The Culture of Coping in Paramedics

by

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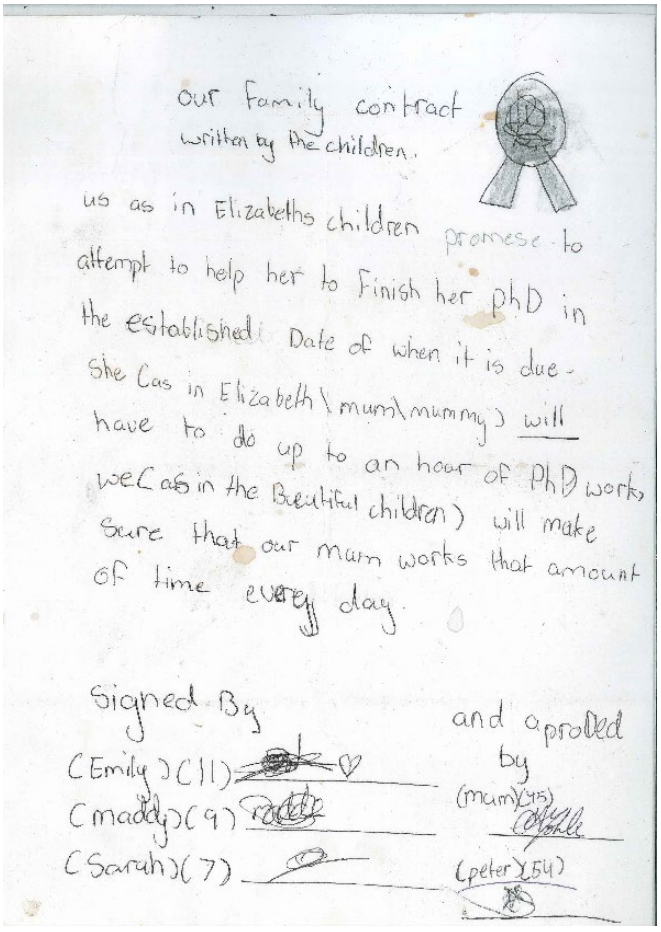
Our family contract
written by the children.

us as in Elizabeths children promese to attempt to help her to finish her phD in the established Date of when it is due.
She (as in Elizabeth \ mum \ mummy) will have to do up to an hour of PhD work, we (as in the Beautiful children) will make Sure that our mum works that amount of time every day.

Signed By
(Emily)(11)
(maddy)(9)
(Sarah)(7)

and aproved by
(mum)(45)
(peter)(54)

And finally, I wish to acknowledge my family for being on this journey with me. My husband, Peter Lawrence, for his unfailing support and constant encouragement, and my daughters, Emily, Maddison, and Sarah, for their tolerance and support (albeit more in spirit than practice!).

DECLARATION

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university: and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Elizabeth Goble

Signature: _____ Date: 18th December 2019

ABSTRACT

Emergency personnel encounter psychologically disturbing or traumatic situations as a matter of course in their daily work life, with their exposure to trauma being far greater than that of the general public and more likely to be outside the range of usual human experience. As a result, they have an increased risk of suffering mental health consequences (Regehr & Bober, 2005, p. 184) which may, in turn, lead to a reduction in work performance and overall quality of life. Research outlining the culture of coping of paramedics, including which strategies they employ, both formal and informal, to manage potential mental health risks and the meanings they attribute to them, is sparse. This study is entitled 'The culture of coping in an Australian ambulance service: a case study in managing the risks of mental health related trauma.' It describes the paramedic culture of coping and the strategies they employ to protect themselves and each other from the impact of traumatic stress.

Drawing on the interpretivist theoretical perspective of Symbolic Interactionism, this research is a case study using the tenets of naturalistic inquiry. The perspectives of 23 paramedics from three different geographic locations servicing very different populations were obtained using semi-structured interviews. The findings demonstrate that the culture of coping differs dramatically depending on paramedic generational position and the location of their primary workstation. Added to this, the passage of time has altered societal expectations and this, in turn, has had an impact on the appropriateness of one of their most utilised coping strategies: humour. These cultural differences are theorised using Tönnies' typology of the differences between society and community (Gemeinschaft and Gesellschaft).

This research will better inform understandings of the cultural ideas and practices that develop within emergency services which enable paramedics to manage stressful and traumatic events. It is hoped that this knowledge will help to underpin new approaches to the management of trauma for paramedics (Moynihan, 1998).

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CHAPTER 1: INTRODUCTION

1.1 Introduction

The paramedic culture has changed dramatically over the last 50 years. Entry into the profession is now far more competitive, education has moved from in-house short courses to three-year full-time university degrees, professionalisation has increased to the level of registration, and the profile of the members has shifted from a male-dominated occupation to equal representation of women. Awareness of the trauma experienced by personnel has also increased dramatically, which has led to organisations investing in resources designed to assist personnel experiencing mental health problems following a traumatic event.

This thesis has been designed to investigate this change in culture; however, the focus is not on the formal resources provided. The point of interest is the paramedic collective perspective on their culture of coping, and how this has changed. This chapter introduces the research and summarises the main points explored in each chapter.

1.1.1 Research question

The foundation question for this research is: - *What is the culture of coping for paramedics? How do paramedics protect themselves and their workmates from psychological trauma?*

In order to understand or describe the culture of mental health wellbeing, it became necessary to formulate both primary and secondary questions. The main direction of the investigation explored:

What coping strategies are:

1. deliberately used and not used?;
2. perceived as being beneficial or detrimental?;
3. culturally encouraged or discouraged by paramedics?

The other associated questions, listed in Chapter 5 below, provide the secondary line of questioning designed to encourage a more complete and rounded exchange of information from the participants. These questions are intended to elicit a number of different perspectives on individual issues, or to encourage interpretations of a number of situations

viewed from different perspectives by the participants specifically on areas that may not be consciously considered as part of the cultural component of the organisation.

1.1.2 Aims and objectives of the research

This research has been designed to facilitate the development of an understanding of the paramedic culture and to identify common themes that appear to influence the meanings used to interpret the experiences of paramedics. This understanding will assist in describing and interpreting the cultural concepts and informal prescriptions that influence official and unofficial psycho-protective resource utilisation. For example, there may be a hesitancy by a member of the ambulance service to approach peer support for assistance if it is believed that such an action would not be viewed positively by the majority of other paramedics they know. In developing this understanding, and describing the culture in sufficient depth, this research seeks to determine whether the psycho-protective resources that are currently available within the everyday culture meet the needs of paramedics.

The Peer Support Program is the main formal resource provided by the organisation, and although paramedic perceptions regarding it's utilisation are covered, this thesis is particularly focused on the informal resources that paramedics turn to in times of need. This culture is important to break down and understand because it has been part of paramedicine since its inception, long before organisations commenced any formal psycho-protective arrangements, and it will influence all other resource utilisation.

In order to achieve this examination of the paramedic culture, the study objectives seek to:

1. Identify the knowledge, beliefs, values, morals, attitudes, norms, customs, rituals, practices, behaviours, and any other capabilities and habits acquired by paramedics in relation to their mental health protection.
2. Identify occupational stressors.
3. Identify the range of coping strategies used by paramedics to protect themselves and to manage the potential mental health risks, and report on how these are experienced.
4. Determine which strategies were preferred, perceived as beneficial, and culturally encouraged or discouraged.
5. Describe this social cultural world from the paramedic perspective.

The thesis provides a basis for analysing the culture (perceptions, understandings, and experiences) of paramedics engaging in psycho-protective behaviour either informally or by revealing conventions that use the mental health resources provided by the ambulance service.

1.1.3 Rationale for the research

The issue of mental health wellbeing for emergency service personnel, in particular paramedics, has increased in significance for governments and organisational management alike. In 2018, a Senate Inquiry was conducted by the Education and Employment Reference Committee that covered mental health conditions in emergency service personnel, including the range of conditions experienced, potential causes including the impact of particular emergency roles, symptom identification, and overall management (Lawn et al., 2019). Two contrasting perspectives were obtained. The personnel focused on how difficult it was to gain support from management and the organisation, the obstacles faced in gaining access to appropriate resources, impediments in actioning compensation claims, and obstructions to re-engagement on any level. The industry perspective revolved around the support that was provided with little acknowledgement of the hindrances that prevent personnel from accessing these resources. The Senate Inquiry was called because the community, the union, providers, and the government were concerned about the high rates of suicide of paramedics (Senate Education and Employment References Committee, 2018).

1.1.4 Significance of the research

This thesis provides a new contribution to the international knowledge base on the nuances of the culture of coping in an ambulance service, and will serve to inform organisations and relevant government departments about the impact their management procedures have on coping, and which informal mechanisms are used and endorsed and why. This will help administrations to identify the best avenues to redesign or enhance supportive strategies that will assist in the protection of the wellbeing of employees in the emergency response sector.

Although case study research methodology is not completely generalisable to other populations, it does lead to analytical generalisation through which the ‘how’ and ‘why’ of

the situations researched can be theoretically applied to other similar situations (Yin, 2018). Therefore, the results of this research may inform other emergency services in different areas/countries of potential directions for staff protection and wellbeing within their own institutions that could warrant further investigation.

1.2 Background to the Research

In order to fully appreciate the scope of this thesis, an awareness of what culture actually is, and how it is focused on in the literature, is necessary. This thesis starts with defining what the term 'culture' means to the researcher and follows with an overview of the progression of the research on culture. When the literature focuses on culture in a non-anthropological way, the most common focus is on organisational culture to evaluate safety or productivity, generally using quantitative techniques in a post-positivist paradigm (Allcorn, 1995; Jung et al., 2009; Patterson et al., 2012; van den Berg & Wilderom, 2004; Yassi & Hancock, 2005).

In organisations such as those which provide emergency or civil services, the enculturation process commences during the education phase, where like-minded people with similar value sets and principles gather together to learn how to think and behave as a member of that culture. As a person becomes a member of the culture, they become an 'insider' with a sense of identity, the knowledge and skills to behave and think appropriately within the group, and are considered further apart from others that do not belong to the group. This is evident in all health and emergency occupations such as nursing (De Bellis, Glover, Longson, & Hutton, 2001), general practice (Thompson, Cupples, Sibbett, Skan, & Bradley, 2001), firefighting (C. Scott & Myers, 2005), policing (Chappell & Lanza-Kaduce, 2010), search and rescue volunteers (Lois, 2003), and paramedicine (Steen, Naess, & Steen, 1997).

Revealing the unwritten rules and norms within culture that require adoption by members of an organisation to feel the solidarity and unity of belonging to that group is a challenge. This is because most members absorb these details in an unconscious manner and without deliberate attention, which makes it difficult to specify what these 'rules' actually are. To finalise the background section of this chapter, two different perspectives through which cultures can be described are provided.

1.3 Literature Review

Chapter 3 provides a review of the literature dealing with this topic over the last 40 years, with emphasis placed on the most recent qualitative findings on paramedic mental health and wellbeing. Qualitative research on this topic had not received much attention when this study commenced. The purpose of this study was to intentionally look at the informal aspects and the culture that has not been previously addressed, which necessitated the use of qualitative techniques, thus increasing the range of knowledge.

Research into culture is also examined, briefly concentrating on the vast amount of quantitative research investigating organisational culture. Mixed methods research is also covered before detailed attention is given to the qualitative contribution to the topic.

1.4 Methodology

1.4.1 Epistemology/Ontology

In Chapter 4, the methodology for the thesis is outlined. The theory of knowledge that is employed in this research is that of Constructionism. This approach takes as a given that all meaning is constructed rather than existing a priori and waiting to be gathered. Further to this, social constructionists hold that meaning takes place between individuals when they interact socially. In order to derive the meanings co-constructed by paramedics in relation to their culture of coping, it was necessary to implement a naturalistic approach to inquiry where the investigator is the research tool and all inquiry is value-bound (the question, paradigm, theory, and context are all affected or influenced by the investigator's perspectives and biases). The inquirer and the "object" of inquiry interact to influence one another (Beuving & de Vries, 2015; Lincoln & Guba, 1985).

From this point, the study moves into a detailed inspection of knowledge and four of its different facets, with tacit and procedural knowledge becoming particularly relevant. This section also covers the breakdown of beliefs, values, and attitudes, in relation to how they can influence the making of meaning within a culture, such as that shared by paramedics.

1.4.2 Theoretical perspective: Interpretivism / Symbolic Interactionism

The most common theoretical perspective that follows the Constructionist school of thought is that of Interpretivism (Cloud, 2016; Denzin, 1989). This perspective primarily utilises qualitative methods to retrieve data from people who are observed or interviewed. The research question is guided by Symbolic Interactionism, which specifically looks for culturally derived and historically situated interpretations of the social life world, rather than the lived experience of individuals or the choice of words and grammar. The focus is on meaning that determines behaviour and influences how people act or react, and the foundational principle is that meaning is actually the product of people's interactions with each other and the object, and that observing how others behave in relation to a thing/event/concept demonstrates how they feel about it and what level of importance its meaning has to them (Spradley & McCurdy, 1972).

1.5 Method

1.5.1 Study design / Naturalistic Inquiry / Case Study

Chapter 5 outlines the methods employed in this study. Having a cultural focus tends to lead to ethnography as the study design of choice; however, participant observation was not feasible for this study so the logical alternative was a Case Study. This was performed using the tenets of Naturalistic Inquiry, including the investigator being considered as the primary data-gathering instrument, and conducting the interviews in a natural setting (on station).

Case Studies within research are evidence-led explorations carried out with strict adherence to research methods, that attempt to unravel the depth and complexity of a particular bounded system, in this case an ambulance service, within an authentic/accurate context (Yin, 2018). Semi-structured interviews were the method of choice, as they allowed the questions to be subtly altered, repositioned, or refocused when necessary to elicit the maximum amount of information regarding the subject under investigation. The shared views and impressions of the participants demonstrated the cultural norms that guided their coping strategies that prevail in the ambulance service under study.

1.5.2 Subjects

The subjects were drawn from three different areas and demographic groups in order to determine whether differences in the culture of coping exist under different conditions and exposures. A total of 23 paramedics of varying qualification levels were interviewed. The sample obtained was not fully reflective of the age or gender breakdown of the organisation for the year of study; however, all interested paramedics who were available at the time were interviewed.

1.5.3 Analysis

A proportion of the interview recordings were transcribed by the researcher, with the remainder being processed by a confidential professional transcription service. The transcripts were then uploaded into the NVivo qualitative research software to assist with coding (examination, conceptualisation, and categorisation) and the organisation of themes (Saldaña, 2013). The selection of the themes was determined by the number of participants who spoke on the same or similar topics in relation to how they perceived the culture of coping, what strategies they used, or alternatively, what strategies they saw others use.

The analysis provided five findings chapters: two describe the current culture (Chapter 6: The Working Environment and Stressors, and Chapter 7: The Current Culture and Future Directions), and three provide detail on how the culture is shaped (Chapter 8: Location, Chapter 9: Generation, and Chapter 10: Societal Evolution / Humour).

1.6 The Working Environment and Stressors

Chapter 6 is the first of five findings chapters, and describes the overall profession and the general culture. It contains a precis of the different roles and functions that a paramedic can work in and how they influence the kinds of patients they interact with over different time periods. They reveal what a “good day” looks like to them, demonstrating what paramedics actually enjoy within their profession, what they appreciate in relation to jobs and challenges, and what makes them feel helpful and useful. There is also an interpretation of how the general public views paramedics, highlighting their expectations and how these views are considered by the paramedics.

The second section of this chapter examines occupational stressors in greater detail. It contains the participants' views on the environment they work in and what they actually find stressful. It also clarifies what they do not consider to be stressful, despite lay assumptions to the contrary.

1.7 The Current Culture and Future Directions

Chapter 7 is the second descriptive findings chapter illuminating the current culture. The chapter includes the collective impressions that were divulged when the participants were asked the question, "What is the culture of coping here now?" It captures the range of comments from positive to negative, with insights as to why they comprehend the situation as they do. This includes a conversation about the organisationally provided Peer Support Program, when, why, and by whom it is used, but more importantly, why it may not be used as much as expected.

The second half of this chapter focuses on the shared thoughts about what the paramedics wish the culture to be, which was elicited by asking the question "What advice would you give to new recruits regarding mental health protection?" This prompted the identification of six main factors: self-awareness, non-avoidant communication, priorities, responsibility, motivation, and confidence.

1.8 Location

Chapter 8 is the first of three findings chapters that reveal the factors that influence the culture of coping in the ambulance service. Three different locations were studied, which were defined by their proximity to a metropolitan centre: rural and remote, country town, and metropolitan (outskirts). The study found that the location of the primary station that a paramedic works from plays a large part in determining the types of jobs attended and the injury profiles, the timeframes experienced (in transit, with the patient, and without back-up assistance), relationships with peers, superiors, the community, and their families, and finally, the range of coping methods that tend to be relied upon. Paramedic perspectives on their own location, as well of their views on the culture in the other locations, are described.

1.9 Generation

This section focuses on the generation each paramedic was born into and the impact this has on the views and experiences of the members. This brings to light the differences in how each age group views their world, their responsibilities, themselves, and others, which has a significant impact on the selection and use of certain coping strategies.

The specific differences that are explored in the second findings chapter include attitudes towards experience versus formal knowledge, general values and principles, entry into and ongoing attitudes towards the profession, respect for authority and company loyalty, communication preferences, and coping strategies.

1.10 Societal Evolution / Humour

The final findings chapter touches on how changes in societal values have had an impact on the cultural acceptance of certain coping strategies. The use of humour, in particular 'black' or 'gallows' humour, is now considered politically incorrect and society has therefore deemed it unacceptable. This has filtered through to the organisation's management team who have now decreed that it is no longer to be a part of the culture. As humour is such an important coping strategy and is woven into the fabric of paramedic culture, this has had an impact on, and disconcerted, several paramedics.

This chapter introduces the functions of humour, concentrating on Australian styles and its occupational focus. It describes what humour does in a collective setting and how it is used as a coping strategy. Paramedic comments on their specific uses of humour follow, with their perspectives on past and present utilisation. The cultural adaptation techniques have primarily involved knowing who will not be offended by the humour, and when it can be safely used to provide the positive aspects without any negative consequences.

1.11 Discussion / Conclusion

In Chapter 11, the cultural differences observed and detailed in the previous five chapters are theorised using Tönnies' typology of the differences between society and community (Gemeinschaft and Gesellschaft). Similar to Durkheim's social typology based on the division

of labour, Tönnies grouped individuals together on the basis of social ties between the members of a society throughout history.

Gemeinschaft relates to the fact that communities are made up of small groups (small families and close-knit kinship groups) which are usually of similar backgrounds and life experiences. Social norms and values are shared and there is limited individualisation. Gesellschaft is more apparent in large technologically advanced societies where the division of labour becomes a necessity because no single person can hold every job available. In Gesellschaft communities, most people are strangers. Each person has their own background and they have little in common with others within the same community. As a result, relationships and social interactions are formed through social rules or immediate tasks, such as purchasing an item or arranging a business meeting, rather than through ties of kinship. This means that social interactions are less personal and more individualised.

Using this typology, it is not difficult to visualise that communities in rural and remote areas would align themselves with social relationships similar to those of historical farmland communities, where everyone knew everyone else and relationships were closer, based on kinship rather than mutual self-interest or roles. The more urban and dense a population became, the further along the continuum towards Gesellschaft (society) they moved. In highly populated urban areas, social relationships are characterised by an increasing division of labour (Slattery, 2003).

This also fits in neatly with the generational differences found. Generally speaking, the older the generation, the closer the paramedic is linked to the sentiments of the Gemeinschaft side of the continuum. The value sets of older paramedics (Baby Boomers) are more communal in nature, with family relationships regarded more highly than impersonal business-style relationships. In this instance, older members of the paramedic team (Baby Boomers) developed relationships with their immediate workmates akin to a pseudo family, with equal protective instincts and trusting communication. On the other end of the spectrum, the youngest generation (Generation Y) considers occupational peers as work connections only. Their pseudo family are their outside friends and study partners, either from their university course or their internship.

This societal evolution over time also sits well with the Tönnies typology. As a community moves across the continuum from community towards society, it demonstrates an increasing tolerance of diversity. As tolerance turns to acceptance, it becomes necessary to protect minority groups from disparagement. Because of this, black humour, where the intent is to objectify outsiders, is no longer considered acceptable. However, as humour is such an important coping strategy for paramedics, they are learning to subtly change the focus to stop the ridicule of people, but to maintain the stress relief of talking about 'the ridiculous' nature of a situation.

Tönnies' theory of community is then expanded using Brint's 2001 model which separates the types of communities by their primary reason for interaction, being either activity-based, such as in a workplace, or belief-based, such as through a philosophy. The thesis concludes with future recommendations to enhance the mental health wellbeing of paramedics.

1.12 Summary

This chapter has established the direction and structure of the thesis. In Chapter 2, the background information important to the research is conveyed, particularly definitions to the central concepts of culture, stress and coping and exploring their association in this thesis.

CHAPTER 2: BACKGROUND TO THE RESEARCH

2.1 Introduction

This chapter explores a number of concepts that are integral to the research question. As noted in chapter one, managing the fall-out from exposure to trauma is a major consideration for paramedics and other emergency workers. Besides formal programs, the culture of the organisation is an important factor in how paramedics cope. Much research has been conducted in this area that contributes to understanding the issues. This is now explored through a review of the relevant literature. The first task is the exploration of culture, it's expression in an occupational setting and it's development during training periods. An investigation of how the unwritten culture is exposed is detailed before the research literature and reporting on culture is broached. The second concept to be defined is stress, where individual perceptions of the intensity of stressors are noted. Finally, the concept of coping is unravelled by way of definition, characterisation, and an observation regarding the social nature of coping, prior to briefly noting the differences between coping and resilience.

2.1.1 Defining culture

When one disregards biological meanings, such as those relating to propagating bacteria, the term culture has been used to refer to the refined tastes of the aristocratic upper classes (e.g. theatre and the performing arts), or the collective preferences of a generation (e.g. music pop culture). However, within the social sciences, the term incorporates a more structured set of information. As it is such a widely used term with several nuances in meaning, a definition of culture needs to be wide-ranging, encompassing basically everything that a group of people collectively learn or produce (Fetterman, 2010; Spradley & McCurdy, 1972).

Culture is inherent in everything that an individual believes or does when connected to a group of people with similar interests, experiences, or environments. One of the forefathers of cultural research, Goodenough, proposed the following ideation:

> *People who deal recurringly and frequently with one another develop expectations regarding the manner of conducting these dealings. They make some of their expectations explicit and formulate some of them as rules of conduct. They do not consciously formulate others but react to a person's failure to abide by them as a breach of appropriate behaviour (Goodenough, 1970).*

These expectations or assumptions can be viewed as a set of standards or guidelines relating to what people believe, how they perceive and evaluate different situations, and how they communicate and act towards one another (Steen et al., 1997). In essence, culture is the set of standards that an individual assigns to themselves and the other members of their group. Other associated expressions include 'rules of thumb' (Abrahams, 1986), 'recipes for mutual ordering', and 'propositions and their preference ratings' (Goodenough, 1964).

