them aside. They allege that these are returned to later, using self-reflective strategies to give honest appraisal to their actions, and the subsequent outcomes for the patient. Although this style of strategy is constructed by the paramedics to be a truth-seeking exercise, the proposed objective of the exercise is specific, and non-negotiable. That objective is to find acceptance and to be able to let go of reactions. Due to this specific objective, the idea of completely honest appraisal becomes nullified. The processes discursively constructed as undertaken to achieve this acceptance, further contradict the concept of truth-seeking. The paramedics claim to reconstruct meanings for themselves, to only selectively seek the opinions of others, and to sometimes make conscious decisions to let go anyway, regardless of the reflective process outcome.

Buddhist psychology proposes that an individual's mind interacts with information perceived in a situation, to create a perspective of an experience (Kyabgon, 2003). This perspective created is suggested to not only inform how we *experience* an event, but also how we *recall* an event. So, the concept of truth regarding a response incident is conceptualised to never be free from the perspective of whoever is recalling or appraising it. In light of this, the objective of finding a point of acceptance to let go, rather than definitively knowing the *right* thing was done, can be seen as commonsense. Strategically, finding a point of acceptance to let go appears to be what the paramedics are doing to manage their reactions post-incident, despite their constructions of the processes as truth-seeking exercises. The function of constructing themselves as truth-seekers may actually be more to fulfill their self and organisational expectations of what

it means to act with integrity and “put your hand up”, if you know you have made a mistake.

During the shift observation, in the ambulance after leaving a patient at the hospital, I seek clarification on this process of finding acceptance and letting go. The paramedics conceptualise for me, that it is generally understood by emergency responders as healthy to actively decide to find acceptance and let go. This decision is constructed as possible, most of the time. They claim to create that possibility by actively reminding themselves that, “this is not my father…. this is not my child….” and that “….this person essentially does not need to continue to play an ongoing role in my life or mind. My job was to get them safely to care at the hospital. Regardless of the outcome at this point….. *here* is where their story stops for me, and this is the point I need to let go of them”.

CHAPTER 7

Weighing up social risks against personal risks

This is the fourth and final chapter exploring the paramedics' understandings of reaction management. It addresses the consequences of not managing reactions, and the accessibility and acceptability of using support should it be required in this situation.

Regardless of their claims in the previous chapter to always find acceptance, to let go, and to move on from their reactions to response incidents, the paramedics claim infrequent occasions when they have had difficulty processing reactions to an incident and subsequently letting go. This may be because they have experienced a large accumulation of responses, or have not had the time to fully process their reactions, and so have been 'not coping'.

> Well I had sleepless nights and goodness knows what else .. and then after a little while comes this kind of .. "OK….. perhaps you need to say something to someone" .. just get it out ..
>
> ……
>
> I had two kids at the time .. and you've got this dead three year old in front of you. That was our first day. Then on the Saturday we did a job ……. a grandmother had got her new 18 month old grandchild and she is handing it back to her daughter over a brick wall …….the foundations broke .. fell over and squashed her 18 month old granddaughter and killed her from the trauma of the head injuries sustained. She was dead at the scene. Police arrived. We immediately got another call and were told that we had another trauma job that we had to got to in Massey …We went to a seven year old that had suffocated under a whole lot of gib board playing in a building site in Massey .. on the Sunday we got to work and within 2 or 3 minutes the bells go off for us to go. Multiple patients .. There is man sitting in the middle of the road with his head like that [indicates] with his legs folded surrounded in a pool of blood. Obviously obviously dead. …….On Monday night went to a 43 old man in Whangaporoa who was a diabetic he was about 6 foot 8 and about 140 kilos and in complete denial about his diabetes. We got there brought his BCL levels back up and said you need to go to hospital and he said "I'm not going anywhere" at 6 foot 8 and about 140 kilos we don't have the power to drag him out anyway…….. we subsequently finished shift and had 4 days off. I came back to work the next set and heard that he had actually died at 9 in the morning post cardiac arrest induced by his diabetic state.
>
> I: Mmm mm.
>
> And that is when I had my .. my emotional breakdown. And burst into tears. Had a month off work.

In this kind of instance there are 'personal risks' proposed for not dealing with reactions that have accumulated. Previous studies with emergency responders have alleged that the risks from this type of cumulative stress can be: increased fear, cynicism, sadness, anger, suicide, depression; interpersonal relationship problems; high workplace

turnover; drug and alcohol abuse; risk-taking behavior; and PTSD (DeValve & Adkinson, 2009; Regehr & Bober, 2005). The paramedics in the present study claim similar outcomes from the stress of dealing with difficult or cumulative, heightened emotional responses.

> And still to this day I don't believe that "Z" has dealt with that [incident] properly .. or processed that properly. Or "Q". They actually quit and have gone to work in [a different organisation]. Yeah .. I have got colleagues that I could tell you about that are suffering post traumatic stress disorder with .. you know .. St John won't tell you .. but we have had staff kill themselves.
>
> I: Yeah?
>
> "X" killed themselves, "V" tried to kill themselves.
>
> I: Apart from trying to commit suicide …… what are the other signs you can see in your colleagues when they are not dealing with stuff?
>
> Drink ..….. yeah just .. a lot of fighting .. *a lot* of domestic fighting…..

The group conceptualise a point of exhaustion, or not coping with this cumulative stress, where paramedics will seek help. In this situation it is conceptualised that a person's personal resources will have become so depleted that the personal risks to their mental health and wellbeing are very high.

> When people can't cope it becomes obvious that they are not coping .. people get sent .. or they get .. it becomes obvious that they have got to find help.
>
> ……
>
> I wondered if it was a bit like .. "I have a cut .. so I will put a bandaid on it .. Oh it's a bit of a bigger cut so I will put a dressing on it and now it's .. shit! .. now I think I had better ring somebody else". You know I wonder if some of that comes into it as well .. "I am distressed by this job .. but I have seen lots of jobs before and I will get over it" .. um and…-
>
> ND: -And if there are a few of those times and you still haven't gotten over it …-
>
> PF: -And then you make the call. I wonder if some of it is that people see some horrible stuff and don't …. I guess they are just making sense of it themselves and they finally get to a point where they either rationalise it and move on .. or they sometimes seek help.
>
> DK: All their normal coping strategies that they would normally use get exhausted.

The paramedics propose that in these circumstances it is acceptable to say that you are not coping, and to reach out for psychological support. "The idea of 'looking after' people in St John who for years had cared for others was unofficially part of the organisation's ethos from its inception" (Hunt, 2009, p. 211). St John has psychological support systems in place, in the form of employee assistance programmes, peer

supporters, and contract psychologists. These resources are an attempt by the organisation to fulfill the workplace hazard management obligations under the New Zealand Health and Safety in Employment Amendment Act (HSEAA; Department of Labour, 2002). The HSEAA now recognises that the management of workplace hazards for employees needs to extend to the management of psychological hazards, as well as the promotion of physical and psychological wellbeing for employees. Despite the stoic roots claimed within the organisation, the paramedics maintain that the culture has shifted enough for these support services to be acceptable to use, and that individuals do access these resources, when they need to, if their wellbeing is at risk.