As mentioned in Goodenough's statement, these norms and values can be either explicit or implicit, and the product of both cognitive and instrumental (habit-forming) learning (Goodenough, 1964). The former is mainly learned during interactions between people. Communication can only occur if the person one is interacting with understands the meanings that are attributed to the words that are vocalised, such as the importance of certain metaphors. This in turn influences a person's perceptions, which involves the organisation, identification, and interpretation of information in order to understand the environment and to be able to represent this to others (Bohannan, 1963).

On the implicit side, there are the unconscious basic assumptions that are entrenched in the subconscious, and these contribute the essence of the culture (Steen et al., 1997). An example would include the body language used to indicate the approval or disapproval of actions or comments. A person in a strange environment is quick to feel when they have made a faux pas and will attempt to correct their behaviour, whether or not they understand which unwritten rule was broken. Another case in point is the example of the potential different meanings of a wink. It can indicate physical attraction, convey support, communicate camaraderie and the sharing of an inside joke, or can simply be a physical anomaly such as a twitch with no overt meaning at all. The context of the behaviour and the understanding of the recipient determines the meaning (Fetterman, 2010; Geertz, 1973).

Abrahams (1986) explained the social construction of the context and the associated emotions:

> *When an experience can be designated as typical, then the doings of the individual and the community become shared, not only with regard to what actually happens under those circumstances, but also how one feels about the happenings. Simply stated, it is not just experiences that are shared, but the sentiments arising from them as well: the doings and the feelings reinforce each other. Moreover, this system of typicality of event and sentiment provides us with a linkage between past and future, for the very recognition of typicality rests on others having gone through that experience (or something like it) before (Abrahams, 1986).*

Put simply, culture consists of standards for deciding:

- what is
- what can be
- how one feels about it
- what to do about it
- how to go about doing it.

These standards are used by people as guides for every decision that needs to be made in the course of everyday life. "As the members of a community go about their affairs, constantly making decisions in the light of their standards, the patterns characterizing the community as a whole are brought into being and maintained" (Goodenough, 1964). Culture is not to be considered as a set of restraints. People feel comfortable working within a culture because of the 'potent psychic benefits': each member of the club will uphold and defend the culture because it gives them safety, esteem, and "a sense of belonging, security, and significance in the world" (Pastor, 2004, p. 619).

2.1.2 Organisational culture

All organisations, whether large or small, public or private, operate with a culture that is essentially a shared set of fundamental assumptions so that its members can identify with each other and be identified as a collective by others. There are specific terms and jargon used between members of a single cultural group that sound foreign to outsiders. Encountering certain situations on a regular basis that are able to contribute to the label of 'typicality' can solidify the identity of the organisational collective (Steen et al., 1997). Several researchers have defined organisational culture as the 'glue' that holds an organisation together, either through shared meanings or degrees of commitment leading

to shared responsibility for performance outcomes (Jaskyte, 2010; van den Berg & Wilderom, 2004).

Research into organisational culture and its determinants is a matter of interest to managers of many different types of organisations in order to understand how to manipulate and regulate change. There is also a sub-category of research that specifically focuses on organisational *safety* culture which concentrates on the collective beliefs and perceptions of workers in relation to the attitudes towards safety of their workplace operations (Patterson et al., 2012). This area of workplace safety has gained importance over the last decade as organisations are legislated to ensure, maintain, or strengthen occupational health and safety practices.

The vast majority of research regarding the culture within an organisation has been conducted using quantitative instruments from a psychological perspective. In 2009, Jung and colleagues performed a review of 70 distinct instruments, concluding that no single instrument is ideal, and that the selection of an analytical vehicle must be made purely taking the research question into consideration (Jung et al., 2009).

2.1.3 Enculturation in training

The term 'enculturation' encapsulates the act of acquiring cultural knowledge, specifically learning how to act under certain circumstances and in certain situations. Within the health industries, this involves the acquisition of all required knowledge and skills, the internalisation of the associated set of values and occupational norms attributed to that knowledge, and a sense of identity in becoming a practitioner (De Bellis et al., 2001).

Currently, enculturation for paramedics begins in the training or educational facility, specifically the university where prospective occupational group members begin to acquire the knowledge that will be expected of them upon initial exposure to the work environment. The selection process, such as that of various Paramedic Degree programs, limits candidates to those with similar outlooks (confident, perhaps personable, resourceful, and dependable), ambitions (competitive, not hampered or intimidated by barriers), interests (medical science, health, injury, and trauma) and levels of determination (not daunted by difficult odds). Once inside the program, students are further socialised through

the intensive clinical focus, and the driving need to obtain very high marks for all work submitted, because this is a significant factor in determining whether graduates are selected for one of the few positions routinely available within the industry. Those paramedic graduates who are now accepted into a service in Australia are generally competitive, ambitious, and highly educated.

2.1.4 Exposing culture

In order to expose the culture of a group, a researcher must be able to describe the culture's standards for perceiving, believing, evaluating, and acting. This happens when subjects can vocalise their perceptions of situations and their responses to them, because this will shed light on the standards they use to guide both themselves and other members of the group. These subjects have an intimate understanding of the information that must be absorbed in order to present acceptable behaviour for a member of that group. As Goodenough explained, members of a culture must know "how to be competent in the things their members are expected to be competent in" (Goodenough, 1970, p. 111). The difficulty in bringing this set of standards to light is the fact that the underlying assumptions have been taken for granted by this group for a long time and, as such, this information is not necessarily within the sphere of conscious reflection or even awareness. Before these unwritten rules can even be questioned or challenged, someone from outside the culture needs to assist to increase their visibility to the group (Steen et al., 1997).

The description, classification, and comparison of the similarities and differences that occur between different societies is the purpose and function of the cultural anthropologist (Spradley & McCurdy, 1972). The science of culture rests on explaining human customs, language, values, and habits of thought, with description being the most important aspect (Goodenough, 1964, 1970). As Crotty (1998, pp. 75-76) attested, it is "only through dialogue can one become aware of the perceptions, feelings and attitudes of others and interpret their meanings and intent".

It is only through the use of significant symbols, essentially language and other symbolic tools, that people communicate. Research that produces descriptive data, based on people's own written or spoken words and observable behaviours, provides insight into the culture under investigation.

Ethnography is commonly regarded as the method of choice for studying the culture of a society because it involves diligent questioning, careful observation, and truthful reporting. However, even without doing participant observation, the dominant ideas, values, and patterns in the manner of talking about concepts can still be observed. In fact, often the actual subject matter and the method of delivery that participants use while being interviewed demonstrates a difference between the unwritten cultural values and those processes and structures that the organisation visibly hold (Steen et al., 1997). The importance of this cannot be stressed enough as it is the cultural "values and beliefs that can unite or divide a group" (Gavriel, 2014, p. 41).

Cultural interpretation can be driven from different viewpoints as well. Materialistic theories state that change is the result of material things (resources, money, and production), and therefore, the focus is on behaviour. Ideational theories, on the other hand, propose that change happens because of what we think. Cognitive theory (the most popular ideational theory in anthropology) assumes that we can describe what people think by what they say, leading again to the interview method as the method of choice (Fetterman, 2010). One theory that incorporates this philosophy is Symbolic Interactionism, which underpins the current research as described in the next chapter. Therefore, the focus of this cultural research is to concentrate on beliefs, ideas, and knowledge, rather than patterns of behaviour, customs, and ways of life, and this requires the study of both the significance of the organisational arrangements as well as the responses of paramedics to the everyday life of the service.

As Blumer (1969, p. 35) argued, "the life of a human society ... consists of the action and experience of people as they meet the situations that arise in their respective worlds" and that it is essential, when studying these worlds, to develop a "firsthand acquaintance with the sphere of life under study." In a similar vein, while undertaking his classic ethnographic study into the social situations of mental patients, Erving Goffman solidified this concept by writing that "any group of persons develop a life of their own that becomes meaningful, reasonable, and normal once you get close to it, and that a good way to learn about any of these worlds is to submit oneself in the company of the members and to the daily round of petty contingencies to which they are subject" (Goffman, 1961). It could be argued that in both of the above cases, the actions of people or the petty contingencies are a result of the

structure of the organisation they operate from, as well as the way they manage and conduct themselves within the organisation and in response to their work. Culture is not simply human interaction, it is human interaction within an organisational arrangement, be this a family, an organisation with all its procedures and protocols, or a network of friends.

2.1.5 Reporting cultural studies: emic and etic perspectives

There are also two perspectives to consider when reporting the findings of a cultural study. Firstly, there is the *emic* way of describing culture, in which discussion revolves not only around the experience itself, but its value from the perspective of someone within the cultural group to whom it happened and others within the same interpretive community. It is from the 'native's' frame of reference, described from the approach of the member inside the culture and how they regard it as meaningful. Goodenough (1970) described this adeptly by saying:

> *Having isolated and defined the primitive elements, one goes on to describe the rest of the culture in terms of them and their relative products. Thus, one takes one's audience into the culture of another people and allows it to experience that culture and to learn something of it from the insider's (the sophisticate's) point of view (Goodenough, 1970).*

The other perspective from which to report cultural findings is termed *etic,* in which descriptions are conveyed using the researcher's own terms, representations, and metaphors, often drawing more from scientific language to express the situations and concepts or experiences and meanings of culture in systematic terms that appeal to other scientists (Abrahams, 1986). "The emic perspective – the insider's or native's perspective of reality – is instrumental to understanding and accurately describing situations and behaviours [often driven by the ideational theories]. The etic perspective is the external, social scientific perspective of reality [which is the primary focus of the materialistic theorists]" (Fetterman, 2010, p. 20). As the researcher has served as a volunteer in EMS organizations including 4 years in the organization specifically under study, the perspective of this report is a combination of both.

Culture encompasses all aspects within a collective. The current research is concentrated on the culture experienced within an ambulance service, revealing the standards that they are expected to adhere to and the values that they are assumed to hold. Within a culture,

individuals will also develop norms, values, and strategies for dealing with difficult situations. The next section of this chapter outlines the research dealing with how paramedics cope with traumatic scenes in a professional manner. In order to do so, the concept of coping is explored along with stress.

2.2 Stress

When stress is present within a culture, it inevitably raises the question of how people cope with the stress. The following section defines stress and the factors that influence its intensity.

2.2.1 Defining stress

Coping happens as a result of insulating from, or dealing with, psychological trauma or life-strains, demands, or critical events that pose a challenge, threat, harm, loss, or benefit to an individual. Therefore, people only need to cope when they have to deal with situations that cause stress (Lazarus, 1993).

The Oxford Dictionary defined stress as a state of mental or emotional strain or tension resulting from adverse or demanding circumstances (Oxford English Dictionary, 2019). A more psychological description is “a state of imbalance within a person, elicited by an actual or perceived disparity between environmental demands and the person’s capacity to cope with these demands” (Maes, Vingerhoets, & Van Heck, 1987, p. 546). Stress is a universal concept; however, the manner in which people experience stress and the situations that are perceived to be stressful differ greatly both individually and within cultural groups.

2.2.2 The stress continuum

Stress involves a continuum of intensity. The level of mental/emotional strain experienced is determined by individual perceptions of the demands to be faced and the resources available to draw upon for each situation encountered. When the resources are deemed adequate to overcome the demands, the situation can be viewed as a challenge, which leads to positive psychological states. However, when the demand exceeds the resources, the situation is viewed as a threat which can prevent the maintenance or achievement of a desired goal. This leads to negative psychological states (known collectively as stress) of

which anxiety is the most common (LeBlanc et al., 2012). Other potential reactions may include:

- Psychological: hostility, anger, and depression
- Cognitive: impaired academic/occupational performance, altered concentration
- Physiological: headaches, fatigue, sleep difficulties, gastric disorders
- Behavioural: substance abuse
- Social: disharmony in interpersonal relationships and social withdrawal (Williams, Arnold, & Mills, 2005).

The negative effects of stress have been prolifically documented (Maes et al., 1987; Malek, Mearns, & Flin, 2010; Moran, 1998; Regehr & LeBlanc, 2017; van der Ploeg & Kleber, 2003; Weiss & Lonnquist, 2009; Wheaton, 1983; K. M. Young & Cooper, 1997; P. M. Young, Partington, Wetherell, Gibson, & Partington, 2014). It can be detrimental to all aspects of physiological, social, and psychological health, and is mediated by numerous other variables such as the environment, culture, society, and individual psychological factors. The experience of stress, as mentioned previously, is also affected by an individual's subjective appraisal of importance of individual factors which, in turn, is influenced by their "beliefs, goals, commitments, values, personality, past experience of similar situations, past actions taken in those situations, and perceptions of self-efficacy or mastery of similar situations" (Williams et al., 2005, p. 201).

Because of these differences, the term 'stressors' can be categorised across many dimensions: time – past, present, or future; duration – acute and time-limited, chronic, or intermittent; frequency – single events or multifactorial; and intensity – mild, moderate, or serious (Williams et al., 2005). These in turn can also affect the level of stress experienced or the severity of the reaction. Somewhat counterintuitively, it is generally not the most intense situations or major life events that lead to the greatest levels of psychological distress. It is the minor day-to-day stressors or daily hassles, known as chronic strains, that contribute the most to negative psychological states.

From a sociological perspective, all behaviour is influenced by social forces or factors; whether from a smaller-scale personal social environment or a larger-scale organisational

social context. It is the latter macro-perspective that focuses attention on the culture of coping, and it's mediating effects on stress. Employers are keen to ameliorate the effects of stress because the related signs and symptoms can lead to a high economic cost by way of their effects on job performance, duration of employment, and health status post-employment (Murphy, Bond, Beaton, Murphy, & Johnson, 2002).

For these and other reasons, individuals attempt to reduce, manage, or resolve stressful situations, and the environmental, behavioural, physical, emotional, spiritual, and cognitive tactics that are used are referred to as coping mechanisms or strategies; the broader the range of resources available to meet the demands faced, the better the individual's stress management (Williams et al., 2005).

2.3 Coping

2.3.1 Defining coping

The term coping covers any behaviour or set of behaviours that assists an individual or group to protect themselves from psychological trauma arising from difficult or challenging circumstances (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986; Pearlin & Schooler, 1978). Coping consists of a repertoire of responses that have been learned through socialisation experiences that evolves over time as techniques are demonstrated to work or fail to work to mediate stress. It encompasses everything that people do to avoid being harmed by the stressors that are confronted in the course of daily living. It is an active behaviour that involves "selecting between alternative options and using situational knowledge to one's advantage" (Gerhardt, 1979, p. 197).

Originally, coping related specifically to behaviours or reactions, such as how people responded during or after a stressful event. The current view also incorporates actions that might prevent the stress, alter the perception of stress, or predict and prepare for the stress (Carver, Scheier, & Weintraub, 1989, p. 1; Folkman & Lazarus, 1988; Frydenberg, 2017; Pearlin & Schooler, 1978; Skinner, Edge, Altman, & Sherwood, 2003; Wheaton, 1983). By adopting the definition that Lazarus has used for three decades of coping research, Ângelo and Chambel (2014) stated that coping is:

> *an effort to manage and overcome demands and critical events that pose a challenge, threat, harm, loss, or benefit to an individual [which] now includes self-regulated goal attainment strategies and also personal growth (Ângelo & Chambel, 2014, p. 1).*

2.3.2 Three components of coping

There have been several attempts to categorise coping into functional units to facilitate research. Pearlin and Schooler (1978) made a distinction between social resources, psychological resources, and specific coping responses, noting that resources in this context are not actions, but available choices in a person's repertoire of strategies.

Social resources are an individual's social support network, which includes family, friends, and co-workers. They can offer three forms of support:

1. emotional support (feelings of comfort, respect, love, caring, and concern)
2. cognitive support (information, knowledge, and advice), and
3. materials support (products or services to assist in handling specific problems) (Pearlin & Schooler, 1978).

Many studies have focused on social support as a coping strategy, specifically relating to the ameliorating effects of strong social support on the cumulative effects of stressors (Redburn, 1992). However, while researching firefighters using both quantitative and qualitative methods, Regehr (2009) determined that although social support was an important mediator of psychological distress, the nature of the job and the culture of the organisation can damage this network over time. There is also a difficulty in determining the level of help or protection that a social network can give, as "the available evidence that help-seeking results in help, or that social supports provide support is largely indirect, inferential, methodologically spotty, and limited in the range of observed problems for which people are seeking help" (Pearlin & Schooler, 1979, p. 204). However, the support network is still considered an important protective coping strategy, perhaps because it was one of the two originally researched key coping resources (Caplan, 1974; Hobfoll, 2002).

Psychological resources are deemed to be personality characteristics that are essentially aspects determining what people are. There are several possible characteristics that could be of research interest; however, in keeping with the Pearlin and Schooler tradition, there are three that are of specific importance. The order of importance of the three factors is:

1. freedom from self-denigration (negativity towards the self),
2. the possession of a sense that one is in control of the forces impinging on one's mastery (locus of control), and
3. favourable self-esteem (positivity towards the self).

Pearlin and Schooler (1979) originally found that, even though neither personality factors nor coping responses had an appreciable statistical effect on occupational stress, the experience of stress was connected more closely to personality factors than on coping responses. However, on an extended analysis performed after critique, they did find that "coping responses are more effective than [psychological] coping resources under conditions of intense strain" (Pearlin & Schooler, 1979, p. 203). It would be reasonable to align the working conditions and challenging incidents encountered by paramedics as conditions of intense strain.

Specific coping responses incorporate everything else, particularly "the behaviors, cognitions, and perceptions in which people engage when actually contending with their life-problems" (Pearlin & Schooler, 1978, p. 5). While psychological resources embody what people are, coping resources covers what people do or the tools at their disposal. Physical distractions, cognitive behavioural interpretations or manipulations, and even the use of humour come under this category.

There are three specific methods through which coping behaviours can provide a protective function:

1. "by eliminating or modifying conditions giving rise to problems;
2. by perceptually controlling the meaning of experience in a manner that neutralises its problematic character; and
3. by keeping the emotional consequences of problems within manageable bounds" (Pearlin & Schooler, 1978, p. 2)

In principle, individuals can either attempt to alter the event or the antecedents of the event, alter the meaning of the event, or reduce the emotional ramifications of experiencing the event.

The first protective function or method of coping focuses on altering the antecedents or essentially changing the event itself. Limited research in the area has shown that the majority of subjects do not focus on attempting to alter stressful events or utilise responses that could potentially modify the situation (Pearlin & Schooler, 1978, p. 6). While concentrating on the type of incidents encountered by paramedics, the occupational situation would not essentially be alterable; however, certain aspects could be, and have been, addressed depending on those parts of the situation that are deemed stressful – e.g. simple isolation or being overwhelmed because there is too much work for one paramedic to handle can be altered relatively simply by quickly dispatching more personnel.

The second method is to alter the meaning or to modify the cognitive assessment of the threat. Some attention has been given to this method, as Pearlin and Schooler stated:

> *The way an experience is recognised, and the meaning attached to it determine to a large extent the threat posed by that experience. Thus, the same experience may be highly threatening to some people and innocuous to others, depending on how they perceptually and cognitively appraise the experience. By cognitively neutralising the threats that we experience in life-situations, it is possible to avoid stresses that might otherwise result (Pearlin & Schooler, 1978, p. 6).*

Considerable emphasis will be placed on the cognitive neutralisation that occurs within the paramedic culture to describe how events that the layperson would consider stressful are perceived by paramedics as exciting, challenging, or even commonplace (Boudreaux, Mandry, & Brantley, 1997).

Mechanisms for altering the meaning include:

1. Positive comparisons – ‘count your blessings’, and ‘we are all in the same boat’.
2. Selective ignoring – extracting an optimistic characteristic or event from within the difficult or problematic situation. When this is achieved, it becomes easier to ignore the toxic or unpleasant aspects by deliberately directing attention to those aspects that are perceived as more meaningful and valuable. “One’s ability to ignore selectively is helped to [sic] trivializing the importance of that which is noxious and magnifying the

importance of that which is gratifying" (Pearlin & Schooler, 1978, p. 7). This mechanism also appears to be in play when certain forms of humour are used to reduce accumulated tension.

3. Devaluing the value – people place different degrees of importance on different factors or parts of their lives. If they are able to confine the bigger stressors in areas of their lives that they place less value on, they are capable of reducing the stress that they experience. If one reduces the importance or the implications of the problems, the subsequent stress is also diminished. "With the relatively impersonal strains, such as those stemming from economic or occupational experiences, the most effective forms of coping involve the manipulation of goals and values in a way which psychologically increases the distance of the individual from the problem" (Pearlin & Schooler, 1978, p. 18).

The third set of coping functions is the management of stress reactions. This method attempts to minimise the discomfort provoked by problems without focusing attention on the problems themselves. In this manner, an individual learns to live with the stress that is inevitable in their lives without becoming overpowered by emotion. This concept also reaches into the beliefs and value systems of the culture one works in, as it takes a collective strategy to imbue the endurance required to manage inevitable hardships with a meaning akin to moral virtue.

Another popular method of categorising coping methods was developed by long-term researchers in the field, Folkman and Lazarus, who devised the oft-utilised Ways of Coping scale. They separated ways of coping into *problem-focused coping* and *emotion-focused coping*. Problem-focused coping concentrates on the problem and modification of the cause, akin to the first protective function identified by Pearlin and Schooler. Emotion-focused coping involves the management of the ensuing distress. The selection of these two ways of coping appears to hinge on the level of perceived control over the situation: if it can be altered, an individual will focus on the problem, whereas emotional manipulation occurs when the situation must be tolerated or endured (Carver et al., 1989; Folkman et al., 1986).

Folkman and Lazarus' Ways of Coping instrument further identified 13 dimensions of coping which assist in deconstructing the concept:

1. Active coping – deliberately altering the stressor or reducing the effects
2. Planning – a priori cognitive efforts proposing action strategies
3. Suppression of competing activities – focusing wholly on the stressor at hand and not being distracted by anything else
4. Restraint coping – deliberately *not* acting until the right moment
5. Seeking social support for instrumental reasons – gaining advice, help, or information
6. Seeking social support for emotional reasons – obtaining moral support, understanding, and sympathy
7. Focusing on/venting emotions – concentrating on the distress (not often a positive coping strategy)
8. Behavioural disengagement – akin to helplessness, basically giving up on achieving that goal
9. Mental disengagement – distraction of any form, including physical activity
10. Positive reinterpretation and growth – finding a positive twist to the situation and focusing on that
11. Denial – disregarding the fact that the stressor is real and authentic
12. Acceptance – realising that the stressor is real and must be dealt with
13. Turning to religion – placing faith in an external deity can be active, support seeking, and a positive reinterpretation (Carver et al., 1989).