> I: What is the attitude around using peer support or psych support at work?
>
> I've been nice to people have used it .. who have told me they have used it and I don't have .. like no .. I don't I think there is any negative thoughts around it.
>
> ……
>
> Yeah I think like for me .. I am quite keen to promote other people to go to it when they have come [to me] .. like one of my friends has used it recently ..
>
> ……
>
> ……I think the culture has changed .. well I don't know I've only been there "X" years .. but yeah I think people will realise that if you need help .. then you need to get help.

This alleged acceptability of psychological support usage, following a build up of reactions, is justified by claims from the paramedics that they have previously used this psychological support themselves. Therefore, they support other people using the services.

> ……so both those times I felt really supported um .. in .. with [peer supporter] and [psychologist] and it wasn't because we had 'lost our .. lost the plot .. it because we needed to talk to someone…….. So I think that night .. when I spoke to you about .. when I had that bigger 'melt down' five years ago .. I jumped about from the rafters telling people "don't be scared of seeking it .. cos it's really good".
>
> ……
>
> But for me .. like I said over the years I have realised that it's all OK. That you are not invincible. You are not 10 foot tall and bullet proof and whether it is work or personal life .. shit happens and particularly with so much now on television about mental health and all the rest of it I think people are being encouraged to try and be a little bit more forthcoming.

However, while they justify their support for the utilisation of these services due to their own use, there are caveats that accompany these claims of previous usage. Most of the

paramedics who have used the services usually maintain very definitive parameters regarding under what circumstances they utilised them. The most frequent claim being that, when they did seek psychological support, it was for *personal* issues, and very definitely not *work-related* issues.

> I: Can I ask whether or not you use any of the services?
>
> Um .. many years ago I did. I went and saw [psychologist]. But that was more of a personal thing. It was when my marriage broke up and because I was a volunteer I was able to go and talk to him about it um .. but that's it. I haven't used ….
>
> ……
>
> I: Have you ever sought out the psychological support through St John .. or peer support yourself?
>
> Not for clinical issues .. but for family issues yes. So yes I have had both psychological and peer support for family and relationship issues.

These constructions start to narrow the conceptualisation of support-seeking acceptability. While it is culturally acceptable to seek support, perhaps it is more acceptable, for non-work related issues. The apparent need to delineate life areas into work and personal, in order to construct a justification for support-seeking, indicates that a there may be some risks involved in being known to have utilised psychological support for work-related issues. So, the question has to be asked, if the support is readily available, the paramedics are utilising and recommending it, and the culture is constructed as having changed over time to be accepting of the use of support, then why are there still risks implied for the use this so-called acceptable support? A broader view is required to consider the surrounding contextual factors that may be affecting decision-making. Koole (2009) has argued that other than attending to immediate needs, the way individuals choose to manage their reactions also takes into account their longer term life-goals. This argument can be used to understand the paramedics' choices of how to manage those reactions where they have not been able to let go. These choices are made in light of their self-view, their perceived relationship to others, and ideas about their position within the world. The paramedics' overt constructions of themselves as technicians, and covert understandings of themselves as extraordinary, inform us of their ideas regarding their positioning. The impetus to justify support-seeking as discretely related to their personal lives, could be construed as functioning to not risk losing that all important, capable, technician positioning. The idea of being seen

to be not coping with work-related issues after an incident may be as similarly unacceptable as not coping during a response incident. Just as the construction of human reacting was overtly claimed to be acceptable by the paramedics, and then later contradicted, the claim to accept psychological support-seeking, may also be a more complex, multifaceted issue.

Why, when the personal risks have been constructed to be so high, would a culture of lack of acceptability for support-seeking, for work-related issues, still pervade? Behavioural theorists construct the notion that a function within the dysfunction can always be found (Grant, Townend, Mills, & Cockx, 2008). This means, decisions made by the paramedics can possibly be better understood in light of the perceived gains or benefits from the outcomes of not being seen to use psychological support. When constructing the acceptability of support-seeking, as we have seen, the paramedics claim that they *themselves* condone the use of psychological support-seeking. Having firmly established their own acceptance, they then construct any hesitancy to use psychological support, and any lack of access to this action, as being created by the St John organisation. In particular they claim that inaccessibility is the responsibility of the managerial level. The implication is that actively seeking support may risk losing their job positioning.

> Maybe if they had someone who was seen as an outside person [I would talk to them] .. an actual psychologist or someone trained where they have that patient doctor privilege type thing then we might be happier talking to them .. because we know that .. you know .. this isn't going to get back to management.

As the interpretation is broadened to consider these contextual factors, contradictions begin to appear regarding both the acceptability and accessibility of support-seeking. Regardless of what the commonsense construction was regarding the need for support seeking by the paramedics, in reality there is a careful weighing up of the potential personal risks they would face from not seeking help, against the perceived social risks they claim exist, for being seen to seek support within the organisation. In the following discursive construction the focus group expands on the concept of social risks in relation to job positioning. They construct the implications of answering "No" to the question "Are you OK?", regarding whether or not they need support.

> MH: Does it depend who asks you [if you are OK]?

> GA: I think it does .. and especially in this job we have .. I think there are so many different cultural values stereotypes or whatever you want to call them .. in this job .. and a lot of people .. and I won't say everybody because you can't be one hundred percent sure .. but the majority of people in this job feel that they can't be completely honest with management because you are continuously feeling as though your job is on the line. Because you don't have that support. So if a manager comes up and says "How are you doing?" of course you are going to feel more like saying "yeah I am doing OK" because if you show a weakness "Oh I feel like crap because I have been to blah blah blah .. and I think I really need some help". There is always that thought in the back of your mind that they are going to take you off the road and then slowly do their best-
>
> JW: -To get rid of you-
>
> GA: -Yeah. So if you start showing weakness or fe[ar] .. I mean I feel if you start showing too much weakness than they might slowly start to try and manage you out of the job. Whether that is right or wrong .. who knows. But I think that there is that culture of "us and them" when it comes to management.

The claim is that by answering "No" you appear to be not coping, and that being seen to be not coping is socially risky. It may not only compromise your present social positioning, as they will "….take you off the road….", but also may risk future career prospects, because they will "….get rid of you….". Occupational health psychologists propose that emergency responders tend to take cues from their supervisors with regards to coping strategies and acceptable ways to manage stress (Beer, Bowling, & Bennett, 2010). This proposal justifies the paramedics' claims that seeking psychological support is inaccessible through management and peers, due to the social risks it poses. If you use it you could lose your current position, or jeopardise your future prospects. During informal discussions in the ambulance bay, paramedics also maintain they would not seek peer support from officers who hold higher positions than themselves, or who hold managerial positions. This claim is rationalised as being due to disbelief that confidentiality will be upheld, when receiving support. This allegation has also been made in previous studies by other emergency responders (Alexander & Klein, 2001). However, confidentiality *is* considered to be upheld when support-seeking from the St John contract psychologist.

> Our peer support group .. it's there .. but I won't speak to anyone because I don't trust them. There is not one person in that group that I would trust.
>
> I: What backgrounds do they have?
>
> They are all ambulance staff .. from advanced paramedics down to AO's to communications officers .. so they have had some peer support training.
>
> I: Why don't you trust them?
>
> Because I…….. um I don't think there is that code of privacy or conduct.

> I: Oh .. so you don't think your conversations with them will stay private?
>
> No. I would rather talk to [the contract psychologist].
>
> I: What is it about the confidentiality? Is that because it goes on you record and if you want to-
>
> -No no .. none of our psych stuff goes on our record.

Therefore, one might assume that approaching the psychologist is an accessible route for support-seeking, given that this route is confidential, and the support use does not become registered on their employee records. Accessing support through the psychologist appears to bypass the social risks proposed to be inherent in support-seeking from management or peers. If the proposed social risks are mitigated, then why did the paramedics still feel the need to claim the caveats for using the psychologist, when speaking to the researcher in the present study? "….I did. I went and saw [psychologist]. *But* that was more of a *personal* thing."

Further analysis of the paramedics' discourse regarding support-seeking demonstrates that the apparent need to supply caveats in this way may be an indication of broader issues regarding the acceptability of support-seeking. These issues appear as three main contradictions regarding their claims of acceptability toward using psychological support. These contradictions are: mismatches between their recommendations for others, and their own use of psychological support services; inconsistency in their opinions regarding others who are using the services, despite their recommendations to use the services; and the overall lack of service use, even when the proposed risks are mitigated by the organisation.

As previously constructed, the paramedics claim that the stoic culture of St John is shifting. Part of this shift is conceptualised to be instigated during the training of new recruits. Those paramedics who are in the position of training new recruits, with regards to support seeking, allege that the topic of not coping is approached openly, and that the action of support seeking is communicated to the recruits as being acceptable.

> I: Or anything that you pass on to new trainees now?
>
> Definitely .. because I mentor quite a lot of the new staff I always tell them to get upset if they feel like getting upset and that's not something anyone told me when I first started.
> ……
>
> I: And is there any standard piece of advice that *you* feel is important that you impart on them as new trainees?

> Um .. I have always said to them .. that if I know we have gone to something in particular that I can see has affected them then I'm always .. it's what you usually do .. you ask if they are OK. But sort of more so now I say to them .. if you are not coping with it then it's OK. You can say .. no one is going to think any less of you.

This discursive construction functions to position the trainers as aware, open, and non-prejudicial regarding psychological support usage for the new recruits. Unfortunately, in light of the proposal from Beer et al. (2010), regarding responders following cues from superiors for how to manage stress, this advice becomes redundant. This is because these constructions of advice regarding support-seeking, appear to be a case of "do as I say, but not as I do". While they overtly encourage the use of support services by others, apart from for personal issues, the paramedics maintain that they do not use the services for work related issues themselves. This is the first of the mismatches regarding the claimed acceptability of psychological support-seeking.

> I: What about talking to a psychologist then about a job that has upset you .. as opposed to about your personal life?
>
> Um .. talking to a psychologist…… I send people to psychologists over nasty jobs ..
>
> I: Yeah .. but would you go yourself?
>
> Um …. I suppose if I …. I don't …. I'm not frightened of that. So yes .. I think I would go to a psychologist to talk about a nasty job.
>
> ……
>
> I: Have you ever used the peer support or the psychological support with [psychologist] ?
>
> I haven't. But I have encouraged other people to. Yup. There has been jobs when I have had to go and talk to my friends about it because it was pretty awful. I have never had to go to EAP or anything. But I imagine if I was still feeling terrible after talking to my mates I probably would have gone and used it.
>
> ……
>
> I: Have you ever attended any peer support or psych support?
>
> No.
>
> I: Would you feel comfortable .. using the support systems?
>
> Yeah .. think I would with .. I'm not sure about psych .. but peer support I would.
>
> ……
>
> I think I would be more than happy to go to someone that was trained in psychology or counseling um …… if I felt that I really needed to go talk to them.
>
> I: Have you ever gone to see [psychologist]?

> Nah.

While sanctioning the use of support systems by others for work-related issues, the paramedics are very careful to maintain that they have not utilised the services themselves, but of course would be willing to. These constructions function to position the paramedics as compassionate and human toward colleagues who have utilised the services. Additionally, the constructions serve as an acknowledgment of psychological support usage as being 'best practice' for wellbeing. Maintaining that they have not "….had to…." access these support services themselves allows the paramedics able to uphold their image of being the capable technician.

The second mismatch to the claim of so-called acceptability for psychological support-seeking appears with regards to conceptualisations of those who have actually utilised the services.

> I: What is the St John culture around knowing that colleagues are seeking peer support or seeing [psychologist]?
>
> I think um .. one not many people are very forthcoming if they are seeing any one. The few people that I know who are .. that I know well and I know have been to see them have talked to me quite openly about it. I guess it depends how you get on with people and who you tell and who you don't tell.
>
> I: When you say people are not forthcoming .. what is your take on why they are not forthcoming?
>
> I think whether it's a sign .. whether it's a sign of weakness .. that you are not coping .. that you can't .. you know what's gong on.

Contradictions to their proposed acceptability for others utilising services appear in the discursive construction of support-seeking being perceived as "….a sign of weakness….". This conceptualisation of support-seeking, highlights another social risk the paramedics perceive is taken, when they reach out for support. When this new social risk is added back into the interpretation, another layer can be seen in the previous group construction, within the claim that the organisation was responsible for the social risks of support-seeking.

> -Yeah. So if you start showing weakness or fe[ar] .. I mean I feel if you start showing too much weakness than they might slowly start to try and manage you out of the job…….

Regardless of the fact that the paramedics claimed that this judgment came from management, they were the ones discursively constructing this notion, that demonstrating you are not coping by seeking support is "….showing weakness….". All

of a sudden, not coping seems to carry multiple layers of social risks, and is perhaps more unacceptable than acceptable.

When constructing the psychology behind emotion regulation, Koole (2009) conceptualises that an individual's experience with social situations and interactions will dictate norms for their expressions of emotional states. These social experiences are proposed to potentially lead people to heavily monitor and possibly down-regulate their emotions, or emotional needs. While personal risks still appear to be being weighed up against the social risks involved with being seen to be not coping, and support seeking, the social risks may be more extensive than initially proposed. While the overtly claimed social risks were proposed to be linked to job security and career prospects, constructions of support-seeking as sign of weakness seem to be more closely linked to the paramedics' self perceptions.

> I: Do you have any other aversion to seeing a psychologist? I'm just wondering because-
>
> -Probably because I am "X" years old and I have learned I don't need to see one.
>
> I: I am just wondering is there a link between-
>
> -I think there is a stigma attached to it.
>
> I: Would you explain that to me?
>
> Um .. maybe it's a sign of weakness. I don't know .. possibly .. a sign of weakness…..
>
> I: Do you think that is a St John thing……. or a New Zealand thing…….?
>
> It's me. It's me. *Possibly* a New Zealand thing. For me it's more of a sign of weakness thing. I'm not a weak person. I have been through a lot of shit in my life.
>
> I: Yeah?
>
> Um…… and I am not a weak person.