The use of any combination of these factors constitutes a person's coping resources or strategies. This breakdown assists in determining which strategies are used by paramedics and whether their culture encourages or discourages specific mechanisms or motivations.

The coping style of emergency workers could also result from the type of work, rather than the type of person. For example, emergency workers frequently describe their reactions at an emergency or disaster site in terms similar to the following: "We have a job to do and we have to get on with it. We can't afford to be upset by the things around us." This type of coping has been referred to as a "trauma membrane" that allows emergency workers to shield themselves emotionally from unpleasant or threatening scenarios (Malek et al., 2010). This is another form of problem-focused coping as the people involved are able to maintain control over the problem inherent within the situation.

2.3.3 Coping efficacy

The effectiveness of different methods of coping is also a factor to be taken into consideration. The capacity, ability, or power of a coping behaviour to produce a desired result or effect needs to be evaluated in terms of how successful it is in reducing the emotional stress that results from the challenge/ threat. Many people experience similar life difficulties or hardships, but experience very different levels of stress responses as a result. Also, people use the same coping strategies for different reasons, at different times; however, in all cases, the aim is to manage stress. Research also suggests that coping efficacy is lowest in occupational settings (Pearlin & Schooler, 1978). The types of coping that are not avoided within occupational roles are centred on the reinterpretation of goals and values, such as reducing the value of extrinsic rewards, including financial remuneration and heightening the importance of intrinsic factors, including the worth of their contribution to society. Also, work-related stress tends to be addressed using problem-focused coping strategies, as most occupational cultures appreciate or expect a certain level of emotional self-control while in the workplace (Folkman et al., 1986). This holds true within the paramedic culture, where according to research in this area, personnel specifically suppress emotion-focused responses in favour of using problem-focused coping strategies (Avraham, Goldblatt, & Yafe, 2014; Boudreaux et al., 1997; LeBlanc et al., 2011; Shepherd & Wild, 2014). This is done as paramedics must be able to cope with the situations they encounter in order to carry out their job. They simply would not be able to function in their occupational role if they were emotionally overcome.

When studying the culture of coping, it is also essential to understand the determinants of stress and to comprehend the relationship between the experience of distressful circumstances and the subsequent development of psychological distress. Lazarus and Folkman theorised that coping mediates this relationship. They also theorised that the adoption of more proactive coping methods increases resistance by reducing vulnerability to future threat or loss and cognitively altering the meaning. In such circumstances, threats can become merely personal challenges. Similarly, when the resources necessary to address a stressor are readily available to employees, the impact depreciates and the resultant potential negative effects such as stress are consequently also diminished (Ângelo & Chambel, 2014).

2.3.4 The social nature of coping

As Ângelo and Chambel (2014) noted, "Coping does not occur in a social vacuum and … the ability of individuals to use available social resources can increase the effectiveness of their coping strategies" (Ângelo & Chambel, 2014, p. 4). In keeping with the cultural nature of their work, Pearlin and Carmi (1978) were not interested in the clinical stance of coping, which was highly individualistic in both person and situation. They believed that the social roles that are continuously performed by many people produce well known life-strains, and therefore, they were only interested in examining coping strategies that were shared by people within similar social networks.

On the same theme, the challenging issues that people deal with are not "unusual problems impinging on exceptional people in rare situations, but are persistent hardships experienced by those engaged in mainstream activities within major institutions" (Pearlin & Schooler, 1978, p. 3). Ordinary people doing ordinary, and even necessary, tasks are required to cope. Perhaps contrary to this, paramedics are required to deal with situations that lie outside the scope of the average individual; however, many aspects that require coping strategies still align with the stressors that employees in a majority of industries experience.

2.3.5 The difference between coping and resilience

The terms resilience and coping are often understood to indicate the same concept, but there are subtle differences in meaning. Coping is more 'active' in nature while resilience is 'passive' (Gerhardt, 1979). Rogerson and Ermes (2008) defined resilience as "the ability to persevere and thrive in the face of exposure to adverse situations" (Rogerson & Ermes, 2008, p. 1). Resilience is considered to be a capacity for protection when faced with stress that advances positive psychological outcomes, essentially by minimising the possibility of certain negative psychological outcomes such as the development of Post-Traumatic Stress Disorder (Karin, 2016). On the other hand, Frydenberg (2017) made the distinction between coping, competence, and resilience by stating that "Coping is the *process* of adaptation; competence refers to *characteristics and resources* required for successful adaptation, and resilience refers to *outcomes* to which competence and coping have been put into action in response to stress and adversity" (Frydenberg, 2017, p. 68). Quite simply, coping is the mobilisation of resources, and resilience is the successful outcome.

The Oxford Dictionary defines resilience as “The capacity to recover quickly from difficulties; toughness”; however, in the research, there does not appear to be a universally accepted definition of resilience (Oxford English Dictionary, 2019). The term has been used to describe the combination of responses that are used by both individuals and groups working within the health professions when faced with traumatic or challenging situations.

Aburn and colleagues (2016) conducted a review of 100 studies in order to identify key definition threads. They extrapolated five concepts of resilience:

- rising above to overcome adversity
- adaptation and adjustment
- ‘ordinary magic’ (defined as an everyday phenomenon that is inherent in all people which enables them to survive and flourish despite current experience of emotional distress; essentially the personal strength that comes from positive experiences combined with social support)
- good mental health as a proxy for resilience
- the ability to bounce back.

Before refining down to these five concepts, Aburn and colleagues originally categorised their definitions into fifteen sub-groups, of which ‘coping’ was one. This implies that coping is a sub-set of resilience. Coping can be characterised as an active mechanism, as behaviours and thoughts can be taught and learned, and social supports can be sought prior to facing any challenge. Conversely, resilience is more passive in nature as it needs to be developed by each individual, group, or society, usually after a challenge or threat has been encountered and endured.

Resilience also has its roots in culture. As noted by Aburn and colleagues,

> *From the lens of a social constructionist, resilience can certainly be seen as a construct that is largely dependent on a situation including the culture of the individual and society or community to which the individual belongs and the context where the term is used. This means resilience as a social construct could be seen as largely dependent on the beliefs and world-views of the individual or the group being described (Aburn et al., 2016, p. 995).*

Despite the fact that resilience is also viewed from a cultural perspective, the fact that there is an overabundance of resilience literature made it seem prudent to limit the scope of this research to the more active concept of coping.

2.4 Summary

This chapter has provided the foundation knowledge with which to respond to the research question. Most importantly, both culture and coping have been defined, and their features pertinent to the current study have been presented. The next chapter will further detail the literature relating to the application of both culture and coping in research, specifically regarding the current focus of emergency health services. The literature on culture is refined to that pertaining to organisational culture, and then specifically to the emergency occupations. Similarly, the coping research has been refined to concentrate on paramedics, commencing with a review of the quantitative literature, which is the predominant form covering this topic, before finishing with a study of the qualitative research that has been increasing over the last decade.

CHAPTER 3: LITERATURE REVIEW

3.1 Introduction

The psychological literature relevant to coping and stress in normal everyday life was addressed in chapter two. The review now concentrates on research performed in these areas that connect the concepts of culture and coping in relation to the occupational experiences of paramedics.

Paramedics encounter psychologically disturbing or traumatic situations as a matter of course in their work life. Consequently, their exposure to trauma is both far greater than that of the general public and more likely to be outside the range of usual human experience. Because of this, they have an increased risk of suffering mental health consequences (Regehr & Bober, 2005) which may, in turn, lead to a reduction in work performance and overall quality of life. In order to reduce this potential outcome, ambulance services have established programs that increase understanding and awareness prior to attending traumatic situations, and offer services such as peer support, debriefing, and one-on-one counselling if warranted, after participating in a psychologically disturbing scene (Silent 1). These are the formal resources.

Besides the formal programs of support provided for paramedics, an informal culture has also developed where individual paramedics, team leaders, or managers support each other to cope with what is often difficult and stressful work. Little is known about this informal culture or how paramedics protect themselves and each other from psychological trauma, what strategies they prefer to use, what the unwritten rules are regarding these strategies, and how they learn them. This thesis explores these cultural understandings, norms, beliefs, values, and informal strategies; specifically, the factors that influence the culture of coping.

In order to explore existing research on the paramedic culture of coping, the following databases were searched: ProQuest, PubMed, ScienceDirect, CINAHL, OVID Medline, PsycINFO, and Scopus. The search commenced with the terms *paramedics/ ambulance officer/ emergency medical technicians/ first responders/ emergency service personnel*, in order to capture all research pertaining to any occupation that encounters similar workplace

stressors and conditions as those anticipated for Australian paramedics. The search was then narrowed by the terms *culture and/or coping*.

No literature was uncovered pertaining specifically to the culture of coping in paramedics, nor the culture of coping in other emergency services. Broadening the search terms led to identifying publications on the coping strategies of paramedics and other emergency services, and occupational culture, often capturing the whole industry practice in focus or targeting safety culture in particular, such as Yassi and Hancock (2005), who explored how to enhance safety culture in the Canadian healthcare sector to improve the wellbeing of both patients and healthcare workers, and Patterson et al. (2012) who examined variations in the workplace safety culture of emergency medical services in the USA.

The following section provides a traditional narrative literature review on the culture of coping in paramedics. The literature was categorised into the following areas of discussion separated broadly into culture and coping. These are the formal resources offered by the organisation, the culture in general, the organisational culture, and the safety culture. This leads to an examination of the literature on organisational safety culture in health and emergency services before narrowing the review down to literature dealing directly with paramedics. From this point, the emphasis turns to coping and associated strategies. Attention is first given to the quantitative literature (which reflects the earliest research in this area), divided into theoretical work, the development of instruments, observational studies undertaken with other emergency and health services, and then those specifically relating to paramedics. Finally, the discussion of the literature turns to the newly burgeoning qualitative research that is more focused on paramedic's subjective experiences of coping. Before moving on to discuss this literature, a brief overview is provided of the formal programs instigated by a number of emergency services to assist staff to deal with the trauma of dealing with human tragedy.

3.2 Research on formal resources

Numerous studies have been undertaken to identify and evaluate early intervention strategies, particularly the practice of debriefing, following attendance at a traumatic event; however, the results have been mixed and often diametrically opposed (Raphael, 2000).

For example, A. M. Mitchell, Sakraida, and Kameg (2003), in their critique of debriefing meta-analyses, stated that the research findings still do not conclusively support the efficacy of Critical Incident Stress Debriefing (CISD). Van Emmerik, Kamphuis, Hulsbosch, and Emmelkamp (2002) maintained that CISD made no difference to recovery, which was supported by the Cochrane Review conducted by Rose, Bisson, Churchill, and Wessely (2002), who went further to say that it could actually be detrimental by increasing symptomatology. However, the focus of their studies was single individual debriefings, which was not a standard use of the technique. One of the founders of CISD, J. T. Mitchell (2009) maintained that the research on this is positive if personnel are properly trained and providers observe official standards.

These studies have almost exclusively employed medical or psychologically based quantitative methods in the form of questionnaires or surveys. The limitations of these self-report questionnaire studies, other than the usual response biases including self-selection, social desirability, and neutral responding (Nardi, 2014), include the inability to obtain complete and rich data as the items are pre-set and the respondents cannot fully express their opinions (Malek, Mearns et al. 2010). These instruments cannot reveal anything that is not built into them by the instrument maker (Lincoln & Guba, 1985). The use of qualitative methods that uncover the thoughts, perceptions, and feelings elicited by paramedics, how they attach meaning, and how this influences their actions is much more likely to provide rich and detailed descriptive information on the culture of coping.

Besides the formal surveys on critical stress debriefing provided by the organisation, what is also necessary to understand is how the organisation and the workers develop strategies, norms, and values (a culture) that supports them given the nature of the work. This leads to studies that have explored the culture of organisations and which places the focus on the norms and values of the individuals.

3.3 Culture Research

Goodenough (1970, p. 104) stated that “the expectations one has of one’s fellows (sic) may be regarded as a set of standards for perceiving, believing, evaluating, communicating, and acting [and that] these standards constitute culture.” In order to obtain a more detailed

account of how paramedics protect themselves and manage the potential risk of mental health trauma, it is imperative to focus on the culture of paramedics in relation to their mental health. Very few studies have focused on the mental health culture of this occupational group. Research specifically regarding the perspective of paramedics and how they deliberately use a range of coping and adjustment strategies to manage potential mental health risks, experience organisational protective services, and the meanings they attribute to them, is sparse.

3.3.1 Organisational culture

As specified previously, all organisations, whether large or small, public or private, operate with a culture that is essentially a shared set of fundamental assumptions so that its members can identify with each other and be identified as a collective by others. There are specific terms and jargon used between members of a single cultural group that sound foreign to outsiders. Encountering certain situations on a regular basis that are able to contribute to the label of 'typicality' can solidify the identity of the organisational collective (Steen et al., 1997). Several researchers have defined organisational culture as the 'glue' that holds an organisation together, either through shared meanings or degrees of commitment leading to shared responsibility for performance outcomes (Jaskyte, 2010; van den Berg & Wilderom, 2004).

Organisational culture has become a focal point of attention for managers and management research because it is now considered "one of the most significant factors in reforming and modernising public administration and service delivery" (Jung et al., 2009, p. 1087). In the increasingly competitive marketplace, it may give a business an important edge to comprehend how different factors can influence organisational effectiveness (Gregory, Harris, Armenakis, & Shook, 2009; Zheng, Yang, & McLean, 2010). This could explain why research in the cultural area has substantially increased over the last decade; organisations might be starting to recognise the worth of such information and so are more willing to provide the funding to explore the cultural domain.

Early studies endeavoured to categorise organisational dimensions or continuums that would assist management to introduce changes that would increase productivity. Organisational cultural dimensions were the focus of studies undertaken by van den Berg

and Wilderom (2004), who attempted to organise previous researchers' concepts and findings by dividing them into categories associated with their orientation or position in relation to goals, support, rules, and innovation. Although they focused on organisational work units and practices, they did conclude that important factors varied between organisational units, stating that "what is important to us is that a large part of these 'intangible attributes' are human and can therefore be captured, in part, by assessing human perceptions about the daily work practices" (van den Berg & Wilderom, 2004, p. 578). They called for more creative approaches, but remained focused primarily on quantitative methods.

A number of researchers have continued to concentrate on how organisational culture is investigated, with many documenting the myriad of quantitative instruments available (Jaskyte, 2010; Jung et al., 2009; Mannion, Konteh, & Davies, 2009; T. Scott, Mannion, Davies, & Marshall, 2003; van den Berg & Wilderom, 2004). Jung et al. (2009) identified 70 instruments and approaches for exploring organisational culture, of which only 6 were qualitative in nature, demonstrating the emphasis given to quantitative methods in the past.

There continues to be a paucity of qualitative research in this field. In his theoretical discussion of organisational culture, Alcorn (1995) stated that culture "contains psychosocial defences against the experience of anxiety in the workplace" (Allcorn, 1995, p. 73). It is specifically because of this form of reasoning that it is pertinent to focus specifically on the 'culture' of coping.

3.3.1.1 Safety culture

One area of organisational culture research that has experienced some attention is that of occupational safety. This focus has been to ensure that the change processes that management instigate are 'safe' processes, otherwise referred to as change management. Grote (2008) analysed safety culture instruments and concluded that four content areas arose as the most important when considering safe organisational change, the extent of radicality of the change, constructive redevelopment, employee self-esteem, and involvement in the change process. Once again, the majority of research in this area is quantitative in nature (detailed in the next section). Hopkins (2006) has suggested that

alternative qualitative methods such as ethnography and document analysis would be valuable in studying organisational safety culture; however, there is not yet much evidence that his advice has been adopted.

3.3.1.2 Organisational culture in health and emergency services

The occupational area that safety culture research has increasingly adopted is that of health and emergency services. Starting with the emergency and civil services, there has been an interest in the culture of police services for many years, from their quasi-military beginnings to the current softening of the culture (Lawson, 2011; Prunckun, 1991; Terpstra & Schaap, 2013; Woody, 2005). For example, Prunckun (1991) used qualitative methods to investigate how the police culture influenced the perception of stress. It appears that the outside perspective was that police experienced stress because of the violence inherent in the job, but Prunckun found that "many cops love the sense of danger. Danger is what makes the job interesting" (Prunckun, 1991, p. 11). The stress comes, instead, from the rigid set of cognisant rules police officers are required to adopt to appear consistent – obliged to deprive people their rights when they behave outside of the law when the officer most likely joined to protect people's rights. This research is another example of detail that would not have been elicited in a study using a questionnaire. Prunckun's critique of the quantitative methods used in past research included the deductive research process, stating that "in previous studies, some researchers came up with their conclusions first and then they went about collecting the data which supported their inference" (Prunckun, 1991, p. 10). It is the inductive process so integrated in qualitative research methods that is needed to gain unbiased perspectives.

Firefighting is another emergency service that has generated significant research interest, especially in the field of stress and coping; however, there is not a large body of work to review on their specific culture (Desmond, 2006; Thurnell-Read & Parker, 2008). In his ethnography, Desmond (2006) described why specifically young men join high-risk occupations such as becoming wildland firefighters, and focused on the process of organisational (and pre-organisational) socialisation, which is how they learn their culture. He attested that neither the socialisation nor the experience within the organisation, or a personality/community culture, contributed to their ease in adapting to the occupation.

The theme of masculinity is also evident in other firefighter culture research (Thurnell-Read & Parker, 2008). What is not always taken into consideration are the ways in which gender effects both the culture and coping in general. It is recognised that the health behaviours of men are different from women (Verbrugge, 1985). As stated by Moynihan (1998, p. 1072), "Numerous surveys report that health behaviour practised by men adversely affects their health outcomes in terms of, for example, the underuse of medical and psychotherapeutic services. Their rigidly stoical stance contributes to some physical and mental disorders that are disproportionately experienced by men." The theme of masculinity may have been more pertinent in paramedic culture several decades ago when it was primarily a male-dominated occupation; however, it is less relevant today as the gender split in membership is much closer to equal (Silent 1). As firefighters in the United States and other countries are often also emergency medical technicians, the work of this occupational group is closer to the experience of paramedics in Australia, but research involving this cohort still incorporates factors that would not be relevant to the Australian occupational landscape for paramedics, as it has been shown that paramedics report higher rates of exposure to death, assault, and situations in which their life is at risk (Regehr & Bober, 2005).

Cultural research specifically looking at emergency medical services and working on improving healthcare worker and patient wellbeing, is another area of research (Mannion et al., 2009; Patterson et al., 2012; T. Scott et al., 2003; Yassi & Hancock, 2005). Once again, these studies have focused on "the collective beliefs and perceptions of workers regarding the organization and safety of their workplace operations" (Patterson et al., 2012, p. 448), rather than those pertaining to the identification and utilisation of coping strategies when faced with traumatic situations that can have an impact on mental health wellbeing.

Although there is increased interest in healthcare improvement by managing the culture in healthcare organisations, the emphasis remains firmly on quantitative methods and the use of survey instruments. Two studies have examined 12 instruments that measure organisational culture in healthcare settings; however, the focus has been on the properties of the instruments to give choices to researchers, rather than using the instruments to undertake primary research (Mannion et al., 2009; T. Scott et al., 2003). As Scott and colleagues (2003) noted, "culture is sometimes ambiguous, often slippery, and difficult to pin down. The investigator has to be reconciled to the nature of what is studied and not rely

exclusively on a single instrument, or even a set of instruments" (T. Scott et al., 2003, p. 942). It could be argued that quantitative methods will only ever provide the researcher with limited detail to answers that can be extremely complex, and that many research questions are much more sensibly tackled with qualitative methods that can elicit the rich detail necessary.

The only research found that was specifically focused on paramedic organisational culture was that by Steen et al. (1997), who looked at how they cared for the relatives of cardiac arrest victims in Norway. This study used qualitative methods and interviewed 33 paramedics on taking care of bystanding relatives. The study touched on paramedics' perceptions of coping, relationships with colleagues, and the effects of a lack of appreciation from the organisation that did not recognise the need or importance of caring for the relatives. The researchers concluded that cultural change that included the positive value of caring and the sharing of stress would be beneficial. This conclusion is assumed to be highly relevant to paramedic organisations in Australia in relation to the need for caring and sharing – being perceived to care for its members with an understanding of what they consider as their needs, and an appreciation that avoidance can be detrimental, so sharing (under trusting circumstances) needs to be encouraged.

Finally, an understanding of organisational culture is important in the quest to unravel the culture of coping because "organisational culture has at its core a confluence of individual unconscious psychological defences that form an interactive social defence system that defends members and groups from anxiety arising from the organizational life and threatening elements in the immediate environment and society" (Allcorn, 1995, p. 74). Because culture is such an important factor in understanding group defences, it is remarkable that there are so few studies on this subject. The fact that culture has a considerable effect on stress mitigation and coping strategies should now be compelling, as the examination of the literature turns to research that is specifically designed to investigate different aspects of coping.

3.4 Coping Research

Coping, as a phenomenon, has been researched under different guises for hundreds of years, to recover from "shellshock" and other traumatic occurrences (Reid, 2014). The military and civil services, emergency services, and community groups have been studied for their reactions to national disasters through to daily hassles; any group of people who deal with stress can be examined for their coping perspectives and strategies.

The research looking into coping was traditionally conducted using quantitative methods; however, over the course of this project, there has been a substantial increase in studies based on qualitative methods. The following section examines the quantitative literature dealing with coping from a theoretical perspective, to the development of instruments that can be used to measure coping. This is followed by a discussion of more directed studies involving other organisations, before refining the focus to paramedics. Finally, the section ends with an exploration of more recent qualitative research on coping and paramedics.

3.4.1 Quantitative research

3.4.1.1 Theoretical

In the late 1970s, Pearlin and Schooler published a number of articles on coping with the simple definition that it refers to "the things that people do to avoid being harmed by life strains" (Pearlin & Schooler, 1978, p. 2). Researchers started examining how coping influenced the experience and effects of stress. Wheaton (1983) looked at dispositional characteristics such as fatalism and inflexibility. From the mid-1980s, the work of Folkman and Lazarus made a major contribution to the field. They divided coping strategies into two main categories: problem-focused coping and emotion-focused coping. Their definition is clearly more complex, demonstrating how quickly and thoroughly the concept of coping was unpicked:

> *Coping refers to the person's cognitive and behavioural efforts to manage (reduce, minimise, master, or tolerate) the internal and external demands of the person-environment transaction that is appraised as taxing or exceeding the persons resources. Coping has two main functions: dealing with the problem that is causing the distress (problem-focused coping) and regulating emotion (emotion-focused coping) (Folkman et al., 1986, p. 572).*

Folkman and Lazarus have been the most cited coping theorists, with many researchers formulating their own work based on these foundations.