These notions of not being seen to be "….a weak person…." can be linked back to the paramedics' constructions of themselves as professional, capable technicians. This technician construction was interpreted to not only relate to how they understood themselves, but also to how they perceived others saw them, in other words 'social risks'. So, if they have these perceptions for *themselves* regarding support-seeking, how socially risky, or truly acceptable, is it for *others* to be support seeking? Regardless of the advice that was explicitly given to trainees regarding the acceptability of support seeking, and not coping, when constructing the reality for the outcome of this behaviour, we see contradictions again to the notion of acceptability.

Advice regarding "not coping" given to trainees
I: And is there any standard piece of advice that you feel is important that you impart on them as new trainees?

Um .. I have always said to them .. that if I know we have gone to something in particular that I can see has affected them then I'm always .. it's what you usually do .. you ask if they are OK. But sort of more so now I say to them .. if you are not coping with it then it's OK. You can say .. no one is going to think any less of you.

Construction regarding "not coping" when it is actually observed in colleagues
I think that coping comes down to an individual and how you are. What's your make up. And I know a couple of ambulance officers out there who actually don't cope that well. And for me personally I kind of sit there and go "what the hell are you doing this job for?". They do seem to have a run of bad luck all the time. But they are consistently .. ah …… kind of breaking down over them all.

I: What's a sign of bad coping .. when you say "breaking down"?

Well I suppose it's kind of harsh saying it's bad coping. It's like I said earlier. You do the job so you are "supposed to be seen to be able to been seen to do these things". And when you consistently are having to be consoled over things you would have to ask yourself "why are you putting yourself in this situation that is having that effect on you?"

There is clear evidence here for the social risks to positioning, in the paramedic's claim to think "….what the hell are you doing this job for….", when witnessing colleagues not coping. McCray, Cronholm, Bogner, Gallo and Neill (2008) suggest that the culture of a workplace, an individual's self-expectations, and the perception of value judgments by peers will affect how these types of risks are perceived and prioritised. In other words, the paramedics understand that regardless of explicit acceptability of support-seeking being expressed in the organisation, there are still implicit social risks attached to support-seeking. These social risks may be prioritised over personal risks to wellbeing by the paramedics when considering the benefits and losses of support-seeking outcomes. Emergency responders interviewed by Regehr and Bober (2005) expressed mixed attitudes regarding the use of psychological support for their job. Some maintained that they had really benefited from peer support, while others percieved that there was an unhelpful 'macho' attitude regarding the expression of emotion, relating to a response incident. This attitude was the alleged reason for not seeking support. Regehr and Bober (2005) summarised this argument by citing one police officer, who claimed that demonstrating or talking to others about emotional distress would ultimately result in a loss of respect in the workplace. In occupational psychology, an individual's priority of not wanting to risk losing their social positioning, is proposed to be an impetus for them to participate in personally risky behaviour (Peterson, Bergstrom, &

Samuelsson, 2008). For the St John paramedics, being part of a team after having earned their position through the rite of passage of coping, during response incidents, could be the motivation to forgo support-seeking post-incident, even when they consider they might need support. In the following discourse from a group discussion, one member provides further support for this interpretation of risk balancing, as they construct the notion of how a paramedic might reach tipping point, and make the decision to seek support.

> I: One of the quotes was "I never HAD to go" .. so I am wondering what "HAD to go" means? Does that indicate that it's [using psychological support] a last resort? Or something you wouldn't do unless you *really really* had to .. rather than actively seeking it out early on?
>
> People that I have seen use peer support .. have been at their wits end normally .. so it has been their last resort. In a lot of cases they haven't cared who has known that they have been seeking help. They have broken their own confidentiality I guess by asking comms for phone numbers or asking to talk to somebody .. ringing up bosses and saying they need to talk to somebody. Um….
>
> I: And what are your thoughts on why that happens?
>
> Um …… I guess at that time they are looking at .. they are clutching at straws,. They know something is not right .. but they .. I suspect they don't want to feel like they are feeling. They just don't want to feel like that anymore so they are trying to find someone to help them. I suspect … or they are at a point where they are sort of just not functioning and people are making that decision for them.

The claim in this construction that "….they haven't cared who has known they have been seeking help….", conceptualises that there is perceived risk in others knowing you are seeking support. This discourse functions as further evidence that support-seeking is not as acceptable as it was overtly constructed.

These first two contradictions to the claimed acceptance of support-seeking suggest that the associated social risks may be more to do with self-image than job security, as it was originally constructed. Yet, because of the strength of the construction regarding inaccessibility of support due to social risks linked to the organisation, there are firm allegations from the paramedics that the responsibility to remove barriers to support lies with the organisation. This claim from the paramedics appears to be commonsense with regards to organisational psychology literature, which proposes that modeling for best practice in stress management and coping strategies is best instigated from those in management and led top-down (Beer et al., 2010).

> ……..in this sort of situation we should be getting offered assistance. We shouldn't have to be searching for it.
>
> I: And tell me .. because you are not the first person to say that .. the "should be being offered" rather than the "have to seek out" .. why is that important for you?
>
> It's an acknowledgement of what we go through and it's a wanting to feel that we are actually valued and supported by our employer.
>
> ……
>
> That's where management I think .. that's where management need to be a bit more proactive with what is happening, so it takes a bit more pressure off us .. as individuals to be responsible for our peers. Because we do need to be responsible for ourselves .. and that is why we have a peer support program in place and they are giving us an opportunity to be responsible for ourselves .. but if they want a well functioning team who provide a really good service EVERY day. Then they need to be a little bit responsible for our welfare as well.

While the overt construction is, that being offered support by the employer would serve as an acknowledgement of being valued, we can consider a secondary gain that would come from this situation. That gain is that the social risks of a paramedic seeking support may be exponentially diminished when the support is not *sought* out by the paramedic, but is proactively *given* by the organisation. The paramedic can remain to be seen as a capable technician and receive the support that they require, without taking the social risk of expressing that they are not coping and potentially be perceived as weak by others, and perhaps also by themselves. However, when previous experiences of this type of scenario are discursively constructed by the paramedics, it does not appear to be such a straight forward solution in practice, and the third contradiction appears.

> I: Is that some thing that would work for you .. if someone checked on you after?
>
> Oh .. you know probably not. Because I think we all have that little bit of a staunch attitude .. as I said .. that you can cope and …
>
> ……
>
> I: ….the question .. "Are you OK?" .. can you say "No" to that?
>
> GA: You *can* say "No" to it. But …….
>
> I: *You* didn't say "No" .. why?
>
> GA: I *kind of* said "No". I didn't come straight out and say "No .. I am not OK". I guess it's that kind of feeling of not wanting to .. coming back to that culture of you need to be strong to do this job. Of wanting not wanting to be seen to be weak but the words that I used .. were giving them the chance to actually ask .. so that I could appear as though I am still strong in the job and that I am doing OK .. but giving them a chance to actually listen and recognise what I am saying and realise that there is something else going on underneath here. And maybe that is the wrong thing to do .. maybe I should have just come out and said "No .. I feel like shit" ..