3.4.1.2 Developing inventories

From this point, numerous studies developed new instruments or reviewed previously used ones with methods of measuring dimensions of coping. Carver et al. (1989) developed the COPE scale, which included social support (dispositional and situational coping tendencies). Downs, Riskill, and Wuthnow (1990) reviewed the Personal Stress Assessment Inventory (PSAI) developed by Kindler, The Derogatis Stress Profile (DSP), the Ways of Coping Checklist (WCCL) by Folkman and Lazarus, the Maslach Burnout Inventory, and the Organisational Role Stress scale by Pareek. By 2003, Skinner et al. (2003) had analysed 100 coping assessment instruments. See Table 1 below for a comprehensive list of higher order distinctions among coping categories compiled by Skinner and colleagues. With so many instruments available and distinctions to use, it is difficult to ascertain which to select when conducting a specific study so that it is comparable where necessary.

The other factors to consider when using these inventories are the common limitations of survey research, such as the myriad of response or selection biases that come into effect: accuracy, social desirability, lack of memory, non-responses, or an inadequate number or style of responses to choose from (Nardi, 2014). All of these factors influence the data that is obtained and analysed using quantitative research methods. The use of qualitative techniques for data collection alleviates many of these issues and provides the analysis with a far more accurate representation of the thoughts, feelings, and perceptions of the sample population, making it a more understandable choice for the current investigation on the paramedic culture of coping.

Table 1: Coping Categories reviewed by Skinner, Edge et al. (2003)

Higher Order Distinctions Among Coping Categories

Distinction	Definition
Emotion-focused coping vs. problem-focused coping	"Coping that is aimed at managing or altering the problem causing the distress" vs. "coping that is directed at regulating emotional responses to the problem" (Lazarus & Folkman, 1984, p. 150).
Problem-focused coping vs. emotion-focused coping vs. appraisal-focused coping	"Dealing with the reality of the situation . . . seeks to modify or eliminate the source of the stress" vs. "handling emotions aroused by a situation . . . responses whose primary function is to manage the emotions aroused by stressors and thereby maintain affective equilibrium" vs. "primary focus on appraising and reappraising a situation . . . involves attempts to define the meaning of a situation" (Moos & Billings, 1982, p. 218).
Responses that modify the situation vs. responses that function to control the meaning of the problem vs. responses that function for the management of stress	"Responses that change the situation out of which the strainful experience arises" vs. "responses that control the meaning of the strainful experience after it occurs but before the emergence of stress" vs. "responses that function more for the control of the stress itself after it has emerged" (Pearlin & Schooler, 1978, p. 6).
Approach vs. avoidance	"Cognitive and emotional activity that is oriented either toward or away from threat" (Roth & Cohen, 1986, p. 813).
Engagement vs. disengagement	"Responses that are oriented toward either the source of stress, or toward one's emotions and thoughts" vs. "responses that are oriented away from the stressor or one's emotions/thoughts" (Compas et al., 2001, p. 92).
Control vs. escape	"Proactive take-charge approach" vs. "staying clear of the person or situation or trying not to get concerned about it" (Latack & Havlovic, 1992, p. 493).
Primary vs. secondary vs. relinquishment of control coping	Efforts to influence objective events or conditions vs. efforts to maximize one's fit with the current situation vs. relinquishment of control (Rudolph et al., 1995).
Assimilation (vs. helplessness) Accommodation (vs. rigid perseverance)	"Transforming developmental circumstances in accordance with personal preferences" and "Adjusting personal preferences to situational constraints" (Brandtstädter & Renner, 1990, p. 58).
Alloplastic vs. autoplastic coping	Coping directed toward changing the environment vs. directed toward changing the self (Perrez & Reicherts, 1992).
Volitional, effortful, controlled vs. involuntary, automatic coping	Responses to stress that involve volition and conscious effort by the individual vs. responses that are automatized and not under conscious control (Compas et al., 1997).
Behavioral vs. cognitive coping	"Taking action or doing something" vs. "mental strategies and self-talk" (Latack & Havlovic, 1992, p. 492).
Social vs. solitary	"Utilize methods that involve other people or . . . be done alone" (Latack & Havlovic, 1992, p. 492).
Proactive coping	"Efforts undertaken in advance of a potentially stressful event to prevent it or modify its form before it occurs" (Aspinwall & Taylor, 1997, p. 417).
Direct vs. indirect coping	Coping in which an individual emits an overt motor behavior to deal with a stressful event vs. coping in which "the organism responds to the stressful event by enlisting the aid of a conspecific" (Barrett & Campos, 1991, p. 33).

3.4.1.3 Other organisations

Several organisations have had their members studied using these instruments and the emergency occupation that has attracted the most research attention is firefighting. Studies in the United States (Dowdall-Thomae, Gilkey, & Arend-Hicks, 2012; Landen & Wang, 2010), Portugal (Ângelo & Chambel, 2014), and Australia (Chamberlin & Green, 2010), to name a few, all focused on coping. Instruments used included the Guidance and Connection Sub-scales of the Social Provisions Scale (Cutrona & Russell, 1987) or the Job Content Questionnaire (Karasek et al., 1998) to measure social support from co-workers, the Survey of Perceived Organizational Support (Eisenberger, Huntington, Hutchison, & Sowa, 1986), the Maslach Burnout Inventory (Iwanicki & Schwab, 1981), and the Coping Orientation to Problem Experience Inventory (COPE) (Lyne & Roger, 2000), the Proactive

Coping Inventory (Greenglass, Schwarzer, Jakubiec, Fiksenbaum, & Taubert, 1999), the Revised Ways of Coping Checklist (Vitaliano, Russo, Carr, Maiuro, & Becker, 1985), and the Outcome Coping Efficacy (for firefighters) (Lambert, Benight, Harrison, & Cieslak, 2012) to measure coping. The themes of the results are all similar: coping mediates the relationship between work cohesion and psychological wellbeing (Landen & Wang, 2010), while proactive coping partially mediates the relationship between job demands and burnout, and resources and engagement (Ângelo & Chambel, 2014). Negative coping strategies tend to include blaming oneself, wishful thinking, and avoidance, while seeking social support, positive reappraisal, and problem-focused strategies increases wellbeing (Dowdall-Thomae et al., 2012). Seeking social support is associated with lower post-traumatic stress symptoms (Chamberlin & Green, 2010). Regehr (2009) also found that these social supports are important mediators, but that they lessen over time, signifying that as the length of time in the service extends, members are less likely to burden their spouses and families, leading to less opportunities to confide about, and process, traumatic information. These results highlight that support is an important coping strategy that warrants further research attention.

Hu et al. (2012) focused on US hospital physicians' needs in coping, ascertaining when they would be happy to seek support, and the barriers to such strategies. One of the important results was that their own colleagues were the most preferred source of support. A similar cohort of senior house officers in the UK were measured for stress and coping strategies, and it was found that the accident and emergency physicians developed higher levels of distress and depression, and that the most successful methods of coping were 'active', including seeking support (McPherson, Hale, Richardson, & Obholzer, 2003). Ørner et al. (2003) came to similar conclusions while surveying emergency services staff after traumatic incidents in England. When it comes to the use of social support, they found that "officers prefer immediate access to colleagues and those with whom they feel close" (Ørner et al., 2003, p. 9). All mentioned the importance of peer connections and trusting relationships as the preferred people to turn to when requiring social support for occupational stress reactions. These findings demonstrate the importance of knowing and understanding the individual worker and the organisational culture, which is the focus of the current research.

3.4.1.4 Paramedics

A small number of quantitative studies have been performed with paramedics; however, the majority of these were completed in the United States and tended to focus on paramedics that are integrated into services that also employ firefighters. Some of these have studied the percentage of paramedics that report levels of distress symptomology that would warrant a diagnosis of PTSD, revealing figures as high as 20% (Clohessy & Ehlers, 1999), 25% (Regehr & Goldberg, 2002), and even up to 30% of their paramedic population (Alexander & Klein, 2001). Some have even expanded on coping strategies, but none have concentrated on the culture and its effects, or how it might support the worker. For example, a study was conducted with 183 fire/EMS professionals in North Carolina on the dangers of detrimental coping in the Emergency Medical Service. The main detrimental coping strategies were found to be escape/avoidance, distancing, and confrontive (aggressive) coping, which was previously observed by Boudreaux et al. (1997). Holland noted that these negative strategies were actually a "harmful traditional philosophy within emergency services" (Holland, 2011, p. 336), possibly reflecting a cultural trait. This would mean that it is part of the culture of their service; however, culture was not discussed in any way by Holland. Rather, he focused on correlating the individual detrimental coping methods with traumatic stress, without the broader application.

Shepherd and Wild (2014) investigated coping in 45 ambulance workers in London who completed self-report measures. They found that those with better coping strategies were able to approach subsequent traumatic jobs with more objectivity. This is pertinent when looking at giving paramedics the necessary time between jobs to cope satisfactorily in order to ensure optimal performance for all. This result may be viewed as evidence for establishing a buffer period between jobs to ensure that appropriate processing of traumatic information is achieved, rather than following the objective of rapid turnaround, despite the desire for reduced response times (Pons et al., 2005).

Opposite to the issue of returning to work too quickly before adequate processing of traumatic information has taken place, is the frustration experienced when there is an off-load delay, increasing the time taken to transfer care to emergency staff, often caused by "ramping" (Flynn et al., 2017; Laan, Vanberkel, Boucherie, & Carter, 2016). In 2017, Kingswell and colleagues performed a scoping review on ramping, including studies from

Australia, the USA, Canada, and the UK, and although the focus was on the effects on the patients, it was noted that "Paramedics also reported increased stress due to missing breaks and working mandatory overtime, verbal and sometimes physical abuse, an inability to give their patients the care they require, and an inability to perform their primary role of responding to medical emergencies in the community" (Kingswell, Shaban, & Crilly, 2017, p. 159).

Quantitative methods do limit the amount of information obtainable and, as already noted, there can be discrepancies when similar questions are asked using the different methods. As Regehr and Goldberg found in their 2002 study on coping strategies used when paramedics develop an emotional connection to the patient, "the qualitative findings of this study suggest that paramedics perceive that both personal supports and supports within the organisation help to ameliorate distress, although this is not supported by the quantitative findings" (Regehr & Goldberg, 2002, p. 512). All of these questions should now be unpacked using qualitative methods to gain the rich detail necessary to clarify these issues further.

3.4.2 Mixed methods

In order to take advantage of the positive aspects of both research methods, the obvious step between quantitative and qualitative studies is to utilise a mixed methodology. Regehr and Bober (2005), in their book "In the Line of Fire", conducted mixed methods studies across North America (Canada) and Australia, researching emergency personnel including paramedics, EMTs, firefighters, and police officers. They investigated the working environment, trauma and coping, the influence of the organisation, the use of interventions, and the effects of social support, all of which are relevant to the current research. For example, in 2009, Regehr reported the results of four studies on the social support experience of emergency responders (career and volunteer firefighters) in the south-east of Australia. The first was a quantitative study concentrating on the impact of trauma and stress reactions using the Beck Depression Inventory (A. T. Beck, Steer, & Garbin, 1988) and the Impact of Event Scale (Zilberg, Weiss, & Horowitz, 1982), and looking at social support using the Social Provisions Scale (Cutrona & Russell, 1987) and an author-derived rating scale. Of the 40% of firefighters that indicated being exposed to at least one critical incident, 82% felt supported by their employer, and any support reduced depression scores

(Regehr & Millar, 2009). The second study was also quantitative and focused on firefighters in Canada and their experience of social support throughout their career. This study showed that as their career advanced, the firefighters generally reported lower levels of support.

Study 3 then moved onto qualitative methods, interviewing 10 firefighters in Toronto regarding their in-depth perceptions of social support, enabling them to explain their experiences in great detail. Themes were extrapolated regarding the three arms of support: management, family, and colleagues. A reduction of stress reactions occurred as support increased from management and from family in a manner that was considered protective. It was also found that although traumatic stress reactions can be predicted by level of perceived peer support, it was noted that "different individuals have different experiences of support from colleagues" (Regehr & Millar, 2009, p. 92). This is important in the current study representing the impetus to focus on culture as a factor responsible for the differences experienced in peer support.

Study 4 also employed qualitative methods and focused on the experience of emergency service spouses and their experiences of the social support provided by the organisation, and is detailed below when looking at maintaining psychological health; however, the experiences are portrayed in detail. It is edifying to see the differences in explanation and richness of the data obtained when starting to incorporate qualitative methods. Much of Regehr's research on these topics have used mixed methods, but none have specifically focused on the culture behind coping (Regehr, 2009; Regehr & Goldberg, 2002; Regehr & Millar, 2007, 2009).

3.4.3 Qualitative research

Before the 21st century, there was little in the way of qualitative research on coping. As mentioned in the previous section, the method of choice was routinely quantitative in the form of many different questionnaires that were developed by a number of authors (Skinner et al., 2003). However, a minority of teams did use qualitative techniques. For example, Steen and colleagues (1997) used interviews to examine the organisational culture of an emergency medical service in Oslo, Norway, but the responses concentrated on coping. Their original research question was to determine the factors that influence the decision to commence or cease resuscitation, but spontaneously, the paramedics discussed how their

job affected them, particularly caring for relatives at the scene. The majority of respondents believed that responding to people in distress was one of the most important and difficult aspects of their work. They also identified a lack of general organisational support, but understood the value of their peers. As one respondent noted: “My colleagues are really the best psychotherapists I can have” (Steen et al., 1997, p. 59). They believe the profession has come far over the last two decades in realising the cumulative impact of dealing with human trauma on the mental health of paramedics. The ‘John Wayne syndrome’ (otherwise known colloquially in Australia as ‘Toughen up, Princess’), was mentioned as the predominant expectation of paramedics when faced with traumatic situations two decades previously. This historical cultural requirement, however, has transformed over that time with the inclusion of younger staff with a different set of internal values and a stronger focus on their own self wellbeing (Cennamo & Gardner, 2008).

As noted in the previous paragraph, when using qualitative methods to address research questions on occupational stress and coping, the subjects are more able to turn the responses to include issues that they really believe are the most important. In Dropkin, Moline, Power, and Kim (2015), the main focus was risk factors and health problems among EMS workers. Many of the responses concentrated on physical issues (musculoskeletal injuries and physical exposures such as lifting heavy patients or climbing stairs); however, a barrier to coping was touched upon as they stated that “lack of trust between EMS workers and supervisors were recurrent concerns among workers” (Dropkin et al., 2015). Mahoney (2001, pg. 138) also found this as her Australian paramedic respondents “had no inhibitions in expressing their frustrations with management even though none of the questions specifically asked as much.” This was seemingly due to the fact that the Australian social service systems, including the healthcare system, tightened up on the use of public funds, forcing the staff to be condensed (and therefore the remainder are generally overworked) and the budget to be considerably diminished (reducing access to necessary resources). Overall, it can be seen that the ability of qualitative methods to elicit accurate perceptions makes them ideal to employ in this study.

It is due to qualitative methods that issues such as the organisational component of occupational stress has become visible. As mentioned previously, quantitative surveys are often designed with the researcher’s opinions built into them, and therefore, only justifying

questions may have been included, even after validation over time. For example, at the turn of the century, Mahoney (2001) decided that the information that she received from officers did not reflect that which was published in the previous literature in relation to the origins of occupational stress. “The expressed stressors … were grouped together as ‘problems with management.’ They were not the stressors given precedent in the literature, such as highly responsible work in life and death situations, working all hours and the risk of experiencing that which is labelled Post-Traumatic Stress Disorder” (Mahoney, 2001, p. 137). If the previous literature had not captured the complete story of the stressors faced by paramedics in this instance, then it probably did not apprehend the full situation regarding the coping strategies, their utilisation, and the cultural aspects.

Since the early 21st century, several studies have been undertaken as well as a number of qualitative dissertations on the topic of coping in paramedics. Lawn et al. (2019) completed a comprehensive scoping literature review of the qualitative research published since the year 2000 dealing with the effects of emergency medical service work on the psychological, physical, and social well-being of ambulance personnel. They identified 6,154 records, which were eventually reduced to 39 studies that fulfilled all the research criteria, and 6 theses that were submitted over the last 5 years. The findings were categorised into 6 themes: Signs and symptoms of stress, Workplace stress: the role of critical incidents, Workplace stress: the role of organisational factors, Positive individual factors in maintaining psychological health, Negative factors in maintaining psychological health, and Organisational supports in maintaining psychological health. The findings from this study (Lawn et al., 2019) that are most pertinent to the current research are outlined below, under the headings: Workplace stress: the role of critical incidents, Workplace stress: the role of organisational factors, and Maintaining psychological health.

Workplace stress: the role of critical incidents

In the 39 studies reviewed by Lawn et al (2019), the paramedics identified that the most stressful jobs they encountered were those involving children, any form of neglect, burns, and mutilation. Another stressor was anything involving violence, such as abuse, assault, or anything that could cause harm to colleagues. In particular, jobs that caused a stress reaction were those that became personally significant in some way, where the paramedic

would identify with the patient, the family members, or the situation (Regehr & Goldberg, 2002). This is comparable to the statements made by paramedics to Avraham and colleagues (2014) relating emotional responses such as "vulnerability, discomfort, and overwhelming compassion" that can be felt after critical incidents (Avraham et al., 2014, pg. 195). However, it is not only the critical incidents that can produce a stress response. Routine jobs also become stressful, especially when they are cumulative.

Workplace stress: the role of organisational factors

In summarising this literature, Lawn et al (2019) went on to argue that organisational factors are just as stressful as specifically distressing jobs. Productivity and efficiency measures, key performance indicators, and expectations around response times increase the pressure felt by paramedics which increases their basal stress levels. Also, when clearance times after jobs need to be met in order to respond to another job, paramedics are not given enough time to informally debrief with their partner or to achieve adequate closure from one job to the next. Paramedics in several studies in several countries identified that organisational demands to meet productivity metrics were a major stressor (Alexander & Klein, 2001; Clompus & Albarran, 2016; Gist & Taylor, 2008; Halpern, Gurevich, Schwartz, & Brazeau, 2009).

Managers and supervisors are particularly important in assisting paramedics to cope with workplace stressors. Brough (2005) found that although the on-the-job threat of violence only influenced job satisfaction, the style of support that paramedics receive from their managers and colleagues did actually influence the psychological strain experienced. Gist and Taylor (2008) also reported studies which stated that managerial issues far outweighed the effects of critical incident exposure in importance. A number of studies stated that the type of managerial supervision was another major factor in a paramedic's experience of occupational stressors, and that their attitudes played an important role in recovery after a critical incident (Hugelius, Berg, Westerberg, Gifford, & Adolfsson, 2014; Mahoney, 2001). The literature suggests that first-line supervisors have the most significant role in effective service delivery and yet they have received "less preparation, less development, less direction, and less support for this critical role than for any above or below" (Gist & Taylor, 2008, pg. 315). Because of this, other researchers have found that paramedics believe that

supervisors do not receive enough support to fulfil their needs (Regehr & Millar, 2009). It is the view of this thesis that the managers are the members who must know the culture in order to provide support where and when necessary.

The lack of appropriate training for supervisors may be responsible for the fact that managers are not routinely dealing with bullying and harassment matters effectively or sufficiently; however, in the summary by Lawn et al. (2019), the cause of erroneous actions may be attributed to the transition of the workforce and occupation in general from "a vocationally-trained, male-dominated, blue-collar occupation to a university-trained and registered profession with an increasing number of women and younger recruits" (Lawn et al., 2019, pg. 8-9).

It is also vital that the organisation values their supervisors and equips them with the resources they need because of the important role they have in assisting mental health wellbeing. This position is detailed comprehensively in the following evaluative response: "The business case for developing supportive supervisors needs to be stronger for organizations to make the investments necessary to develop supportive supervisors. There are time constraints and other practical considerations for those in the role of supervisor that may get in the way of supportive supervision unless supervisor support is recognised as a valuable business expense" (Paustian-Underdahl et al., 2013, pg. 324). This also becomes important because values that are encouraged within an organisation necessarily must emanate from upper management.

Maintaining psychological health

Informal debriefing with colleagues and/or family remains the most positive and well used coping strategy (Bledsoe & Barnes, 2003; Halpern et al., 2009; Steen et al., 1997; P. M. Young et al., 2014). This aside, some paramedics do not burden their family members with discussing their traumatic incidents out of concern for vicarious traumatisation, or as a means of avoidance in thinking about it themselves. Although focusing on firefighters at the time, Regehr (2009) interviewed the wives of these emergency service workers who claimed that for the firefighter, withholding information may have been partially a protective mechanism to protect their wives from vicarious traumatisation, and partially, a self-

protective strategy to avoid a sensitive or emotional conversation with their spouse. However, direct communication was not necessary for the spouses to be fully conscious that a stressor or traumatic incident had occurred. Of the 14 women interviewed, the general consensus was to assist in their husband's avoidance and mitigate the potential for emotional volatility. This may not be the most helpful approach; however, with no support or advice from the organisation, they feel isolated.

Other supports are emerging as the need becomes more overwhelmingly apparent. The charity 'Sirens of Silence' was created in 2015 after the suicide of 3 emergency service personnel in quick succession in part due to the lack of support/perceived intimidation from management (Senate Education and Employment References Committee, 2018).

The formal systems have gained far more attention in the research sector than the informal supports. The formal system of CISD (discussed in detail above) has many associated difficulties besides the lack of peer-reviewed evidence of effectiveness. Stigma, cynicism, training, and believability concerns prevail, resulting in a reduced willingness to use the resource (Gould, Greenberg, & Hetherton, 2007; Lawn et al., 2019; Shakespease-Finch & Scully, 2004; Wallace, 2010). All of these issues arise in the current project and are developed further from the perspectives of the current sample of paramedics.

3.5 Summary

This chapter has examined the literature relating to culture and coping in regards to paramedics. After the evidence on the formally provided resources was covered, the research pertaining to general culture was examined and narrowed to concentrate on organisational culture before the natural progression of the literature in this field focused specifically on organisational safety culture.

From this point, the attention was transferred to the research addressing coping, commencing with the predominantly quantitative studies that were undertaken prior to 20 years ago. When this research commenced, there was still a paucity of qualitative research, but in the last decade specifically, researchers have embraced the methodology; therefore, the chapter finished with the newly burgeoning collection of qualitative studies.

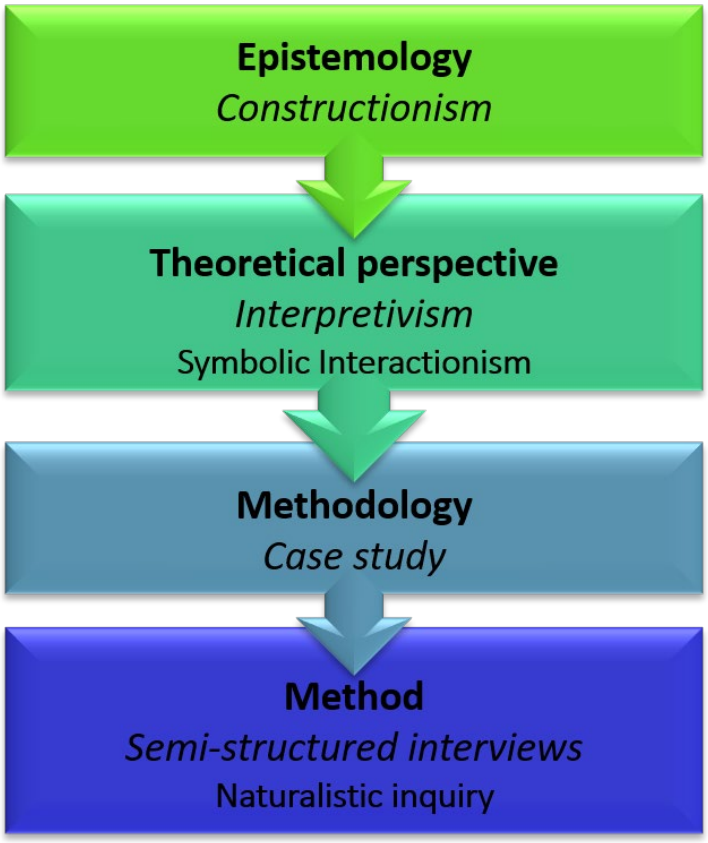
In the next chapter, the methodology that underpins the current literature will be explored. The epistemology and ontology will be discussed before examining knowledge as it is broken down into tacit knowledge, beliefs, values, and attitudes. From this point, we turn to the construction of meaning, considering the rationale from a position of Interpretivism, to Constructionism, and then Social Constructionism. The chapter concludes with a discussion about the theoretical perspective of Symbolic Interactionism.

CHAPTER 4: METHODOLOGY

4.1 Introduction

The previous research performed in areas of occupational culture and coping strategies was outlined in chapter three. This chapter outlines the theoretical framework and its application in understanding paramedics and their culture relating to the informal and protective aspects of their mental health wellbeing. The chapter explores and interprets the meaning attributed to these strategies and techniques through the eyes of the paramedics by documenting their experiences and thought processes, including the importance attributed to these from their own perspective, rather than imposing meaning and associated levels of importance upon them. The framework used to undertake this research, and therefore, the organisation of this chapter is based on that presented by Crotty (1998), whereby the epistemology of social constructionism leads primarily to the adoption of the theoretical perspective of symbolic interactionism (See Figure 1).

Figure 1 The four elements of the current research.



4.2 Epistemology and Ontology

Epistemology is a philosophical attempt to understand whatever is most fundamentally understandable about the nature and availability of knowledge (**the theory of knowledge**), whereas ontology is the philosophical study or knowledge of the **nature of being**, becoming, existence, or reality (Grbich, 2007). Structuring the gathering of information allows concepts to be laid out in a way that makes sense to researchers; organising ideas that are meant to be universal within the field and allowing for a common language to be spoken. It also provides a common background and understanding of a particular field of study, and it helps show the connections and relationships between concepts in a manner that is generally accepted within the field (Park, 1931).

When studying the natural and physical sciences, the earliest research methods were entirely empirical in nature, using quantitative methods. While **empiricism** depends on *facts developed from observation*, the framework or research assumptions rely almost universally upon the epistemological approach known as **positivism**. Positivist theorists believe in hard data, and therefore, "human beings were conceived as the product of forces that could be quantified, predicted, and manipulated" (Cloud, 2016, p. 1). In general, positivistic assumptions include the idea that:

1. There is a single tangible reality "out there" which is fragmentable into independent variables and processes, any of which can be studied independently of the others, and questions can be posed regarding such a small portion of that reality that, eventually, it can be predicted and controlled.
2. The researcher and the subject/s are completely independent of each other.
3. The results of this research will hold anywhere and at any time, thereby being free from context and time.
4. The results are value-free.
5. Causal associations are determinable (Lincoln & Guba, 1985).

In having this perspective, positivists look exclusively at isolated situations in isolated conditions. As cited in Crotty (1998), Giddens explained the concept by saying that they are "able to ignore categories used by people in everyday life and avoid or minimise ordinary language, using its own scientific metalanguage instead" (Crotty, 1998, p. 56).

Even though, historically, the vast majority of research conducted in this area uses this approach where knowledge is gathered, this study takes on a different epistemological stance known as Constructionism, where knowledge and meaning are co-constructed through social interaction. This stance is developed further below, after an elaboration of 'knowledge', and other terms that relate to the development of meaning are defined.

4.3 Knowledge

Knowledge can be dissected under the headings of tacit knowledge, beliefs, values, and attitudes. If the definitions found in several dictionaries are combined, a statement of knowledge might resemble:

> *Knowledge is a familiarity, awareness or understanding of someone or something, such as facts, information, descriptions, or skills, which is acquired through experience or education by perceiving, discovering, or learning.*

Separating knowledge into its component categories is difficult because there is no common list that is universally adhered to. The usual grouping of knowledge categories is into pairs, which are often the antithesis of each other. Two such pairs of categories that are important to the current research are described below:

1. **Explicit** knowledge is recorded and communicated through mediums, such as materials included in libraries and databases. The material point is the manner of expression rather than 'what' is expressed, from individual to individual, in a group, or to millions of people simultaneously.
2. **Tacit** knowledge is the opposite of explicit knowledge in that transferring it through a medium of some form (as for explicit knowledge) is almost unachievable. It can only be communicated and shared by consistent relationships and extensive contact.
3. **Declarative** knowledge is knowledge that can be expressed in declarative/indicative sentences or through suggestive/investigative propositions (the knowledge *of* something rather than the knowledge of *how* to do something). It is also known as propositional or descriptive knowledge and can be grouped with *a priori* and explicit knowledge, as it is gained via traditional education.

4. **Procedural** knowledge is the opposite of declarative knowledge in that it is knowledge that can specifically be *used* and that is acquired by '*doing*' and thereby gained through experience. It is also known as non-propositional knowledge and can be grouped with tacit knowledge (Gemma, 2014).

For the purposes of this research, the category of knowledge that is most relevant is tacit knowledge: those forms of knowledge that are obtained through interactions with others and are therefore culturally maintained and transferred.

4.3.1 Tacit knowledge

Tacit knowledge is achieved through personal experience and can incorporate interpersonally shareable statements relating to observations of objects and events, and inexpressible associations which can lead to the formulation of new or altered meanings or ideas. Examples of tacit knowledge include body language and facial recognition, the knowledge of language, and the nuances involved in comprehending metaphors, sarcasm and humour, intuition and emotional intelligence, innovation and leadership, and aesthetic sense and the appreciation of beauty. It is everything that remains of what is remembered after removing all that has been learned using words and symbols. It is, in essence, the experience of 'feeling'; statements like "I could tell" or "I just knew" that are elicited when one draws from their tacit knowledge, and it is the stories that are built upon when developing new understandings.

The concept of tacit knowledge was primarily developed by Michael Polanyi (1891-1976) who argued against the then dominant position that science was somehow value-free. He provided the statement "we know more than we can tell", and he coined the term 'tacit knowledge' to refer to a pre-logical phase of knowing. He believed that creative or exploratory acts (especially acts of discovery) are motivated by, or charged, with strong personal feelings and commitments or passions. He also recognised the strength by which we hold opinions and understandings, and our resistance to changing them.

Polanyi's notion of tacit knowledge is useful when looking at more informal methods of education, particularly in a workplace setting, such as how people acquire the knowledge to grasp the meanings of different situations, develop accurate intuition, and improve their

hunches (Smith, 2003). It is this view of informal education that is drawn upon in this research, as it is the informal process of developing methods or strategies to protect themselves from the potential mental health-related trauma that paramedics are continually exposed to, that is described and understood in this thesis. In order to elicit specific tacit knowledge on the culture of coping, the paramedics in this research were encouraged to express their beliefs, values, and attitudes on the topic.

4.3.2 Beliefs

Beliefs are assumptions we hold to be true. When we use our beliefs to make decisions, we are assuming the causal relationships of the past, which led to the belief, will also apply in the future (Immigration Advisers Authority, 2018). Beliefs are also contextual: they arise from learnt experiences, resulting from the cultural and environmental situations we have faced. In this way, it is important to be aware that as years pass, and cultures evolve, the beliefs of older members may not be identical to those of the younger generation of the same culture.

The beliefs that we hold are an important part of our identity. They may be religious, cultural, or moral, and are precious because they reflect who we are and how we live our lives (Kumar, 2018). Our values and beliefs affect the quality of our work and all our relationships because our beliefs govern or shape how we interpret our experiences, including reality (Feldman, 1988; Hetherington, 2016), and how we behave.

4.3.3 Values

The term “value” refers to the regard in which a person or object is held; it denotes the importance, worth, or usefulness of something or someone which can guide principles or standards of behaviour and influence judgement as to what is important in life. Values are internalised principles, standards, or qualities that an individual or group of people hold in high regard. Values guide the way we live our lives, and influence the judgements we grasp and the decisions we make. A value may be defined as something that we hold dear, those things/qualities which we consider to be of worth.

A ‘value’ is commonly formed by a particular belief that is related to the worth of an idea or type of behaviour (Hetherington, 2016; Immigration Advisers Authority, 2018). This research

is looking to decipher the standards and values that paramedics believe are important to them when it comes to preserving their mental health wellbeing.

4.3.4 Attitudes

The word 'attitude' can refer to a lasting group of feelings, beliefs, and behavioural tendencies directed towards specific people, groups, ideas, or objects. It usually describes what we think is the 'proper' way of doing something. The attitudes that we feel very strongly about are usually called values. Other attitudes are not so important and are more like opinions. Sometimes, our own attitudes can make us blind to other people's values, opinions, and needs. Attitudes will always have a positive and negative element and will have an impact on the way we behave towards individuals or objects (Hetherington, 2016; Passer et al., 2009).

Beliefs, values, and attitudes all influence how an individual interprets meaning and interacts with others. For example, a specific set of attitudes held by members of an ambulance service will influence the way they view a particular scene or respond to a person in need, although not necessarily the way they act. All three are important components of a workplace culture. Understanding the attitudes, values, and beliefs that are held, specifically by paramedics, will lead to a more in-depth understanding and interpretation of the meanings attributed to events and situations encountered while on the job. These interpretations reveal the underlying culture; the shared meaning-making that occurs around the issue of coping and mental health wellbeing, which aligns with the epistemology of Constructionism that informs this study.

4.4 Interpretivism

Interpretivism is essentially an approach to the social sciences that opposes the positivism of the natural sciences, and underpins qualitative research methods. Social scientists such as anthropologists and sociologists generally, but not exclusively, rely upon qualitative research. **Qualitative** methods are used to examine people, situations, and events that cannot be specifically counted, such as emotions, values, beliefs, and attitudes (Cloud, 2016).

The interpretivist approach emerged between the 1920s and 1930s (up until the 1950s) within the Chicago School of Sociology. While conducting their research, this group of sociologists (including such notable originators as George Herbert Mead, Edward Franklin Frazier, Herbert Blumer, Howard Becker, and Erving Goffman) developed a different framework focusing strongly on qualitative research. The members of the Chicago School focused on the construction of theories about how humans live in their environment by allowing the participants they interviewed to give subjective information about their own experiences, values, attitudes, and beliefs. The scientists organised and interpreted the information, but the data was wholly from the people interviewed or observed. This was the beginning of interpretivism. Like other qualitative methods, interpretivism is empirical in nature, but it uses a different approach than the traditional scientific method employed by the physical sciences, as it proposes the position "whereby the self is constructed in interaction with society and, in turn, society is constructed in interaction with the individual" (Cheek, Shoebridge, Willis, & Zadoroznyj, 1996). The work of the Chicago School led to improved methods in sociology in general, and to the development of the theoretical and methodological use of symbolic interactionism in sociology, particularly in urban sociology.

The study of humans and social life is more complex than the study of physical and natural phenomena. Human beings operate in a more complicated web of social, behavioural, and cultural variables (Cloud, 2016). Research in the social sciences requires a different set of skills and a completely different viewpoint. For example, when researching the natural and physical sciences, it is characteristic to employ an experimental method where certain conditions or variables are controlled, and one or more variables is manipulated to determine its effect on a dependent variable in order to establish causality. Generally speaking, this is impossible when researching social phenomenon, as causality (or even milder associations) is problematic owing to the overall complexity and difficulty of controlling for all confounding extraneous variables in natural settings (Bowling, 1997). Rothman (1986) reiterated that in the social sciences, "investigators need to recognise the *impossibility*, in theory, of proving causality and the incompleteness of scientific research in the light of advancing knowledge" (cited in Bowling, 1997, p. 108).

Furthermore, utilising the positivist perspective when conducting social science research may be misleading as, "it encourages an emphasis on superficial facts without understanding the underlying mechanisms observed, or their meanings to individuals" (Bowling, 1997, p. 111). So, to use the tools of the natural sciences would in fact "distort reality …, as human action is not seen as a response to the system, but as a response to interaction with others and the meanings to the individual" (Bowling, 1997).

The two important Interpretivist epistemologies that can guide interpretation when conducting research of this nature are constructionism and constructivism. Constructionism is the view that meaning comes into existence through our engagement with the realities in our world; that meaning is constructed. Constructivism, conversely, focuses exclusively on the meaning-making activity of the individual mind and points to the unique experience of each of us (Crotty, 1998).

4.5 Constructing Meaning

As mentioned above, when holding a constructivist theoretical perspective or worldview about meaning and the acquisition of knowledge, one believes that meaning is not merely discovered, residing latently within an object until someone perceives or exposes it. Rather, meaning is constructed by human beings as they engage with the world they are interpreting. Because of this belief, it is held that there is *no* 'true' or 'valid' interpretation. All perspectives are valid; some may be more logical or easier to understand than others, but they are all valid.

Crotty (1998, p. 42) defined this as the view that:

> *All knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world and developed and transmitted within an essentially social context.*

4.6 Constructionism

The basic concept of constructionism rests on the fact that meaning is constructed rather than discovered. This point of view leads conveniently into the next epistemological level which is **social constructionism**, which holds that all meaning is collectively or socially

generated (and transmitted), and therefore, presumes that culture shapes the way we see and feel events, individuals, and objects (Crotty, 1998). This view lends itself readily to the current research because it is the culture of the emergency services that is under examination.

After dismissing positivism and the experimental method of the physical sciences, the epistemology chosen to undertake this research was Interpretivist in nature. Taking all of this into consideration, it was essential to adopt a more naturalistic paradigm to undertake the current research. Consequently, the naturalistic inquiry method defined by Lincoln and Guba (1985) was selected, which states that the social scientist must hold that:

1. There are multiple constructed realities that can be studied only holistically; instead of focusing closer and closer to a single point of interest. Inquiry into these multiple realities will inevitably diverge (each inquiry raises more questions than it answers), so that prediction and control are unlikely outcomes, although some level of understanding (*verstehen*) can be achieved.
2. The inquirer and the "object" of inquiry interact to influence one another; the knower and the known are inseparable.
3. The aim of inquiry is to develop an idiographic body of knowledge in the form of "working hypotheses" that describe the individual case.
4. All entities are in a state of mutual simultaneous shaping, so that it is impossible to distinguish causes from effects.
5. Inquiry is value-bound by the inquirer, the choice of paradigm, the choice of substantive theory utilised, and the context (Beuving & de Vries, 2015; Lincoln & Guba, 1985).

4.7 Social Constructionism

When all the members of a community view or deal with an object or event and share the meaning, they are working with a social construction. The 'good' or 'right' way to perform a role is determined by the agreement of everyone within the group. This social construction or construct is acknowledged as an established fact and accepted as natural by the members of the society who hold that view; however, members outside of that community

or society may not share the same view or reality; indeed, this partly explains cultural differences.

These facts that are accepted as natural are referred to as "taken-for-granted" knowledge and they come about through interactions between members of a social group or society. Furthermore, as different groups construct different taken-for-granted knowledge and, in essence, construct alternate realities, it appears obvious that there must be multiple realities that compete for importance (truth and legitimacy), rather than the positivistic stance that there is a single objective truth that is waiting to be uncovered (Crotty, 1998). The primary objective of social constructionism is to reveal the specific methods that groups and individuals employ while creating their social reality, specifically looking at the ways they are internalised and turned into habits, and eventually, traditions.

Social constructionism emphasises the hold our culture has on us: it shapes the way in which we see things (even the way we feel things!) and gives us a definite view of the world. Everyone is born into a culture and sees the world with the meaning that was attributed to it by their culture and, in doing so, uses culture to direct behaviour and organise experience. "Culture is best seen as the source rather than the result of human thought and behaviour. It is 'a set of control mechanisms – plans, recipes, rules, for the governing of behaviour" (Crotty, 1998, p. 53).

Social constructionism is interested primarily in the 'taken-for-granted' knowledge that everyone uses to organise their everyday events or situations. This "social stock of knowledge" consists of recipes for the mastery of routine problems. It includes expected appropriate behaviours and the rules we follow to play our 'roles' adequately. "Habitualised actions, of course, retain their meaningful character for the individual, although the meanings involved become embedded as routines in his (sic) general stock of knowledge, taken for granted by him (sic) and at hand for his (sic) projects into the future" (Berger & Luckmann, 1966, p. 71). Everyday knowledge is socially constructed through a process of socialisation, and the way in which these behaviours, beliefs, values, and attitudes become habitual is detailed below.

4.8 Constructivism

The other perspective available when discussing the construction of meaning is constructivism, which is specifically focused on the individual's experience and understanding of the socially collective generation and transmission of meaning (looking at the products of individual minds and cognitive processes). In this way, knowledge and reality are constructed within individuals. Burr stated that constructivism is more akin to a personal construct psychology and that it fills in "the subjectivity 'gap' in social constructionism" (Burr, 2018, p. 369).

The differences between the two paradigms are concisely summarised by Guterman (2006) (cited bySommers-Flanagan & Sommers-Flanagan, 2018):

> *Although both constructivism and social constructionism endorse a subjectivist view of knowledge, the former emphasizes individuals' biological and cognitive processes, whereas the latter places knowledge in the domain of social interchange (p. 284).*

The current study acknowledges that while paramedics are individuals with differing views, thought processes, and feelings, there is a shared reality that the study seeks to uncover. When common themes are elicited from several paramedics, and are shared within the group, this is evidence of the socially constructed nature of this culture. As the emphasis of this study is on the culture of coping, specifically examining the shared sentiments and understandings of this group of paramedics, the focus remains firmly on the social construction of meaning, leaving constructionism the paradigm of choice here (Crotty, 1998).[1]

[1] This is an excerpt from the beginning of Chapter 11 of *Counselling and Psychotherapy Theories in Context and Practice* (2nd ed., John Wiley & Sons, 2012).

Once upon a time a man and a woman met in the forest. Both being academic philosophers well-steeped in epistemology, they approached each another warily.

The woman spoke first, asking, "Can you see me?"

The man responded quickly: "I don't know," he said. "I have a plethora of neurons firing back in my occipital lobe and, yes, I perceive an image of a woman and I can see your mouth was moving precisely as I was experiencing auditory input. Therefore, although I'm not completely certain you exist out there in reality—and

4.9 Theoretical Perspective

4.9.1 Symbolic Interactionism

The theoretical perspective adopted for this research is a form of interpretivism known as symbolic interactionism. This approach draws on the work of sociologists from the Chicago school, solidified by such pillars of sociology as Herbert Blumer, Anselm Strauss, Barney Glaser, Howard Becker, and Erving Goffman. It specifically looks for culturally derived and historically situated interpretations of the social lifeworld. It places primary importance on the social meanings that people attach to the world around them.

Crotty (1998) stated that there are three assumptions upon which this philosophical stance is based, that originated with Blumer:

- That human beings act towards things on the basis of the meanings that these things have for them. Thus, people do not simply respond to stimuli or act out cultural scripts. It is the meaning that determines action.
- That the meaning of such things is derived from, and arises out of, the social interaction that one has with others. "The meaning of a thing for a person grows out of the ways in which other persons act with regard to the thing" (Blumer, 1969, p. 4). Essentially, people learn how to see the world from other people.

I'm not completely certain there even is a reality—I can say without a doubt that you exist . . . at least within the physiology of my mind."

Silence followed.

Then, the man spoke again; "Can you hear me?" he asked.

This time the woman responded immediately. "I'm not completely certain about the nature of hearing and the auditory process, but I can say that in this lived moment of my experience I'm in a conversation with you and because my knowledge and my reality is based on interactive discourse, whether you really exist or not is less important than the fact that I find myself, in this moment, discovering more about myself, the nature of the world, and my knowledge of all things." (continued on next page)

There are two main branches of constructive theory. These branches are similar in that both perspectives hold firmly to the postmodern idea that knowledge and reality is subjective. Constructivists, as represented by the man in the forest, believe knowledge and reality are constructed within individuals. In contrast, social constructionists, as represented by the woman in the forest, believe knowledge and reality are constructed through discourse or conversation.

- That these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things they encounter. Therefore, social actors attach meanings to situations, others, things, and themselves through a process of interpretation (Blumer, 1969; Cheek et al., 1996; Crotty, 1998; Handberg, Thorne, Mitdtgaard, Nielsen, & Lomborg, 2015; Taylor & Bogdan, 1984).

Meaning is the core concern of symbolic interactionism. The important factors in determining behaviour are the meanings that have been attributed to things or events by humans towards which they act, rather than the alternative stance of focusing on other factors, whether biological, psychological, or cultural, that may produce specific behaviours. This is important in the current research because factors of interest are the informal strategies that are considered valuable, and which are therefore utilised by the paramedics.

The source of the meaning is the second defining concept of symbolic interactionism. Initially, the source of meaning was thought to come from one of only two directions; from within an object (internal/intrinsic) or as being placed upon the object (external/extrinsic). The 'realist' viewpoint is the former; that all objects already have their meaning and it is up to us to discover it. The second outlook is more psychological in nature, that meaning is determined by individuals' emotions, attitudes, memories, and perceptions. However, the interactionist stance takes this perspective one step further by stating that meaning is actually the product of people's interaction with each other and the object, and that observing how others behave in relation to a thing/event/individual demonstrates how they feel about it and what level of importance it's meaning has to them. This is refined knowledge that is only obtained through social interaction (Spradley & McCurdy, 1972).