> I: Is it the wrong question?
>
> JW: I think it's how you put it.
>
> I: What if I am the person who called you up and I said " GA how are you feeling? After that job?"
>
> GA: I probably would have just answered "I am feeling alright" .. " I am feeling OK"

This contradiction almost appears be a circular argument, as we are back to the claim that answering "No" to the question "Are you OK?", infers that you are not coping. Then, being seen to be not coping in a culture where "….you need to be strong to do the job….", risks being seen as 'weak'. This then means that the paramedic claims that they cannot overtly say "No" when asked if they are coping, but that management need to *know* that they actually mean "No", even though they do not say it. So, even if the organisation could mitigate the explicitly perceived social risk of job loss by being the ones to offer support, the more implicit social risk of appearing weak may still be inhibiting the accessibility of psychological support. This demonstrates that workplace culture is not only something the responders are being affected by, it is also something they participate in creating and perpetuating.

The paramedics claim that there are personal risks experienced as a result of cumulative stress in their role. These risks are to their mental health and wellbeing, as well as knock-on negative impacts in their personal lives. To mitigate these personal risks the paramedics propose they condone the use of psychological support services provided by the St John organisation. While they propose the use of these services is acceptable within the organisation culture, the action is complicated by social risks that are claimed to occur, when being seen to seek support. These risks are alleged to be related to job positioning and security, and therefore the responsibility of the organisation to ameliorate. For some paramedics this risk to positioning appears to function as a commonsense, and a socially acceptable justification for not seeking support, but remains an untested theory.

> I think .. maybe we just assume that if we said to them "No" we weren't OK and maybe we assume that if they sent you .. you know .. suggested that we went and saw someone that it would have a detrimental affect .. I don't know .. maybe we are just assuming that. Have we actually stepped over that line and made that comment and had that referral and had that thing happen? And *not* lost your job because of it?

Contradictions to the notion of true acceptability for support-seeking appear in mismatches between constructions of support service use being acceptable, and then their own lack of service use, as well as unfavourable constructions of those who do use the services. A secondary social risk is interpreted from these mismatches as a notion, that being seen to access support services is a "….sign of weakness….". This conceptualisation of weakness complicates the original claims of social risks as being largely organisationally related. Further discourse reveals that even when overt barriers or social risks to service usage are removed, the ideas of how they appear to others, or desire to appear to themselves, may still be being weighed up against the personal risks to their wellbeing. One could conclude that social risks are indeed outweighing personal risks, or appreciate that perhaps these risks are 'one and the same'. That perhaps the social risk of appearing weak to themselves and others, becomes a personal risk to their psychological wellbeing, if it challenges their self-constructed image of being the capable technician, and being capable of doing the job.

> BL: See I wouldn't do that at all. I don't do that at all. I don't talk to junior staff about [coping] … Sign of weakness! As far as I am concerned. Just that is me personally.
>
> I: Because .. you're more experienced .. do you mean?
>
> BL: I don't know.
>
> I: What do you mean it's a "sign of weakness?"-
>
> BL: -On my part I think! I am said to have this aura about me .. people are petrified to work with me. New staff. I have no idea why .. ha ha .. I am such a nice person .. ha ha um .. and for me to show any sort of .. any emotion in a job like this is a sign of weakness.
>
> I: You think they will see you as weak? Or you will see yourself as weak?
>
> BL: Possibly both. That's just me!
>
> ND: Is that the way that you protect yourself?
>
> BL: Possibly! It probably is yup.

CHAPTER 8

Conclusion

The objective of this study was to explore *how* the St John paramedics understand what they do to manage their reactions in an emergency response situation. During the interpretive process, the question of *how* was very quickly superseded by the question *why*. Why would the paramedics construct managing their reactions in a particular way, and then proceed to propose contradictory constructions? The question *why* became answered by exploring their understandings of their role as a paramedic, and the expectations of actions they perceived are required within that role, by themselves and others.

The interpreted findings of the study identified four main areas that contributed to the paramedics' understanding of their reaction management. These four areas became the four chapters for discussion and interpretation. Each of these areas contained complexities and contradictions within the discursive constructions. The first chapter explored the paramedics' constructions of their role and the expectations that come with it. This exploration revealed expectations from others for the paramedics to be extraordinary, which were in conflict with their own claims to be ordinary people. Investigations uncovered the protective nature for the paramedics of this construction of being ordinary, as well as their more implicit understandings of themselves to actually be extraordinary. The second chapter investigated the mismatch between the paramedics' ideal notions of how they function when responding, and the contradictory claims of what is actually more functional. These ideal notions were self-conceptualisations of being emotive and human within their job functioning, which conflicted with their claims to mostly use more emotionally distanced technical strategies during responses. The third chapter looked at the paramedics' desires to be truthful when self-reflecting post-incident. The idea of being truthful raised issues of whether the 'truth' actually exists. The self-reflection process was revealed to actually be more of a meaning-making exercise to facilitate acceptance for the paramedics. The fourth chapter explored the consequences of reactions that had not been managed in some way. The concept of support-seeking was investigated, and complexities regarding the acceptability and accessibility of the available support services was revealed. These investigations uncovered that various social risks are weighed up by the paramedics

when contemplating seeking support. These various 'risks' were claimed to inhibit support service usage. The interpreted understandings from the four chapters highlight the complexity of reaction management during and after incidents for the paramedics.

To better understand the complexity and contradictions within their constructions, the contextual factors impacting the paramedics' understandings have been considered during interpretation. The findings support a conceptualisation that reaction management is essentially constructed at three levels which impact upon the paramedics. Firstly, reaction management is constructed socially and historically by the psychological research and counseling community, as an identifiable phenomenon of interest with preconceived understandings. The paramedics have often had previous exposure to these understandings, and are impacted by them again during their interactions with the researcher. Secondly, reaction management is constructed socially, historically and linguistically by the paramedics through their own experiences, and then again through their recollections of response incidences. These recollections are also affected by different discursive contexts. Thirdly, reaction management is also socially and culturally constructed by those who are stakeholders in the outcome of the paramedics' reaction management. These stakeholders are the organisation they work for, the colleagues they work with, their family and friends, and the public they manage these reactions in front of. This conceptualisation, that reaction management is constructed and influenced by multiple stakeholders, is the overarching commonality between the four chapters. This commonality is interpreted as constant sense of *balance* the paramedics attempt to maintain. In a broad sense, what the paramedics appear to be balancing is a notion of how they understand themselves, and how they *perceive* others understand them.

In all four chapters, there are claims from the paramedics to experience cognitions and emotions as a response or judgment of their initial reactions. These types of responses to initial reactions have conceptualised as 'meta-reactions'. These meta-reactions relate to the social, cultural and personal implications the paramedics perceive arise, for not managing their reactions, when you are "supposed to be seen to be able to do these things". The findings in the four chapters support a notion that the constant sense of *balance* being maintained relates to the management of these meta-reactions.

The findings of this research contribute to emergency response research, and coping or reaction management research. These contributions are primarily with regards to the differences in the findings and interpretation from previous research. These

differences will contribute to the field theoretically, empirically, academically, and inform policy-making for the St John organisation.

The interpretations of the paramedics' motivations for choosing reaction management strategies, and the understood utility of these strategies are the main differentiations in this study from previous research. This is because previous research has typically neglected to construct reaction management from the participants' own understandings, and also has often failed to explore the contextual utility of the strategies. Previous research on emergency responders' reaction management most often requires the participants to select items from questionnaires, that best describe what they understand that they do (Alexander & Klein, 2001; Alexander & Wells, 1991; Fannin & Dabbs, 2003; Geraerts et al., 2006; John & Gross, 2004; Koole, 2009; Regehr et al., 2002; Ursano et al., 1999). These questionnaires, which have predetermined causal outcomes linked to the reaction management styles, have been developed and updated by psychologists based on somewhat contentious, and potentially outdated, stress appraisal models (Lazarus & Folkman, 1984). The most frequently used questionnaires are the Brief COPE (Carver, 1997) and versions of the WCQ (Folkman & Lazarus, 1980). The Brief COPE Questionnaire (Carver, 1997) which was reduced down from the COPE (Carver, Scheier, & Weintraub, 1989), was originally developed using University of Miami undergraduate students as subjects. The WCQ (Folkman & Lazarus, 1980), still considered to be the standard measure in the field of coping (Kieffer & MacDonald, 2011), was originally developed by Folkman and Lazarus (1980) from analysis of coping techniques, using a participant sample they described as an American middle-aged community. These participants answered questions and gave ratings regarding *one* stressful event they had experienced that year. Reflecting back upon quotes from the paramedics describing elements of their job role, in the preceding chapters of the present research, it is apparent that these questionnaires are a mismatch to an emergency responder's context of coping. The utility of a strategy, such as 'mental disengagement' or 'suppression', would clearly be very different for a paramedic attending multiple traumatic deaths during one ten hour shift, than for a University undergraduate student, or a one-off stressful event experienced by a middle-aged community member. Instead of using questionnaires or scales, in the present study open-ended question methods and multiple data collection techniques have captured a broader range of strategies, and facilitated a return to participants to clarify interpretations and gain better understanding of the utility of strategies. In previous

research, limiting the strategy options to predetermined lists developed on vastly different populations not only risks omitting different strategies used by the paramedics, but also risks applying causal inferences that are irrelevant to the paramedics. In legal terms these causal inferences are called 'circumstantial evidence'. To solve this issue in a court of law it may be decided that the accounts from the defendant and witnesses need to be heard, photos of the incident viewed, and perhaps evidence provided explaining the build up of events to the incident. In other words information needs to be *contextualised* in order to then be analysed and interpreted, not merely subjected to causal inferences as it is in much of the previous research within the field.

This brings us to the consideration of the contextual utility for strategies, which has also been neglected in previous research. Contextualising the paramedics' understanding of their reaction management is the second way in which the present research contributes theoretically to the field. Locating the strategies utilised by the responders within their situational contexts revealed the functionality of the strategies. For example, strategies that were previously labeled 'avoidant' or 'suppressive' automatically came with preconceived agreement from the psychological community as being 'negative' or 'risky' strategies (Derakshan et al., 2007; Geraerts et al., 2006; Hayes et al., 2004). In the present study the paramedics' claimed utility of strategies were understood once they were recontextualised as a component in a longer sequence of reaction management, which extended into the post-incident timeframe.

Positivist psychology has developed a habit of wanting to provide neat answers of what are 'good' and 'bad' reaction management strategies for emergency responders. It appears that after around forty years of previous research on coping strategies it is still repeatedly proposed that emergency responders use 'bad' reaction management strategies (Derakshan et al., 2007; Kirby, Shakespear-Finch, & Palk, 2011; Marmar et al., 1996; Regehr et al., 2002). Much of this research stops at the point of collating lists of what strategies responders use to manage their reactions, and then creating links to 'negative' outcomes from these strategies. Did anyone stop to ask why nothing had changed in forty years, and why the responders are still using 'negative' strategies? "If it ain't broken, don't fix it". Perhaps the strategies themselves are not seen as 'negative' by the responders for a commonsense reason. The present research contributes theoretically to the field by providing understandings of *why* the responders are doing what they are doing, not just *what*. Asking *why* has uncovered the complexities of *utilising* reaction management strategies, such as support-seeking for the paramedics. At

face value a strategy such as support-seeking may appear to be acceptable and accessible to the paramedics. However, within their discursive constructions, are claims of complex social risks that render some actions inaccessible. This research therefore contributes a theoretical understanding of reaction management being just as much of a social practice, as it is a functional practice for the paramedics.

An additional contribution that this social constructionist research provides to the body of empirical research is a more expansive investigation than is possible with the usual deterministic approach used in reaction management research. Instead of hypothesising what might be problematic with regards to reaction management for the paramedics, the present study gained more extensive understanding of the phenomenon from the paramedics themselves. The contribution of these findings to empirical research then is to shift the focus for investigation onto the correct 'problem' within reaction management as it is understood by the paramedics, rather than by the researchers. Rather than continue the focus on identifying causal links between 'bad' coping strategies used during response situations and negative symptoms occurring later, the focus of research can now shift to investigate factors which inhibit and facilitate the accessibility and acceptability of receiving support, and reaching acceptance to let go of reactions post-incident. The contextual understanding provided by the social construction approach will then ultimately benefit the paramedics, not just the research community.

A further contribution of the present research to the academic field is a demonstration of the utility of the combination of data sources used in this study: individual interviews, focus groups, and field observation. The end combination of data sources provided three very different discursive contexts in which to observe changes and consolidations in the paramedics' constructions regarding the same issues. Additionally these three contexts provided opportunities to revisit topics and explore why contradictory constructions may be appearing in the paramedics' conceptualisations of reaction management. The data source combination was further enhanced by harnessing the opportunity to compare emerging themes with unplanned informal discussions from the field observation. The step taken to include paramedics' discursive constructions from informal discussions during the field ambulance shift observation was a move beyond the planned data sources. Identifying these spontaneous informal discussions as useful and rich sources of data was in keeping with social

construction theoretical ideas of allowing the study to evolve and develop out of the research process itself.

This research will contribute to the St John organisation by providing information to facilitate socially and culturally relevant policy decisions. The results of this study indicate that 'best practice' recommendations for reaction management are better to come from understanding how certain actions are accessible and acceptable within the existing contextual constraints. The key finding in this research regarding reaction management *during* responding, was that coping learning tends to be a combination of advice given, observations and modeling from senior officers. Acceptable strategies are strongly linked to social ideas of how a paramedic is "supposed to be". In practical terms for St John, this may mean introducing psycho-education that reiterates the 'tried and true' functional strategies that the trainees will later witness senior paramedics using. This will provide a consistency between the formal and informal levels of training received by new staff. Additionally it links training to strategies that will be accessible and acceptable socially within the actual work field.