The techniques that people have learned to define their world are shared, and the activities of others determine the factors used in the formation of an individual's own conduct. To highlight this, Blumer (1969) stated that "in the face of the actions of others, one may abandon an intention or purpose, revise it, check or suspend it, intensify it, or replace it" (Blumer, 1969, p. 8). To extend upon this point, it is this process that lead Donnan (1976) to describe the rules of interaction as being "informal prescriptions or norms of behaviour that must be followed if one is to interact successfully and without sanction within the particular group to which they apply" (as cited in Holy & Queen's University of Belfast. Dept. of Social,

1976, p. 81). An individual's interpretation is altered in light of the actions of others. This is important in the current research because the investigation explores how paramedics describe the informal structure, how they construct it, and how they pass it on, including the knowledge that is created regarding the norms and the values governing them.

The link between meanings or predispositions to act in a certain way and the behaviours themselves is the dynamic process of interpretation. It is how a person weighs up a situation from the meanings available that will determine that person's interpretation. Interpretation takes place over two phases: the individual communicates or interacts with themselves firstly, determining that something has meaning, and secondly, they use that meaning to guide action. This interpretation is a deliberate process whereby meanings are manipulated and modified as a mechanism to shape behaviour (Blumer, 1969). For the current study, interpretation is the key. Individual interpretations can be vocalised, and therefore, are accessible to collect and analyse.

While dissecting the interpretive approach of Interactionism, Denzin (1989) observed that life is day-to-day existence encompassing a constant process of interpretation whereby decisions about behaviour are made in regard to oneself and those we associate with. "Everyday life revolves around persons interpreting and making judgements about their own and others' behaviours and experiences" (Denzin, 1989, p. 11). Taylor and Bogdan described it succinctly when they stated that "from a symbolic interactionist perspective, all organisations, cultures, and groups consist of actors who are involved in a constant process of interpreting the world around them. Although people may act within the framework of an organisation, culture, or group, it is their interpretations and definitions of the situation that determine action and not norms, values, roles, or goals" (Taylor & Bogdan, 1984, p. 10). Therefore, it is not the group's collective norms etc. that govern action or behaviour. Behaviour is regulated by the individual's interpretations of their own and other's behaviour. These interpretations are constantly being made and revised. Although this study examines the mental health protective strategies of paramedics from a cultural perspective, it is the individual interpretations of the meaning of these strategies that will form the interview content.

Lewis and Hansen (1975) argued that the focus above constitutes a purely individual and psychological perspective which relates to motives and intentions; the reasons people have for doing what they do. To study culture, however, the researcher must interpret these motives and intentions in terms of their relationships to one another, in order to gain implicational, veiled, or obscure meanings. He stated that "institutional questions focus on cultural phenomena in their own terms and not on people ... they concern the consequences of the things in question – the way those things are linked by logical implication to other ideas, norms, customs, (and) patterns of behaviour" (Hanson, 1975, p. 9).

Blumer (1969) confirmed this noting that "only through dialogue can one become aware of the perceptions, feelings, and attitudes of others and interpret their meanings and intent." It is only through the use of significant symbols, essentially language and other symbolic tools, that people communicate. Research that produces descriptive data: people's own written or spoken words and observable behaviours is, intrinsically qualitative, and therefore these methodologies are appropriate to use while conducting research that is concerned with meaning. One of the tenets of symbolic interactionism encompasses the fact that the perceptions and attitudes of others can only be revealed, and their meanings only interpreted, through engaging in dialogue (Blumer, 1969).

4.10 Methodology

With the desire to experience the lived world of another and to adopt the perspective of that world, researchers using symbolic interactionism generally employ the research methodology developed within cultural anthropology known as ethnography. When performing ethnography,

- the social settings to be studied, however familiar to the researcher, must be treated as anthropologically strange;
- the objective is to document the perspectives and practices of the people in these settings;

- the purpose is to describe and interpret the shared and learned patterns of values, behaviours, beliefs, and language of a culture-sharing group;
- the aim is to 'get inside' the way each group of people sees the world (Crotty, 1998).

However, due to the sensitivity of information that might be uncovered, the principle method of data collection employed by ethnographers, participant observation, was not an option for this research. Other equally information-rich data collection options were still available. For example, the difference between the ethnographic and case study approach is essentially the intent. Ethnography describes ***how*** *a culture works*, whereas case study methods attempt to ***understand*** *an issue* or problem using the case as a specific illustration (Creswell, 2007). Taking this into consideration, the case study approach was actually the better methodology of choice. In essence, "the 'why' informs and enriches our notions of the 'how'" (Desmond, 2006, p. 414).

Denzin (1989) believed that fieldwork, or participant observation, is possibly the only effective way to obtain the thick descriptions, accounts, and observations that can be used to elicit taken-for-granted knowledge and the methods that are used to formulate these accounts (Berger & Luckmann, 1966). Although participant observation was not employed, a rich description of perspectives, behaviours, and interpretations was obtained using in-depth interviews. Despite the fact that direct observation of individual and collective behaviours, patterns of behaviour, casual conversations, social networks, and demographic characteristics was not possible, careful questioning enabled the meanings of non-verbal actions to be elicited, along with an examination of the 'common knowledge' that is shared between members of the culture, but which may not be explicit (Taylor 2002). Therefore, the method chosen to conduct this research was in-depth interviews, which can be defined as face-to-face encounters between the researcher and the informants, directed towards understanding their perspectives on their lives, experiences, or situations as expressed in their own words (Brinkmann & Kvale, 2015).

Denzin (1989) advised the adoption of five phases for evaluating interpretations: deconstruction, capture, bracketing (reconstruction), construction, and contextualisation. This process encourages the researcher to:

1. Critically analyse and interpret prior conceptions
2. Secure multiple instances of the phenomenon under review
3. Isolate the key or essential features of the process
4. Interpret the event
5. Locate the phenomenon back in the worlds of lived experience.

Denzin added his voice to that of Geertz (1973), who stressed the importance of obtaining 'thick descriptions' or densely textured accounts from informants rather than 'thin descriptions' which only relate uncontextualised facts. By doing so, the researcher can "provide a vocabulary in which what symbolic action had to say about itself – that is, about the role of culture in human life – can be expressed" (Geertz, 1973).

Blumer (1969) revealed that "the life of a human society ... consists of the action and experience of people as they meet the situations that arise in their respective worlds" and that it is essential, when studying these worlds, to develop a "firsthand acquaintance with the sphere of life under study." While undertaking his classic ethnography into the social situations of mental patients, Erving Goffman solidified this concept by writing "any group of persons develop a life of their own that becomes meaningful, reasonable, and normal once you get close to it, and that a good way to learn about any of these worlds is to submit oneself in the company of the members and to the daily round of petty contingencies to which they are subject" (Goffman, 1961). Because of the universality and importance of experiential understanding, and because of their compatibility with such understanding, case studies can be expected to continue to have an epistemological advantage over other inquiry methods as a basis for naturalistic generalisation (Stake, 2000).

4.11 Summary

This chapter has established the epistemological and ontological foundations of the current research, describing in detail the forms of knowledge that are at the centre of a culture and the means of obtaining that knowledge by way of constructionism, primarily by tapping into the beliefs, values, and attitudes that are held both individually and collectively. The particular aspects of the social construction of meaning are specified within the slight differences between available paradigms, leaving social constructionism the logical

perspective with which to view the findings. All are underpinned by the theoretical perspective of symbolic interactionism. The next chapter will reveal the process of data collection, including a case study design approach which also leads to a naturalistic inquiry set of tenets through which to conduct the research using semi-structured interviews. The subject profile and recruitment techniques are detailed, and the chapter will conclude with demonstrating the form of analysis that was adopted, including an overview of the coding techniques.

CHAPTER 5: METHOD

5.1 Introduction

After establishing the intellectual fundamentals underpinning the current research in the previous chapter, this chapter opens with a brief outline of the difficulties encountered while attempting to conduct this research, specifically moving from the ideal cultural study methodology of ethnography which was seen as problematic by the industry, towards the current interview-only style of case study design. After summarising the research objectives, questions, and aims, this chapter outlines the design based on the tenets of naturalistic inquiry. The chapter also provides an overview of the case study approach and the form adopted to carry out the current endeavour. This is followed by a discussion of the interview style, including the techniques and presuppositions (concepts that were held in mind while listening to the answers which guided the questions) that directed the process of data collection. The chapter illustrates the style of sampling used, establishes how the participants were recruited, and then describes the specific characteristics of the ambulance personnel that took part in the interview process. Finally, a review of the processes used while transcribing, coding, and analysing the data for emergent themes concludes the chapter.

5.2 The Process

5.2.1 Gaining ethics approval and access to the field

5.2.1.1 From ethnography to interviews

The original aim was to conduct a qualitative study using ethnography. Ethnography was chosen given the dearth of studies taking this approach with first responders, particularly paramedics, so that the original ethics application form for this project was designed to research the mental health culture of a particular emergency service using ethnographic methods including participant observation and interviews. Previous meetings with a number of individuals within this community to discuss the feasibility and level of potential interest in the research met with enthusiasm. However, the management of any organisation is entrusted with the protection of their members from exposure to potential risk, and ethnographic research is often considered particularly difficult to conduct in clinical settings

(Long, Hunter, & van der Geest, 2008). Hence, it was not surprising that the executives of this and several other emergency services deemed the prospect of participant observation problematic due to the intrusive nature of the research method, and the fact that the topic of interest investigated highly sensitive issues in participants that are already under considerable pressure and currently the topic of a Senate Inquiry (Senate Education and Employment References Committee, 2018).[2]

Generally speaking, the most difficult component of ethnographically styled qualitative research is that of gaining access to the field of study and the necessary participants, given that the presence of a researcher at such close quarters is seen as disruptive to what is highly intensive work. The ability to achieve this goal relies heavily on the researcher's ease in establishing trust and credibility with the gatekeepers, and first impressions are crucial (Patenaude, 2004). Many formal processes are required (other than university ethics approval) to establish access to certain organisational environments, including negotiations with different levels of the relevant industrial hierarchy.

One of the initial issues concerned the inability to de-identify the results due to the fact that these services are quite small. When it was discovered that discomfort regarding the participant observation component of the research was a considerable factor in the proposal's rejection, it became necessary to remove the entire participant observation component and confine the data collection entirely to information that was able to be elicited through semi-structured interviews. This of course raised difficulties where 'culture' is the area for investigation, because often participants do not actively recall what the reasons are for thinking and behaving in a specific culturally sanctioned manner, and of course, do not always act as they claim to do.

The focus of the research became an ambulance service. The ethics application form for this research was submitted in 2015, proposing to research the mental health culture of ambulance personnel, and the CEO signed off on the approval. As immediate interest in the

[2] The sensitivity of this area was made apparent when the federal government instigated a Senate Inquiry into the mental health of all first responders (Senate Education and Employment References Committee, 2018).

research came firstly from team leaders located in rural and remote areas, a modification request form to the original ethics application was submitted in August 2015. This requested the alteration of the project title from "The culture of coping in an ***urban based*** ambulance service" to "The culture of coping in an ambulance service" to enable the recruitment of participants outside of an urban area, and to capitalise on the issue of location that I had been alerted to in previous discussions with the emergency workers. Approval for the modification was granted. Data collection in the form of semi-structured interviews commenced in September 2015.

5.3 Research Objectives, Question, and Aim

5.3.1 Research question

The initial question for this research was: 'What is the culture of coping in paramedics?' In order to understand or describe the culture of mental health wellbeing, it became necessary to formulate both primary and secondary questions. The main direction of the investigation explored:

'Which coping strategies are: deliberately used and not used; perceived as being beneficial or detrimental; and culturally encouraged or discouraged by paramedics to maintain their mental health and wellbeing?

The other associated questions listed below provided the secondary line of questioning designed to encourage a more complete and rounded interchange of information from the participants. These questions were intended to elicit a number of different perspectives of individual issues or to encourage interpretations of a number of situations viewed from different perspectives by individual participants, specifically in areas that may not be consciously considered to account for the cultural component. As Steen and colleagues (1997) stated while discussing whether paramedics' basic assumptions towards coping may be dysfunctional:

> Making basic assumptions visible for them as a group, confronting and debating them can start the process. Outsider involvement is required as insiders cannot see their own basic assumptions because they have dropped out of awareness and are taken for granted *(Steen et al., 1997, p. 62)*.

In addition to the primary questions, these extra points for discussion included topics such as:

- How do first responders appraise a traumatic situation / what situations are considered traumatic?
- Does perception of trauma change over the course of a career?
- How are coping strategies learned/developed? (e.g. the socialisation of emotion management)
- Do preferred coping and adjustment strategies change over the course of a career?
- Do organisationally provided resources support the coping and adjustment strategies used by paramedics, and therefore, meet the perceived needs of these first responders?

5.3.2 Aim

The aforementioned questions are intended to facilitate the development of an understanding of the paramedic culture through social interaction, and to identify common themes that appear to influence the meanings used to interpret their experiences. This is assumed to have an impact on the ability to describe and interpret the cultural concepts and informal prescriptions that influence official and unofficial psycho-protective resource utilisation. In developing this understanding and describing the culture in sufficient depth, this research seeks to determine whether the psycho-protective resources that are currently available are meeting the needs of paramedics.

5.3.3 Objectives

In order to achieve this examination of the paramedic culture, the study objectives are to:

1. Identify the knowledge, beliefs, values, morals, attitudes, norms, customs, rituals, practices, behaviours, and any other capabilities and habits acquired by paramedics in relation to mental health protection.
2. Identify occupational stressors.
3. Identify the range of coping strategies used by paramedics to protect themselves and manage the potential mental health risks and report how these are experienced.
4. Determine which strategies are preferred, perceived to be beneficial, and are culturally encouraged or discouraged.

5. Describe this social cultural world from the paramedic perspective.

This thesis provides a basis for analysing the culture (perceptions, understanding, and experiences) of paramedics engaging in psycho-protective behaviour either informally or through utilising the mental health resources provided by the ambulance service.

5.4 Study Design

Despite the absence of a full participant observation component in this research, I was still able to follow most of the tenets of a naturalistic inquiry resulting in a case study. When the intention of research is to assist in the understanding of human situations or issues, the researcher must present them in a manner that accommodates the language of personal experience. It is of particular importance that the information exposed is delivered in a style that is most comprehensive for those that are to benefit from an enhanced understanding of the topic (Stake, 2000).

Sociologist Howard Becker (1964) spoke of a conflict around the superiority of the sociological perspective or the perspective of everyday life. The scientific perspective may be better for publishing in sociological journals, but for reporting to lay audiences and for studying lay problems, the lay perspective will often be superior. And frequently, everyday life perspectives will be more beneficial for discourse among scholars as they share more ordinary experiences rather than special conceptualisations. The special is often too special. A more scholarly report will not always be more effective (Stake, 2000).

In conducting this case study, in-depth interviews were used, as this approach elicits rich, detailed, and diverse information, despite a relatively small sample size (Von Dietze & Gardner, 2014; Williams et al., 2005). Theoretical sampling was used to select the participants to be interviewed. Taylor and Bogdan (1984) stated that in theoretical sampling, the actual number of “cases” studied is relatively unimportant. What is important is the potential of each “case” to aid the researcher to develop theoretical insights into the area of social life being studied. After completing interviews with several informants, the researcher should consciously vary the type of people being interviewed until the full range of perspectives held by the people of interest have been uncovered. This point has been

reached when interviews with additional people yield no genuinely new insights (formally known as ‘saturation’).

The interview questions started by being broad and quite general, so that the participants could construct the meaning of a situation, a meaning typically forged in discussions or interactions with other persons. The more open-ended the questioning, the better, as this allows the researcher to listen carefully to what people say or do in their life setting. Thus, constructionist researchers often address the “processes” of interaction among individuals. They also focus on the specific contexts in which people live and work in order to understand the historical and cultural settings of the participants. Researchers also recognise that their own background shapes their interpretations, so they “position themselves” within the research to acknowledge how their interpretation flows from their own personal, cultural, and historical experiences. Thus, researchers make an interpretation of what they find, an interpretation shaped by their own experiences and background. The researcher’s intent, then, is to make sense of (or interpret) the meanings others have about the world. This is why qualitative research is often called “interpretive research” (Creswell, 2007, p. 20). Overall, qualitative methods are better able to provide rich insights into human behaviour and social processes.

5.4.1 Naturalistic Inquiry

In their book entitled ‘Naturalistic Inquiry’, Yvonna Lincoln and Egon Guba (1985) defined several characteristics that they prescribe for the appropriate or essential conduct of such an inquiry. These are the criteria that were adhered to while conducting this study:

1. The natural setting
2. The researcher is the human instrument
3. The utilisation of tacit knowledge
4. Qualitative methods
5. Purposive sampling
6. Inductive data analysis
7. Emergent design
8. Case study reporting mode (Lincoln & Guba, 1985).

5.4.1.1 Implementing a Naturalistic Inquiry

A naturalistic inquiry is always carried out in a natural setting, as context is heavily implicated in meaning, and "realities are wholes that cannot be understood in isolation from their contexts" (Lincoln & Guba, 1985, p. 39). Context can be expanded to include activities or behaviours, language, the particular people or actors involved, the social situation, the specific culture, and the historical era (Turner & Bruner, 1986). For this study, although three interviews were conducted at non-AAS facilities, the remainder of the interviews were (by request of the team leaders and members alike) conducted at a station, and therefore, the participants were located in their own environment that was rich in the context of the information essential to the research topic.

Naturalistic inquiry occurs when the primary data-gathering instrument is the investigator themselves. Researchers using this approach believe that only the human-instrument is capable of adjusting to, and grasping, the vast variety of realities and associated meanings, the only one that is fully adaptive to the predicted, but essentially unknown, situation that will be encountered. The human instrument builds upon his or her *tacit* knowledge as much as, if not more than, upon propositional knowledge, and uses methods that are appropriate to humanly implemented inquiry, such as interviews, observations, document analysis, and unobtrusive clues (Lincoln & Guba, 1985). In this study, which uses semi-structured interviews, the questions were subtly altered, or the wording of the questions shifted, to accommodate the direction and flow of the conversation and the depth of understanding of each participant. This method is essentially participant-driven, in that all themes are identified from the participants' comments during the interviews (Von Dietze & Gardner, 2014).

Once in the field, a naturalistic inquiry takes the form of successive iterations of four elements: purposive sampling (relying on the researcher's judgement of what kind of participant would elicit the best quality data), inductive analysis of the data obtained from the sample, development of theory based on the inductive analysis, and projection of the next steps in a constantly emergent design. As the researcher cannot possibly know the extent of the patterns of mutual shaping and the influence of value systems, they necessarily allow the data and the accompanying interpretations to emerge, rather than entering the field with preconceived theories that the collected data will be required to 'fit'

(Taylor & Bogdan, 1984). Repetitions of the required elements are made as often as necessary until redundancy is achieved, the theory is stabilised, and the emergent design fulfilled to the extent possible, given time and resource constraints. In the current study, sampling was more 'convenience' than 'purposive' and, as this was designed as an exploratory/descriptive study, there was more elicitation and confirmation of themes rather than the development of a particular theory.

Generally speaking, throughout a naturalistic inquiry, but especially near the end, the data and interpretations are continuously checked with the respondents who have acted as sources, as well as with counterpart individuals; differences of opinion are negotiated until the outcomes are agreed upon or minority opinions are well understood and reflected. Although the practice of member checking was not specifically used in this study (returning manuscripts to participants for review), issues, situations, and meanings that were discussed with the initial participants were deliberately introduced, if they were not forthcoming, in the responses to the questions by later participants, so that others' interpretations could add weight to the initial comments, and the unwritten/unconscious rules could become visible.

The information was then used to develop a case report – a case study. The case study is primarily an interpretive instrument to capture cases in their uniqueness rather than in their generalisability. The information gathered may, however, be tentatively applied to other similar contexts if empirical comparison of the sites seems to warrant such an extension. The term 'case' can refer to an individual, an event, an institution, or even a whole country; however, a 'case study' investigates the selected 'case' in considerable depth (Stake, 2000). The case under investigation in this study is that of an entire ambulance service rather than individual paramedics or stations. The entire study is then bounded by the nature of the research problem, the evaluand, and the policy option being investigated (which are, however, themselves subject to revision and extension as the study proceeds).

5.4.2 Case Study approach

Case study research has a long, distinguished history across many disciplines, being particularly familiar to social scientists because of its popularity in psychology, medicine, law, and political science (Yin, 1984). Hamel, Dufour, and Fortin (1993) traced the origin of

modern social science case studies through anthropology and sociology focusing on such notable researchers as the founder of French sociological fieldwork, Frédéric Le Play, who concentrated on the working class in France and extending across Europe and Asia between the 1830s and 1870s; the Polish-born Austrian anthropologist Bronislaw Malinowski, who commenced observational research in Melanesia in the early 1900s (while avoiding World War I); and the renowned series of researchers that heralded from the University of Chicago's Department of Sociology, particularly between 1920 and 1950 (Creswell, 2007; Hamel, Dufour, & Foutin, 1993).

The case study approach could be defined as the study of an issue explored through one or more examples or instances within a "bounded system" (i.e., a particular setting within a specific context). Creswell (2007) defined case study research as "a qualitative approach in which the investigator explores a bounded system (otherwise known as a ***case***) or multiple bounded systems (cases) over time, through detailed, in-depth data collection involving ***multiple sources of information*** (e.g., observations, interviews, audio-visual material, and documents and reports), and reports a case description and case-based themes" (Creswell, 2007, p. 73). Stake (2000) further defined the case study as "the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances." Simons (2009) defined the case study in a similar vein to the previous authors; however, this definition particularly resonates with the perspective of the current research:

> *Case study is an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, programme, or system in a 'real life' context. It is research based, inclusive of different methods and is evidence-led (Simons, 2009, p. 21).*

Unfortunately, a "case" is often misconstrued as an individual person or activity (often utilised in medical science). A case is also often thought of as a constituent number of a target population, but as single members poorly represent whole populations, a case study is then considered a poor basis for generalisation. The need for generalisation is more likely to be required between similar cases rather than populations, therefore the priority is that the target case is properly described. As readers recognise essential similarities to cases of interest to them, they establish the basis for naturalistic generalisation. Yin (1984) clarified the issue by stating that "case studies, like experiments, are generalisable to theoretical

propositions and not to populations or universes …, the investigator's goal is to expand and generalise theories (analytical generalisation) and not to enumerate frequencies (statistical generalisation)" (Yin, 1984, p. 21).

As previously mentioned, a case need not be a person or enterprise. It can be whatever 'bounded system' is of interest, including institutions, programs, a responsibility, a collection, or a population. It is distinctive because it places great emphasis on what is and what is not 'the case' – the boundaries are kept in focus. It is the views and impressions of the society or culture that is being studied that is the focus of attention; it is "created from meanings provided by the social actors themselves" (Hamel et al., 1993, p. 30). What is happening and deemed important within those boundaries (the emic) is considered vital and usually determines what the study is about, as contrasted with other kinds of studies where hypotheses or issues previously targeted by the investigators (the etic) usually determine the content of the study. The emic perspective depicts the culture from within that cultural sphere – from members of that cultural group, whereas the etic perspective originates from outside of the cultural group – observing and reporting behaviour from an outsider's point of view (Hoare, Buetow, Mills, & Francis, 2012).

Although case studies have been used in anthropology, psychoanalysis, and many other research fields as a method of exploration preliminary to theory development, the characteristics of the method are usually more suited to expansionist than reductionist endeavours. The case study proliferates rather than narrows; in other words, the reader is left with more to pay attention to, than less. The case study attends to the idiosyncratic more than to the pervasive. The best use of case studies appears to be for adding to existing experience and humanistic understanding, as its purpose is to dissect real-life issues that are "too complex for the survey or experimental strategies" (Simons, 2009, p. 21). Its characteristics match the 'readiness' people have for added experience. Intentionality and empathy are central to the comprehension of social problems, just as is information that is holistic and episodic. The discourse of persons struggling to increase their understanding of social matters features and solicits these qualities (Stake, 2000). And these qualities match nicely with the characteristics of the current case study.

In summary, the qualitative case study:

- Is conducted systematically using qualitative methods of data collection
- Deliberately gathers multiple perspectives of stakeholders and participants
- Observations can also be accumulated in naturally occurring circumstances
- Number of cases may be small, but the amount of detailed information collected about each case is comprehensive
- Interpretation can only be made in context
- Contributes to the cumulative public knowledge of the topic (Simons, 2009).

Finally, the case study builds on these characteristics by considering the in-depth descriptions and associated interpretations of the context specifically from a cultural perspective. The program or social entity under focus is understood expressly in a socio-cultural context and with concepts of culture in mind.

5.4.2.1 The current Case Study

The current research is a single, explanatory case study looking at the methods or strategies that are culturally acceptable within the ambulance service to manage the risk of mental health trauma, other than the formal provisions provided by the service, such as the Peer Mentoring Program. The ambulance service does present a unique situation and occupational environment which constitutes a single case study (the culture of coping); however, sub-units of the case (differences in the culture of coping) have been given considerable attention. The account focuses on the informal or unofficial perspective, but also includes the perceptions of those interviewed about the resources provided by the service.

5.4.2.2 Limitations of Case Studies

Episodic subjective procedures that are common to the case study have been considered weaker than experimental or correlational studies for explaining phenomena. When explanation, propositional knowledge, and law are the aims of an inquiry, the case study will often be at a disadvantage. However, as Stake (2000) countered, “when the aims are understanding, extension of experience and increase in conviction in what is known, the disadvantage disappears.” Because the issues that are observed using a case study approach

are especially complex, and in-depth techniques are used to obtain rich 'thick descriptions', this method can generate a mass of data that may be difficult to process, resulting in reports that are very long and detailed (Simons, 2009). In order to mitigate this potential difficulty in this study, the focus of the research question was contained as much as possible without limiting the content of the data, so the paramedics were free to lead the conversation where they felt it was important to go, as long as it was part of their culture of coping.

The transferability or generalisability of the findings can be questionable because each dataset is completely context-specific and, with this in mind, a potential limitation of the case study methodology is the fact that the concepts elicited are "locked in time while the people in it have moved on" (Simons, 2009, p. 24). This is a significant issue in this research as the paramedics were interviewed in late 2015, and occupational stressors and the intensity of their distress has altered with the passing of time. This fact does not, however, limit the applicability or contribution to knowledge that the study provides.

The subjectivity of the researcher has also been criticised as a limitation of this approach, specifically regarding its influence on the inferences drawn and the resulting usefulness of the findings. Researcher subjectivity is inevitable, however, after a detailed discussion of the impact this may have on the interpretations, awareness of this fact can be reflected in any conclusions that the audience may arrive at (Simons, 2009). Subjectivity has been limited in this research by the constant requests for clarification of meanings by the researcher of the paramedics involved, to ensure that the interpretations were aligned with the intentions of the paramedics being interviewed.

5.4.2.2.1 Acknowledgement of researcher bias

I have had several years' experience in different emergency services in a voluntary capacity over the last 30 years, commencing with 4 years' experience within the service under investigation. Since this time, I have always been occupationally involved in the health system, and for the last 17 years have been involved in mental health wellbeing in some form. The affinity and concern for this occupational group is longstanding and would conceivably influence the interpretation of the meanings of many facts discussed within the interviews; however, attempts were made to not assume connotations or implications. The

most apparent of these efforts related to allowing each paramedic to fully disclose the information they wished to impart without any interruption, or insertion of comments of understanding or contradiction by the researcher to pre-empt the details.

5.4.3 Interviews

Qualitative research interviews are social constructions between two people that are specifically designed to understand the meanings underpinning the central themes that have been articulated from the subjects' own perspective of their lived daily world. These interactions involve a collaboration between researcher and participant where both are engaged in the processes of making meaning and producing knowledge (Silverman, 2013). They react towards each other and mutually influence each other; the resultant interview data is essentially contingent upon the rapport/dynamics or interpersonal relationship established in the brief period of time that the interview is conducted. This must be taken into consideration in the analysis because information obtained by one interviewer will not be identical to that obtained by another (Brinkmann & Kvale, 2015). In line with this, qualitative researchers must also recognise that their own background shapes their interpretation, and they "position themselves in the research to acknowledge how their interpretation flows from their own personal, cultural, and historical experiences. Thus, the researchers make an interpretation of what they find, which is an interpretation shaped by their own experiences and background. The researcher's intent, then, is to make sense (or interpret) the meanings others have about the world" (Creswell, 2007, p. 20).

Interviews are descriptive, specific, focused, and sensitive: specific situations, actions, and experiences are described by the participant as precisely as possible. There is a great variety of styles and approaches to the interview process, such as that of an ethnographic interview which looks and feels little different from an everyday conversation, and is inherently spontaneous and without any specific agenda unless intentionally certifying certain interpretations that were previously mentioned. Semi-structured interviews, however, provide data collection by asking focused, but often also open-ended questions; not fully structured but also not directionless. The research interview, while still emulating an everyday conversation, actually targets both the factual content and the foundational meanings attributed to them. The emphasis is on allowing the participant being interviewed

to be able to answer without being limited by pre-defined choices – something which clearly differentiates qualitative from more quantitative approaches. To complete the comparison, "the precision in description and stringency in meaning interpretation in qualitative interviews corresponds to exactness in quantitative measurements" (Brinkmann & Kvale, 2015, p. 33).

It is generally the researcher's task to focus on the themes of the research, but within these boundaries, it is the responsibility of the subject to emphasise the components or dimensions of the issues that are important to them. The interview questions usually start by being broad and general so that the participants can construct the meaning of a situation, a meaning typically forged in discussions or interactions with other persons. The more open-ended the questioning, the better, as the researcher listens carefully to what people say or do in their life setting. Thus, the researcher often addresses the "processes" of interaction among individuals. They also focus on the specific contexts in which people live and work in order to understand the historical and cultural settings of the participants. However, situations and meanings may be interpreted in several different ways and there can be ambiguity and contradictory statements, but the researcher needs to ascertain if they accurately reflect objective contradictions within the lived experience.

There is also a fine line between researcher sensitivity and knowledge regarding the topic and their ability to be as 'presuppositionless' as possible; always open to the introduction of new meanings or viewpoints. Brinkmann and Kvale (2015) addressed this difficulty by recommending that the researcher acts as with *deliberate naiveté*: displaying open curiosity rather than pre-formulated ideas. In conducting this case study, the in-depth interview was used due to its ability to elicit richer, and more detailed and diverse information, despite the relatively small sample size (Von Dietze & Gardner, 2014; Williams et al., 2005). Qualitative methods are better able to provide rich insights into human behaviour and social processes, and the qualitative research interview has been successfully used in research regarding the decision-making process pertaining to the specific use of coping strategies in the face of particular stressors (Williams et al., 2005).

5.4.3.1 Limitations

Even in semi-structured interviews, questions tend to be, through necessity, specific and focused. The topics are still pre-set by the researcher, with the researcher's view of what is important being paramount and, as such, it may be impossible for the respondents to express their opinions as fully as they may wish to, making it difficult for the interviewer to elicit all the data or information required (Malek et al., 2010). However, in adopting the *deliberate naiveté* stance recommended by Brinkmann and Kvale (2015), it is hoped that the participants can feel comfortable enough in leading the direction of the interview by what they consider to be the most important or significant information. A small sample size may present some problems as a result of the limitation of the range of participants; however, this is counteracted by the richness of the data or the 'thick description' that each individual participant is able to provide (Von Dietze & Gardner, 2014). The diversity of the participants interviewed, and the range of ages and levels of experience acquired, can be considerably broad.

5.4.3.2 Current interview design

In order to develop a rapport with the participants, preliminary enquiries involved simple, unambiguous demographic questions about age and marital status, which were aimed at enabling the participants to relax, and indicated the style that the following interaction would take. Each participant was initially asked to describe their motivation for becoming an ambulance officer or paramedic, and what was good / positive / fulfilling about their role. This transitioned reasonably into a discussion about the contrary issue of the bad / negative / stressful aspects of being an ambulance officer/paramedic, with an emphasis on both characteristics of the work process and also specific traumatic jobs or cases. Questions about the possibility, logistics, and expectations of mental health protection while traveling to a job, while at the scene, and post-event were also explored with each individual. Furthermore, popular methods of coping were examined, including perceptions of the utilisation of formally provided services designed to assist members in their efforts to cope.

Other specific questions included:

What makes a good paramedic? Is there a specific personality?
Is it possible to prepare emotionally for a tasking?

Is it acceptable to display emotion while at a scene?

What do you do after a stressful/extreme/upsetting job; what happens?

What coping strategies do you use and where did you learn them?

What coping strategies have you seen others use?

Does your team have your back / support you?

Is it acceptable to use Peer Support?

5.4.3.2.1 Refining the questions

In this study, the wording of certain questions was subtly altered to ensure the correct information was obtained. For example, originally, in order to determine which jobs or taskings were potentially psychologically disturbing, the term 'upset' needed to be intermitted with terms such as disturb, bother, unsettle, concern, and worry, because different paramedics attributed slightly different meanings to each term. Clarification would be extracted by reframing the question to incorporate terms that the paramedic used to describe the situation or issue, paraphrasing statements, or stating an opposing view so that the participant would need to correct the researcher. I also reflected back to participants using the same terminology as they did, in order to stay with their meaning. The order of the questions also became more consistent over the course of the recruiting period, as a predictable flow in the conversation was established and the progression of thought processes had developed.

5.4.3.2.2 Recordings

Some of the interviews were occasionally unfinished due to a) technical failures, or b) the participant was called out to a job and the interview was suspended and recommenced if the participant returned, time allowed, or they were prepared to meet me again at another time. Due to these factors, the interviews lasted between 16 minutes and 2 hours and 20 minutes, averaging one hour long (see Appendix 1: Interview Durations and Participant Demographics). Informed consent was obtained from every participant prior to commencement of each interview (see Appendix 3: Informed Consent Form).

5.4.3.2.3 Sampling

The method of sampling used to select people to interview was a combination of theoretical and convenience sampling. Taylor and Bogdan (1984) stated that in theoretical sampling,

the actual number of “cases” studied is relatively unimportant. What is important is the potential of each “case” to aid the researcher in developing theoretical insights into the area of social life being studied. After completing interviews with several informants, the type of people approached for the interviews varied until the full range of perspectives held by the people of interest had been uncovered; this point was reached when the interviews with the additional people yielded no genuine new insights or saturation was reached.

Although this was the guiding principle, the actual method of selection was more dependent on convenience. The invitation to take part in the research was distributed to every member of the organisation which essentially included every member of the target population, potentially enabling a true random sample. However, obvious biases immediately came into play. Voluntary response samples are always biased because they oversample people who have strong opinions and are motivated to have those opinions heard. Responses were obtained only from members who had an interest in mental health and a respect for the research process. Nevertheless, taking this fact into consideration, I assumed that members who have an interest in mental health wellbeing were much more likely to have applied critical thought processes to the topic in their private lives, and may well have been better equipped with knowledge / thoughts / ideas / experiences relating to the topic at hand. Returning to a more theoretical basis for the sampling enabled the themes to emerge and to be explored with the 23 participants.

5.5 Subjects

5.5.1 Profile and recruitment

The participants in this study were sourced from within the entire population of operational members of the ambulance service. Within the recruitment period, there were approximately 1,400 members on the organisations’ email listings, the majority of whom were operational and therefore could potentially have taken part in this research. An email with the Letter of Introduction (from both the university and the Professor of Paramedics of the university that educates the local paramedics), the Participant Information Sheet, and the Consent Form attached was sent to all team leaders by the office of the Executive Director Clinical Performance and Patient Safety of the organisational body. The team leaders were requested to encourage members of their team to register an interest in

taking part. Originally, it was stated by the administrative officer that three or four members of the same team (with or without the team leader) were needed to agree to conduct an interview to achieve the objectives of the research. As recruitment was severely limited when participation was contingent on the interest of several members within a single team, the requirement was relaxed to include individual operational personnel. Very few participants registered an interest outside of their team leader's encouragement. All other members were recruited either by their team leader directly informing them about the research, or by the team leader allowing me to be present at the station for a period of time to distribute information sheets and to strike up conversations with members who flowed into the station while I was in attendance.

The recruitment period was essentially undefined, but occurred in short bursts of intensive activity. Interviews were conducted during September and November 2015. Although other periods of time were spent discussing the research with other team leaders and attending other stations, no further participants were obtained after November 2015. As the number of interviews achieved by that time marginally exceeded the number that had been approved by the Social and Behavioural Research Ethics Committee, and themes had emerged and been confirmed, extended, and described exhaustively by the remaining participants indicating saturation, the recruiting period was terminated after January 2016.

5.5.1.1 Participant demographics

In total, 23 participants took part in the interview process. Just under two-thirds were male (n=15, 65%) and the remainder female (n=8, 35%). This is not representative of the current population of paramedics within this state, as the Ambulance Service Annual Report 2015-16 disclosed that the female composition of the workforce is now at 46% (Silent 1). A broad range of ages were represented in the respondents (23 to 68 years), with an average age of 45 years. Unfortunately, despite several attempts/requests to interview them, the age bracket of 30 to 39 years of age was entirely unrepresented. However, when dividing the participants into three distinct age brackets according to their associated generation, Generation X (a category to which half of the 30's age range would fall) was over-populated, and this corresponded to the proportionate figures reported in the Ambulance Service Annual Report 2015-16. Therefore, it is expected that this 'deficit' will not appreciably affect the findings.

There was a diverse and almost complete range of occupational roles accounted for among the participants. These included: interns, graduates of the Rural Sponsored Degree Program, newly contracted employees, ambulance officers, paramedics, extended care paramedics, intensive care paramedics, team leaders, union and ex-union representatives, and peer supporters. This inevitably provided differences in experiences, and therefore, opinions on the topic at hand. Other factors influencing experience and exposure level was the incidence of members initially becoming exposed to emergency transport work by volunteering for the service. Ten participants had achieved their preliminary experience within a volunteer unit.

The localities of the participants were also reasonably evenly represented, with 26% working in a rural/remote area, 30.5% working in a large country town, and 43.5% working in a metropolitan city. As this was necessarily a convenience sample, it was to be expected that the number of rural/remote and country participants would not reflect the population of personnel distributed around the state, understanding that considerably more members are employed to cover the metropolitan area (see Table 2).

In order to launch into a meaningful discussion on social support as a coping mechanism, specifically that relating to the utilisation of the family, the question of a spouse's understanding of the work environment/taskings came into play. Colloquially, spouses have been separated into three categories: another ambulance personnel, a member of an allied health service (nurse or other health system employee), or someone employed in an occupation that has nothing to do with health at all. The level of similarity in the spousal occupation was expected to affect the extent to which they were included in debriefing conversations with their paramedic partner. Of the 20 participants who mentioned significant others, there was an equal mix of health related and non-health related partners, with a slight majority of health-related spouses actually being paramedics themselves.

Table 2: Participant demographics

Interview	Gender	Generation	Location
1	Male	Gen X	Remote
2	Male	BB	Remote
3	Female	Gen X	Remote
4	Male	BB	Remote
5	Male	Gen X	Remote
6	Female	Gen Y	Remote
7	Male	BB	Country town
8	Male	BB	Country town
9	Male	BB	Country town
10	Female	Gen X	Country town
11	Male	Gen Y	Country town
12	Male	BB	Country town
13	Male	BB	Country town
14	Female	Gen X	Metro
15	Female	Gen X	Metro
16	Male	Gen X	Metro
17	Male	Gen Y	Metro
18	Male	Gen X	Metro
19	Female	Gen Y	Metro
20	Male	Gen Y	Metro
21	Male	BB	Metro
22	Female	Gen Y	Metro
23	Female	Gen X	Metro

5.6 Analysis

5.6.1 Transcription

Transcription was performed partly by the researcher and by a professional transcription service under the terms of a confidentiality agreement.

5.6.2 Coding

“In qualitative data analysis, a code is a researcher-generated construct that symbolises and thus attributes interpreted meaning to each individual datum for later purposes of pattern

detection, categorisation, theory building, and other analytic processes … a code represent[s] and capture[s] a datum's content and essence" (Saldaña, 2013, p. 4). Coding is a process of methodically arranging data that allows the researcher to combine sets of phrases that have similar meanings, explanations, and essential attributes. It assists in the exploration of patterns of all descriptions within the data and helps to promote potential explanations for the existence of these patterns. Pattern development initially occurs as codes are grouped into categories because of shared characteristics, and it is the discovery of these patterns due to the repetitive nature of human behaviour and culture that is essentially the primary role of the researcher (Saldaña, 2013). However, this is an extremely subjective process and all interpretations may be questioned and must be justified and backed up with logical evidence.

First cycle coding involves the selection of single words, phrases, or paragraphs, and combining them under a single symbolic term indicating their similarity of meaning. During the second cycle coding process, codes and categories become more refined as some are absorbed into other codes, more sophisticated sets of meanings emerge requiring the alteration of terms, or initial codes are determined to be the views of the researcher rather than participant-generated processes, emotions, or values, and therefore, need to be eliminated altogether (Saldaña, 2013). The transcripts of the interviews were coded using a combination of techniques. The first cycle coding methods centred around open (or initial) coding in which all statements were completely unravelled and the individual components thoroughly examined for variances. The wording of the codes called for the utilisation of sub-methods including: structural coding (particularly suited to transcripts of semi-structured interviews, where the codes are question-based), descriptive coding (essentially topic coding), process coding (terms describing actions), and simultaneous coding (where a single datum is included in more than one code). The second cycle initially involved sub-coding (as the initial codes required more extensive categorising) and axial coding (to strategically reassemble the data after the first cycle) (Saldaña, 2013). First and second cycle coding was performed using QSR International's NVivo 11 Qualitative Data Analysis Software (QSR International, 2015).

5.6.2.1 Thematic analysis

While interpreting the data obtained during the research, thematic analysis was used whereby the key issues raised by the participants were coded together and examined individually to elicit a number of themes (ensuring there was minimal overlap between themes). Once all the material had been analysed, each theme was summarised, and the quotes judged to be the most relevant or that best captured the essence of the theme were selected for use. Each theme was also reviewed against the transcripts and codes to ensure that they accurately reflected the issues raised by the participants (Von Dietze & Gardner, 2014). Thematic analysis breaks down components of a participant's descriptions of observations, actions, and perceptions of their 'lived' experience which is constantly embedded within the socio-cultural context (Simons, 2009). To quote Silverman (2014), "Discourse is constructive in the sense that these assemblages of words, repertoires and so on put together and stabilise versions of the world, of actions and events, [and] of mental life" (Silverman, 2014, p. 319).

The data obtained were analysed by identifying common knowledge, beliefs, opinions, and strategies stated by the paramedics while discussing their practices, relationships, habits, and specific episodes regarding their experiences with personal mental health wellbeing maintenance. Patterns developed after ascertaining that several paramedics shared similar attitudes to events, situations, or issues, and the actual magnitude of stress attributable to them, which were novel to the researcher. The data also identified characteristics regarding the use of specific coping strategies, including preferences and the determination of when particular strategies were necessary. Likewise, opinions concerning the practicality and worth of the support services formally offered by the organisation were expressed. The themes that emerged from this research effectively described the experience of paramedics about how they look after the mental health wellbeing of both themselves and each other. This might shed some insight into how this knowledge could be included in the education of future paramedics, or as background for investigating further possibilities in formal support strategies. The emergent themes were categorised according to the following criteria:

- What is actually stressful and what, despite public perception, is not
- Coping methods most commonly adopted

- Humour
- Differences in culture/attitudes/behaviours based on location
- Differences in culture/attitudes/behaviours based on generation
- Relationships with colleagues
- Debriefing and reflections
- Organisational support

All efforts were made to ensure that any interpretations were unequivocally connected to the original transcript statements to enhance credibility and validity (Fereday & Muir-Cochrane, 2006).

5.7 Research Integrity

The trustworthiness of a research study is tested by four naturalistic analogues to the conventional criteria of internal and external validity, reliability, and objectivity, which are termed “credibility”, “transferability”, “dependability”, and “confirmability”, respectively (Lincoln & Guba, 1985). In qualitative data, internal validity is essentially the credibility of the interpretations; whether or not the extrapolations that the researcher makes, or the conclusions they draw, are actually sustained within the data and that the evidence is located within the participants’ accounts and different explanations or interpretations that have been explored (Silverman, 2013). This also enhances the ‘transferability’ of the data. Also referred to as ‘representativeness’ or ‘generality’, the validity of this research has been taken into consideration by including the rationale or criteria for the inclusion of specific quotes over others, tabulating frequencies of specific pertinent phenomenon, and attempting to ensure that an applicable level of member checking of information has occurred.

Both reliability (referred to as “dependability”) and objectivity (“confirmability”) are addressed by using a participant’s ‘concrete’ verbatim accounts as often as practicable, including enough length of transcript for the reader to be made aware of the context of the conversation and to enable them to come to their own conclusions, rather than predominantly offering only reconstructions and paraphrases (Silverman, 2013).

5.8 Summary

The current research was performed using a case study design which specifically employed the tenets of a naturalistic inquiry. Data collection took the form of semi-structured interviews, which were openly coded, from which themes were extrapolated. The information obtained will be further discussed within the socio-cultural context of the data in the chapters that follow.