The key finding regarding 'negative' outcomes from reaction management *post* responding was that lack of accessibility to support following incidents was problematic, not the actual strategies used during the response. This reaction management post-incident is particularly important to the paramedics to facilitate acceptance. Perceptions of acceptability and accessibility of support are strongly linked to social risks of organisational positioning and personal image. Being seen to seek support presently at St John is conceptualised as a sign of weakness by the paramedics, and as potentially risking their current job position and future career prospects. St John would benefit from addressing the inconsistencies between what is recommended with regards to support, and what is modeled through actual use. In practical terms, the use of support modeled by senior officers may assist in breaking down the "do as I say, not as I do" problem, and assist with starting to shift the construction of weakness around support-seeking.

These recommendations for policy, having been taken from the paramedics' own understandings of the problematic elements, will have greater resonance and acceptance by St John paramedics than introducing concepts retrieved from prior psychological theory. Recommendations expressly taken from their own understandings seem particularly important for individuals that claim to respect the authority of medical

discourse, and admit skepticism toward psychological advice. The contextual information this research provides will assist the St John organisation with understanding why training and new policy may or may not be embraced by employees, due to personal, social and organisational cultural factors.

The results of this study provide understanding for how the various constructions of reaction management by the paramedics have come about, are being maintained, and may evolve. The study produced rich in-depth commentary on the experiences of a group of St John paramedic officers, and an interpretation of their understandings from within their unique work context, at this particular time. The predictive ability of these qualitative research findings is proposed to be neither necessary, nor possible (Westerman, 2004). Due to the socially constructed nature of understandings regarding phenomena, the meanings interpreted from this research will continue to evolve with time, with the participants' ongoing experiences, and with differences relating to researchers. Acknowledging this ongoing evolution of understandings is vital to the utility of research. Rather than proposing to reveal 'laws' or 'truths' regarding reaction management, the present research has generated theoretical insights which may benefit similar populations in similar circumstances.

The present study revealed potential gender-related issues affecting reaction management. Discursive constructions of the stoic historical organisational culture of St John were linked by the paramedics to the previously larger percentage of male paramedic staff. Further studies of the organisation could investigate possible historical and present social factors that affect the accessibility and acceptability of reaction management strategies and support-seeking, differently for male and female paramedics.

Within the present research reaction management expectations and choices appeared to not only be affected by the organisational culture, but also the wider New Zealand culture. Further studies focusing on the ethnic cultures within this broader New Zealand culture could investigate whether the ethnic cultures of paramedics adds additional layers to their constructions of reaction management, and their perceived role expectations.

The chosen sample size and the triangulated data collection methods used in this study generated abundant rich data, which enabled a deep level of comparison and analysis. There is potential in future research to collate further rich data, collected in a similar manner from additional samples of St John paramedics, or other groups of

emergency responders, to build upon the present research. Additional data collection could facilitate comparisons to see if the problematic *balancing* nature of reaction management, and the issues of support acceptability and accessibility transfer onto other St John divisions, or other emergency responder populations. This research can then become the foundation from which to explore ways to improve or mitigate these perceived obstacles.

Within each of the four interpretive chapters of this study has been a unifying notion that the paramedics experience response incidents, and the accompanying role expectations, from a subjective perspective. We can see that the sense of *balance* that the responders strive to maintain in their self-constructions, both during and after their responding, is very tied to their judgment of how they believe other stakeholders in their response management see them. These judgments or 'meta-reactions' they experience are the driving force to achieve the sense of *balance*. As discussed using the concept of "we don't see things as they are, we see things as we are" (Nin, 1969, p. 124). we understand the paramedics themselves generate these meta-reactions. Therefore, the meta-reactions can be understood as potentially more reflective of how they actually see themselves, than how others do. This appreciation of individual perspectives, which are brought to an experience, is not limited to the research participants, and can equally be applied to the experience of conducting psychological research. I have quoted Heisenberg (1958, p. 58) as saying "we do not observe nature, as much as we observe nature exposed to *our method of questioning*". As was discussed, much of the previous research in this field has used a method of questioning founded in preconceived answers. This notion in itself appears to be an oxymoron, which essentially means that as researchers we only ever see things as *we* are ourselves. In the present study, by changing the method of questioning from *what* to *why*, and listening carefully to the answers, the paramedics moved me beyond any preconceived perspectives, and into understanding their experiences. The subtlety of the meta-reactions have been able to be identified and interpreted, the perceived functionality of the reaction management strategies has been expressed, and the area of post-incident support that the paramedics perceive to be the 'problem' has been identified for future research and policy changes.

Appreciating our role of co-construction in how the paramedics understand their own reaction management might seem unsettling, yet at the same time is potentially rewarding. As one of the contributors to these constructions we have the ability to acknowledge the complexities and contradictions of their position, that exist equally for

them as they do for us. Some days we know ourselves as extraordinary, and other times we need the protection of being seen as ordinary. We like to understand ourselves as functional and efficient in our work, but will have experiences that touch our humanity and expose our emotions. We make meaning and retell our life stories so that they make sense to ourselves and to others. In small ways every day we weigh up social risks against our goals in life; every time we pick up the phone, open our mouths, open the door, choose to smile, or take a chance and maybe say “No”, when someone asks if *us* if we are OK.

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APPENDIX A

Information Sheet for Individual Interview

How do you manage your personal reactions during emergency responses?

My name is Annabelle Ryburn, I would like to invite you to participate in a study specifically focused on your Auckland St John Ambulance unit. This study will be utilised for my Psychology Master's thesis, supervised by Professor Kerry Chamberlain of Massey University, Albany. Professor Chamberlain specialises in qualitative research approaches in the areas of health and social psychology, and psychological wellbeing.

This information sheet aims to provide you with a brief overview of the study and should you choose to participate, what that would involve.

What is the study about?
This study will aim to explore what strategies you use as paramedics to manage your personal reactions in emergency/disaster response situations, and how effective you consider these strategies to be. 'Personal reactions' is a term used to encompass any physical, mental and emotional responses you may be aware of during an incident response. This study will consider how aware of these reactions you are, how you respond to these reactions, and why you respond in the way you do.

Who can participate?
You have been invited to participate based on the length of your experience as a paramedic. I would like to interview approximately 10 officers. There are no additional selection criteria for participation, other than an expression of interest in participating.

What is required if I decide to participate?
You will be invited to participate in an individual interview, conducted outside of work hours, in a private room at your local work premises. This interview will take approximately 30 to 60 minutes of your time, and will be audio taped.
At a later date (probably a month following individual interviews) there will be focus group discussions held with 3-4 officers in each group. These groups are to provide the opportunity to discuss and clarify concepts that are emerging from the initial interviews. These discussions will take approximately 30 to 60 minutes of your time, conducted outside work hours, at your local work premises.

What are your rights if you choose to participate?
While your participation in the research would be greatly appreciated, you are under no obligation to accept this invitation. Should you choose to participate in the study you will have the right at all times to decline to answer any particular question(s), to withdraw your data from the study up to two weeks after the interview, to ask any questions about the research, to request the audiotape to be turned off at any time during the interview, and to have access to a copy of the transcript to review and edit, before analysis starts.

What support is available?
You may request for me to pre-arrange to have peer support or the St John Kaumatua present during your interview, if you desire. If any emotional discomfort arises during or after the interview, you will have the opportunity to receive psychological support

through St John Ambulance Service. Contact details for this support appear at the bottom of this information sheet.

How will your confidentiality be protected?
Once the transcription of your interview is complete, the audiotape will be securely stored by me. Your identity will be made anonymous from this point onward in the research through a coding system. All data collected will remain confidential, will be stored securely and will only be accessible to my supervisor, and myself. After completion of the thesis the audiotapes will be destroyed by me, and the anonymous transcript data will be securely stored by my supervisor (as per Massey University research policy), and then destroyed after five years.

How will your information be used?
A copy of the thesis will be given to St John Ambulance Service upon completion. A briefer summary of the research findings will also be provided to you and all paramedics who have participated in the study, and a copy will be given to your Health and Safety Advisor. All information provided by yourself and your team will be given on the understanding that your name will not be used, and your confidentiality will be protected.

Contact Information
If you have any questions regarding the research project before or after the interview process, please contact me, Annabelle Ryburn on 021 801012, or email annabelleryburn@gmail.com.

Alternatively, my supervisor Professor Kerry Chamberlain is available to help with any queries. Professor Chamberlain can be reached on (09) 414 0800 Ext 41226, or email K.Chamberlain@massey.ac.nz

If you would like to arrange for psychological support after the interview process, please contact Julian Reeves on 027 4852 584

This research project has been reviewed and approved by the Massey University Human Ethics Committee: Northern Application 11/022 If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Chairperson (Northern), Massey University Human Ethics Committee: (09) 414 0800 Ext 9570
or email humanethicsnorth@massey.ac.nz

APPENDIX B

Human Ethics Approval

MASSEY UNIVERSITY
ALBANY

5 July 2011

Annabelle Ryburn
c/- Professor K Chamberlain
College of Humanities & Social Sciences
Massey University
Albany

Dear Annabelle

HUMAN ETHICS APPROVAL APPLICATION – MUHECN 11/022

Understanding the Experience of Managing Personal Reactions during Paramedic Emergency Call Out Responses: The Perceived Utility of Strategies Used

Thank you for your documentation of 1 July 2011, seeking a variation to your protocol MUHECN 11/020 approved on 28 April 2011 by the Massey University Human Ethics Committee: Northern.

Your variation, using a different group of participants, has been approved.

Approval is for three years. If this project has not been completed within three years from the date of this letter, a reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Ralph Bathurst
Chair
Human Ethics Committee: Northern

cc: Professor K Chamberlain
College of Humanities & Social Sciences

Te Kunenga ki Pūrehuroa
Research Ethics Office
Private Bag 102 904, Auckland, 0745, New Zealand Telephone +64 9 414 0800 ex 9539 humanethicsnorth@massey.ac.nz

APPENDIX C

Information Sheet for Focus Group Discussion

How do you manage your personal reactions during emergency responses?

My name is Annabelle Ryburn, and this research is for my Psychology Master's thesis, which I am completing through Massey University. My supervisor is Professor Kerry Chamberlain, of Massey University Albany campus.

Thank you for your participation in the individual interviews, and time you have given to the research so far. I would now like to invite you to participate in focus groups discussions for this research. This information sheet aims to provide you with a brief overview of the focus group portion of the study, and what this will involve.

What is the study about?
As you know, this study aims to explore what strategies you use as paramedics to manage your personal reactions in emergency/disaster response situations, and how effective you consider these strategies to be.

Why is a focus group discussion held?
The focus group discussions provide an opportunity to discuss and clarify concepts that are emerging from the initial interviews. These groups also provide a chance to discuss how you jointly understand the process of managing reactions, and for you to discuss similarities and differences in your individual experiences. While I will introduce 'topics' for group discussion that have emerged as themes from your individual interviews, none of the individual information shared in individual interviews will be disclosed.

Who can participate?
All of the paramedics who have completed individual interviews will be invited to participate in focus group discussions. There are no selection criteria for participation, other than an expression of interest in participating.

What is required if I decide to participate?
Focus group discussions will be held with 3-4 paramedics in each group, depending on availability of officers. These discussions will take approximately 30 to 60 minutes of your time and will be conducted outside of work hours, at your local work premises.

What are your rights if you choose to participate?
While your participation in the focus group discussion would be greatly appreciated, you are under no obligation to accept this invitation. Should you choose to participate in the study you will have the right at all times to decline to answer any particular question(s), to ask any questions about the research, withdraw from the focus group discussion, and to request the audiotape to be turned off at any time during the discussion. Due to the complications involved in separating and editing group discussion audio, time will be allocated following the group discussion for the group to decide if there are any portions of the discussion they would like altered/removed before analysis begins.

What support is available?
If any emotional discomfort arises during or after the discussion group, you will have the opportunity to receive psychological support through St John Ambulance Service. Contact details for this support appear at the bottom of this information sheet.

How will your confidentiality be protected?
All paramedics participating in focus group discussions will be required to swear on tape to confidentiality of the discussions taking place. Once the transcription of the discussion is complete, the audiotapes will be securely stored by me. Your identities will be made anonymous from this point onward in the research through a coding system. All data collected will remain confidential, will be stored securely and will only be accessible to my supervisor, and myself. After completion of the thesis the audiotapes will be destroyed by me, and the anonymous transcript data will be securely stored by my supervisor (as per Massey University research policy), and then destroyed after five years.

How will your information be used?
A copy of the thesis will be given to the St John Ambulance Service upon completion. A briefer summary of the research findings will also be provided to officers who have participated in the study, and a copy will be given to your Health and Safety Advisor. All information provided by yourself and your team will be given on the understanding that your name will not be used, and your confidentiality will be protected.

Contact Information
If you have any questions regarding the research project before or after the interview process, please contact me, Annabelle Ryburn on 021 801012, or email annabelleryburn@gmail.com.

Alternatively, my supervisor Professor Kerry Chamberlain is available to help with any queries. Professor Chamberlain can be reached on (09) 414 0800 Ext 41226, or email K.Chamberlain@massey.ac.nz

If you would like to arrange for psychological support after the interview process, please contact Julian Reeves on 027 4852 584

This research project has been reviewed and approved by the Massey University Human Ethics Committee: Northern Application 11/022. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Chairperson (Northern), Massey University Human Ethics Committee: (09) 414 0800 Ext 9570, or email humanethicsnorth@massey.ac.nz

APPENDIX D

Individual Consent Form

How do you manage your personal reactions during emergency responses?

INDIVIDUAL PARTICIPANT CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time. I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: ..... **Date:** .....

Full Name - printed .....

If you would like to receive a copy of your transcript from this interview, please provide:

Email address: _____

Or

Postal address: _____

_____

_____

APPENDIX E

Group Consent Form

How do you manage your personal reactions during emergency responses?

FOCUS GROUP PARTICIPANT CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time. I agree to participate in this study under the conditions set out in the Information Sheet. I agree not to disclose anything discussed in the Focus Group.

Signature: ..... **Date:** .....

Full Name - printed .....