The following five chapters describe the perspectives of the paramedics. The first two of the finding chapters relate the foundation opinions of the paramedics to set the scene of the current occupational climate before focusing on the issues under closer scrutiny. The first of these, Chapter 6, describes the working environment that paramedics encounter while performing their responsibilities, including their roles within the service, what they enjoy about their work and how the observe the expectations of the public. Chapter 7 illustrates how the paramedics view their current occupational culture and that specifically relating to coping, before elaborating on what they believe a new recruit would need to know in order to protect their mental health into the future while engaging in this occupation. The following three chapters expand on the culture of coping and how this differs for paramedics due to a number of factors. The factors under review in this thesis are the location of a paramedic's primary station, their age or generation and conditions which they encountered when embarking on working life, and the changes that transpire due to societal evolution, such as the effect of political correctness on a paramedic's use of humour.

CHAPTER 6: THE WORKING ENVIRONMENT AND STRESSORS

6.1 Introduction

In order to appreciate the development and maintenance of a culture of coping, there must be an understanding of the environment that paramedics are immersed in and consistently dealing with. Assumptions should not be made about the issues and situations that are considered to be stressful and, by their very nature, require strategies to cope with. From the moment an individual commences their pre-hospital emergency medical education, the organisational culture plays a part in determining what a paramedic will judge as disconcerting or challenging, and overwhelming or exciting.

The first component of this chapter describes the working environment of the interviewed paramedics, including their differing roles. What they enjoy or appreciate about their occupation is touched upon by relating what a 'good day' looks like from a paramedic's point of view. This section concludes with an account of the particular beliefs of the public and the occasional pressure of living up to these expectations. The second component of this chapter develops in greater detail the stress that is experienced by paramedics. The specifics of what, contrary to expectation, is not considered stressful, and the reasoning behind it, followed by the situations and issues that are considered stressful, is also discussed.

6.2 The Working Environment

Within a state-wide paramedic service, it is understandable that the various locations will have different working environments and conditions, and therefore, different norms and expectations of what a work shift is likely to encompass. In rural and remote regions, the average day consists of low category, non-urgent work; for example, hospital transfers. An average 24-hour period would apparently see a crew sent out to 3.85 jobs (personal communication). One member summed up the situation concisely:

> *So, its rosters, personnel management, work, auditing, and that's pretty much the day, and sitting around looking for something to do. There's always something for me to do (Int. 2).*

The working environment of the metropolitan area is different. Paramedics often go from one job to another without pause, and even meal (crib) breaks are delayed or missed because of the numbers of jobs pending. Time with individual patients may be shorter than their rural counterparts and the nature of the jobs may be different:

> *In the country you'll be with your patient a lot longer. There's a bit of an unwritten rule that in the country, people will call you because they're quite unwell, whereas in the metro, people call you when they're not unwell (Int. 14).*

> *Most ambos have learnt how to scoff a full meal within 20 minutes and even then, you can still get that broken, so you just eat as fast as you can and then just in case the pager goes off. There's always that little listening out post just waiting for that pager to go off as you're eating (Int. 1).*

There are some working situations that transcend location. The pre-hospital environment presents unique challenges that can also be physically and/or emotionally demanding. The following paramedics described this in some detail:

> *We don't work in 4 walls, we don't work with fluoro lighting, we don't work with … a large team room. We're pretty much on our own with our partner ... But we work outside, we work in 40-degree heat, we work in muddy fields, we work on beaches, we work upside down in vehicles trying to cannulate people (Int. 1).*

> *It's quite a heavy, can be a heavy job, a difficult job if, if someone's unconscious in a house and you drag them out, it's quite a big job, it's quite a strenuous job on your back, on your shoulders (Int. 15).*

> *An ambulance doesn't get called when you're having a birthday party and you need people to come around to help celebrate. We're getting called because people are in varying stages of probably one of their worst days. So, you sort of go in already knowing that you're going into emotional and stressful situations (Int. 1).*

The actual work has altered over time with advances in technology and engineering. However, certain aspects remain comparable. The next set of paramedics stated how the kinds of patients they attend to remain similar and that their role is equally constant:

> *Yeah, but like she said, 90% of your job doesn't involve blood and gore. Maybe not 90%, but a lot of them are chest pain, short of breath, they've had a fall, they've got a fracture, it's not all blood and gore everywhere. Even cars are so safe nowadays you get a big MVA and air bags and crumple zones and you look at this car and think oh my God, nobody can survive that, and up jumps somebody and walks away and you go oh, do you think they can fix it? (Int. 18).*

My job is to make sure that they're safe, I'm safe, my partner's safe, and get them to the hospital. End of the day, that's what I do at every case. So, it's just a matter of making sure that we can facilitate a transport that's safe for everyone (Int. 19).

Yeah. I mean it's a case by case basis. Sometimes, we have lots of information, sometimes we have not much, sometimes we see a job on the screen and we go, well this is a generic job that we've been to 100 times before, a certain type of, groups of patients that they fit in, like the drunk 18 year old down the Bay which we had last night – even though it's unique in it's an individual person that we're being called to its still, we've been to that patient 100 times before if you know what I mean (Int. 20).

6.2.1 Roles

For the sake of simplicity in this research, all members have been referred to as paramedics; however, there are a number of operational roles within the service that personnel can train further for to specialise in. The different roles determine what type of patients and conditions each member will primarily be dealing with during the course of a shift, but also the support they are able to call upon and the inter-professional personnel that are available to interact and discuss cases with. The following four roles require different skill sets and expose the officer to different patient cohorts, conditions, and supports:

6.2.1.1 Ambulance Officers **(AOs)**

These officers have completed a Diploma, receive the standard emergency care and transport training, and have limited responsibility due to the reduced number of protocols they are approved to perform. They are usually rostered with a more highly qualified practitioner or are restricted to non-emergency transports and low acuity work, such as hospital transfers. This equates to the majority of jobs entailing transferring elderly patients to and from hospital outpatient department appointments. While jobs of a more emergency nature are encountered, the overall stress load is reduced.

As an ambulance officer, I don't have the responsibility that I've had before, you know with drugs and the doing this and doing that and everything else ... you know if I run into trouble, all I have to do is get the radio on and say I need help, as opposed to having the responsibility myself (Int. 8).

6.2.1.2 Paramedics

Officers with a paramedic qualification have completed a three-year university degree in paramedicine and been involved in industry training in the form of an internship year (this includes those in rural areas who have completed Vocational Education Training under the title of the Rural Sponsored Degree Program [RSDP]). They are able to execute the complete range of protocols ratified by the employer's medical committee.

6.2.1.3 Intensive Care Paramedics (ICPs)

These are paramedics who have also completed an advanced training course in intensive care. They often work alone and are dispatched to a scene as a rapid response (referred to as a SPRINT car – Single Paramedic Response Intervention which can achieve a shorter response time than a conventional crew), or as a more qualified backup to a more complicated scene. Working alone may be perceived as more challenging due to the limited time available to process a clinical plan or to think through emotional protection.

> *I work by myself … so I'm driving, I'm looking at the traffic and I don't really have a chance to consider what I'm going to until I get there, which is a little more challenging. So, you're sort of going in, not blind, but you're not able to prepare as much as you might if you're on an ambulance or something like that, it's a bit different (Int. 21).*

6.2.1.4 Extended Care Paramedics (ECPs)

The other advanced training option available to paramedics is essentially in palliative care and care of patients with chronic conditions, in order to enable them to stay at home:

> *Extended Care Paramedics, it's based around the world. It's all city-based programs and it's now keeping people out of hospital as best they can (Int. 2).*

ECPs tend to work more autonomously, but also liaise more frequently with other healthcare professionals (nurses, physicians, etc.) for the benefit of the patient. There is also more support in the form of backup decision-makers with the same training who are able to look at the situation from a different perspective because they are not at the scene. There is often repeated exposure to patients, and the intimacy of getting to know the patient and their families in vulnerable circumstances may lead to an increase in emotional investment, and therefore, potential stress. However, the next paramedic described the comfort or ease of tension/stress by having the opportunity to prepare for what they are going to encounter:

Yeah and the only difference is with this role because we do so much palliative care. At least on that, the other, is I've got someone in the communications centre, another ECP who's phoned the scene. So, we've got some discussion of what's going to happen when we get there, but that's while we've got time to do that. It's not an emergency. ***It's not lights and sirens, it's got silence,*** *but it's still end of life palliation and that sort of stuff. I don't think it increases emotional involvement, but at least you're more prepared to what you're thinking you're going to have to do and who's involved, because the other part of this role which is good is, and this is what I like about the ECP role, is there's a lot of liaison between different groups ... so, there's the sharing aspect of it (Int. 16).*

6.2.1.5 Other institutional roles

Other roles within the organisation have an impact on the level of occupational stress and exposure to potentially traumatic emotional pressure. The two that have the greatest bearing on the variety of stresses encountered are team leaders and peer support officers. Team leaders have an extra managerial component to their workload. Managing staff seems to mean taking up their issues as well as, if not before, one's own.

For me as a team leader, it's mainly just, um, mothering the team really and doing whatever paperwork happens. Interestingly enough, the teams of 6 take up as much time as the team of 200, when I was looking after a large group of volunteers and a career team, and it doesn't matter how many people you have, they just take 100% of your time, because they can (laughs) (Int. 2).

I've seen it happen to people [getting emotional at a scene], not very often but a couple of times, and as my role as a team leader, I've tried to deal with that at that point in time, so I remove that staff member from the scene, sort of try to counsel them at the time getting them support. Everybody is human and with the job you're confronted with things that are not in part of the normal view of what life should be, and you might find something that triggers something from somewhere and it just plays on your emotions I guess (Int. 18).

Another set of members, the communications officers and personnel in the call centre, were not interviewed and therefore were excluded from this analysis. This does not imply that their culture of coping is in any way less important, but it is apparent that their daily stressors are different to those members confined to the road and, as such, their opinions and perceptions need to be captured on this subject, rather than assumed through the perceptions of others. The paramedic views on this are captured in the section entitled 'Issues with Communications'.

After developing an understanding of the paramedic working environment and the impact that different roles have on the stressors encountered, the account moves to identify what is enjoyed and appreciated within the occupation, before dissecting the details of what is stressful or traumatic on an emotional level.

6.2.2 A good day

An understanding of what motivates a paramedic to be involved in this first responder work will help to clarify the differences in perspective when describing what is perceived as stressful or non-stressful. Paramedics do not crave a quiet peaceful shift and, for the majority, their foundation incentive is helping others. The following paramedics revealed that the aspects that many would expect them to find stressful are actually the most enjoyable in a day, and that it is the scope of jobs from the challenging traumatic jobs to the mundane jobs where they are able to make a difference that counts to them:

> *[Laughs] I have a good day if I get a coffee and a muffin too! But I'll have a good day if someone has a massive heart attack, and I've put in a cannula and I managed to get them to hospital in time. And then I had this job where I got to do this skill and we had a good outcome ...* ***so, my good day will be several people almost dying and not dying!*** *… I went to an attempted murder once ... which is terrible ... but it was a great job and I had a great day ... like there were police there and this happened ... It was great, and everything went really well, and we had a good outcome, and it was fantastic! (Int. 6).*

> *One of the good things about this job is that you can walk away at the end of the day knowing that you have made a difference to somebody, even if it's just pain relief or it might be saving a life, or it might be just that you helped a little old lady put her cat out before you took her to hospital. So, if you're in the job for the right reasons, I think that's – that helps because there is an end goal rather than just oh I didn't do anything useful today, which is a complaint I hear a lot. So – I didn't do a good job today, all I did was take people to hospital and none of them were sick; you know, I didn't do the big, bad road trauma or I didn't – and that, some people tend to focus on the "I'm an Intensive care paramedic and I didn't use any of my skills today, so clearly, my day was a waste of time", as against "I might not have intubated somebody or cannulated somebody or cardio-verted somebody, but on the other hand, I've held a little old lady's hand because she wasn't coping at home (Int. 21).*

> *The most I get out of the job is the time just spending in the back of an ambulance with oldies who tell you all sorts of fabulous stories so, and just feeling, I suppose, like you just make it that bit easier, make time go a bit quicker by just chatting (Int. 10).*

6.2.3 Public expectations

One of the factors that influences the experience of stress for paramedics is the general public's view of the paramedic. When the paramedic puts on the uniform, they feel like they have to live up to the trust and faith shown by the public. Several paramedics expressed surprise at the level of trust afforded to all ambulance personnel. They are called when individuals are at their most vulnerable, but patients and family members allow complete strangers into their homes without a second thought.

> *Well, yeah. I mean I think ambos have had "most trusted profession" for God knows how many ... and nurses ... because there's not too many other jobs that you can just walk into someone's house and not be a threat to the people in the house. They don't know you, but because you're in uniform, they've got either respect for the uniform or ... there's just a zero-threat level from us when we come in, and that can be quite beneficial when we come in on some scenes, especially if there's any form of angst or aggression or anything like that, because we're going in there and just wanting to do the job; we're not there to judge. I personally wouldn't let just anyone walk into my house, but to have ambos come in, you just open the door and let them walk straight in (Int. 1).*

Members of this service recognise and appreciate this fact and have often counted on it. Trustworthiness has been integrated into their identity with the realisation that they are not a threat in any way and not going to steal anything. However, others believe that trust is given too easily. Looking out from underneath the role of the paramedic, some members do not appear to wear the perception as comfortably as others.

> *We're a bunch of immature children who, if the public really knew what we were like, we would not be trusted at all because we're – and I think it's just how we are. It's our culture of how we are. We're not a serious bunch (Int. 14).*

The automatic trust can have a bearing on the level of influence achievable. It is occasionally beneficial, especially when encountering a potentially difficult negotiation scene to help get the best outcome for all involved. As the paramedic below noted, this trust helps them form a close bond with patients that is highly valuable given the time constraints:

> *To form a bond with people quite quickly and for most of us we love our patients. Even the wankers. You can, it always surprises you just how much influence we've got on people. Sometimes, you just go, I'm never going to get through to this bloke, we're very different, I'm an older female and he's a younger man, he's intoxicated and I'm in a uniform. So, we've got, we've certainly got some barriers already there, and it always surprises me that you've got an ability, and I don't know how you get it to kind of find common ground (Int. 14).*

The general public value what paramedics do, the jobs they perform, and the tasks they complete. However, some paramedics do recognise that there are potential side-effects if the adoration is not kept in perspective:

> *People value what you do, and when you are valued you just get a really big head! (Int. 2).*

But this reverence can also be a separator, and some have experienced situations that demonstrate that they are not viewed the same as other members of the general public. This is the same issue experienced by GPs and other medical practitioners where they are not expected to be ill in any way:

> *I think it's a funny thing when you go to the doctors for something which is an injury or something ... you just need to go to the doctor, and people recognise you, there's this comment comes out "Ohh, what are you doing here?" and it's almost like your superman, you've got this invincibility, you can't get sick (Int. 4).*

This idolisation is also apparent in the way the public perceives the job that paramedics perform, compared to the paramedics' understanding of the tasks they complete:

> *I hate it when someone says "Oh how do you do your job? You're special people." We're not special people. It's a job (Int. 4).*
>
> *I mean, certainly got a lot of friends that when you talk about a job, they go "oh God, I could never do that", and you go "that's fine, I could never do what you do either (Int. 11).*

Paramedics must always convey a calm and collected appearance, even if this contradicts how they feel in that moment. These paramedics talk about the experience of dealing with this situation:

> *To the public, we've come out and we're ... they haven't got a good visual sight of the paramedics or anything, but if we get out and just we think oh shit, oh shit, but then if we give the appearance that yes, this is what we are going to do, everyone's reassured that we do know what we're doing, and things will run a lot more smoothly (Int. 5).*
>
> *For ambo's for instance, if you appear panicked or don't appear completely in control or even slightly bored at a job … you've got to, there's a, you've got to be like a duck. You've got to be cool and groovy on the outside, paddling like a mad thing underneath (Int. 14).*

The elevated levels of trust can also leave the general public with expectations that are not grounded in reality. The following quotes pick up on the powerlessness or frustration that this can generate:

> *People think we can save or do anything, that's not always the case (Int. 8).*
>
> *Because some people have an expectation of what you're going to do, which is probably completely inappropriate or the old style of exercise in futility that we're doing CPR to keep everyone happy until we can get them to hospital and some mean person can say, no they're dead (Int. 16).*
>
> *But I think people's perceptions of paramedics, not many people know what we can do and what we have got the chance to do, so quite often – because that's not what they see on television or they don't quite understand what pads are or things like that, they sort of – they can't put one and two together, and then they go, we haven't done everything or you need to take them to hospital, what do you mean you're stopping here? You can't do that (Int. 22).*

Public perception of what is stressful to a paramedic is often just as unrealistic as their belief in their capabilities. The attitude that 'gory' is either exciting or terrifying is also inaccurate, and often serves to reinforce and intensify the sense that paramedics are isolated or separated from the reality of other people and that only other paramedics will understand what they are experiencing.

> *I mean, like all of the stuff that we go to, like it's not the big bad gory stuff that everybody thinks that it is (Int. 19).*
>
> *Coz you go out with a group of mates, what do you do, oh paramedic, bet you see some … What's the worst thing you've ever seen? It's like the number one question, you must see some horrible things, what's the worst thing? No, I don't want to talk about that, just do whatever we're doing … and what's the worst thing, you know that they're looking for something gory (Int. 18).*
>
> *When you tell people that you're a paramedic, and they go "Oh, you must see some terrible things", it's almost the generic response, greater than 90% of respondents, and they're expecting you to say that "Oh yeah, I see people's brains and blah, blah, blah." No – when people say that, I'm thinking – yeah, I went to this real bitch last night that told me that I was worthless, and blah, blah, blah (Int. 20).*

As the above paragraphs indicate, there are many situations that paramedics do not find stressful. The following section outlines the paramedics' views on their jobs, the people, and the issues that do touch them emotionally.

6.3 Stressors

In order to understand how paramedics cope with the stressors they encounter in the sphere of their working environment, their description of what stress is, and their perception of what occurrences or situations cause stress must first be established. 'Stressful' as a term can be construed as annoying, aggravating, disturbing, upsetting, horrifying, challenging, or saddening, despite the fact that these are not interchangeable concepts. The Oxford Dictionary defines stressful as "causing mental or emotional stress", whereas another term used by the paramedics was 'upsetting', which is defined as "causing unhappiness, disappointment, or worry", which has a more negative connotation (Oxford English Dictionary, 2019). The level of stress felt is also influenced by the expectation of what will be encountered, and the knowledge of what needs to be achieved:

> *I think we are pretty prepared every day because this is the job. The average person driving along in their car isn't expecting to see a baby that's dead, or a birth that's just occurred, you know, or you've just hit a cow and decapitated a cow, you know – that's horrific. And yet they make the call. I don't know how they cope. And to me, they're more at risk because there's no expectation that they're going to come across these things, but they're the ones that come across things first, they're the ones that always see the grotesque things first (Int. 2).*

> *They're upsetting, that doesn't make them stressful. Any unexpected death is upsetting. No-one expects a 4-year-old or a 6-month-old to die. Where they get stressful is the reaction of everyone around it (Int. 16).*

When the organisation believes that a paramedic has attended a scene that may cause them some psychological distress, they deploy a member of peer support. This is a set of off-duty, operational paramedics who have had specific extra training in counselling skills, recognising signs of acute or chronic unresolved distress, and providing social support. These peer support officers will contact a paramedic by phone when requested by the individual, the team leader, or the communications room, when they send crews to particular jobs. The comfort and support felt by paramedics on receipt of these calls differs widely, as will be discussed below.

6.3.1 What is not considered stressful

All paramedics are in essence enculturated from the beginning of their training. They quickly become intrigued or fascinated with challenging cases, and because of the competitive nature of the entrance criteria into university education programs and the knowledge that

only those with the highest marks will progress in this career, those who are not thriving on this challenge will have difficulty surviving. Jobs are segmented to enhance the focus on a series of tasks that need addressing according to a relatively fixed checklist or protocol. In this manner, issues that the general public could believe were highly stressful, become commonplace or even mundane. The following quotes reflect how unexciting many situations are, and that even death is not stressful to them:

> *Sick people are sick people, a broken leg's a broken leg, it's just on a different body (Int. 8).*
>
> *Even a dead patient's no more than a bag of wheat to me really (Int. 9).*
>
> *Because they just become a job to me … like a hanging is just a job (Int. 6).*

However, it doesn't follow that paramedics do not treat people as human beings and interact with compassion, empathy, and respect.

> *After 20 odd years, a lot of jobs are repetitive, but you don't treat them in a repetitive manner. You treat them each time as an individual case (Int. 4).*

Even though they do try to be holistic where necessary, it is in fact their ability to compartmentalise that appears to be the most efficient and most utilised coping mechanism. They are able to separate viewing the human as a whole, and only focus on the immediate part that requires medical attention.

Out of the 23 participants who were interviewed, 9 found it difficult to identify anything stressful about their job at all. With some considerable effort, two of these participants added cases that might make them physically uncomfortable, which included anything to do with bodily fluids and unpleasant aromas:

> *The worst thing is probably seeing poo and vomit and stuff, because nobody wants to touch that (Int. 2).*
>
> *Yeah … like smelly patients, smelly environments, and the smell just tends to linger, like if someone's vomiting or whatever, that's not a big deal, but having that smell hang around in the vehicle afterwards is gross (Int. 18).*

However, generally speaking, outside of human resource issues or those situations that arise from merely working with other people (which will be discussed below), the jobs are not universally regarded as stressful:

There's a saying and its 99% bullshit, 1% oh shit! (Int. 14).

6.3.1.1 Bread and butter jobs

What does not appear to have any ramifications for the paramedics, that lay persons assume must be emotionally challenging, are what are known as 'bread and butter jobs'. These are jobs that specifically utilise the skills that a paramedic has acquired and which are common. For example, as unpredictable as a shift normally is, cardiac arrests, respiratory episodes, and major trauma are possibilities that are generally expected to be encountered. When you consider as well the proportion of patients that die either prior to paramedic arrival, on the scene, or during transit to hospital, dealing with death is also necessarily a situation that is encountered often and considered an integral component of the work performed. The following paramedics spoke about the routine jobs and how they are not affected emotionally. This can divert them when the organisational support service (Peer Support) will call them to inquire about their mental health wellbeing:

> *You've got your bread and butter jobs which you don't really have to think about so much … Your bread and butter chest pains and respiratory stuff … you could do with your eyes closed anyway (Int. 2).*
>
> *We used to go to nasty trauma, probably every 7 days ... And I've been to some nasty, nasty trauma down here. But trauma is pretty easy to handle. I mean it's there in front of you, you can see what's happening (Int. 8).*
>
> *I mean, like all of the stuff that we go to, like it's not the big bad gory stuff that everybody thinks that it is, and if you do go to that, like we're pretty lucky that everybody that we work with is really down to earth and they've all been through it too (Int. 19).*
>
> *Dealing with the living is a lot harder than dealing with death, um, because I was going to say that things like fatalities and stuff probably, as much as they are horribly sad and everything, they're after the fact (Int. 10).*
>
> *You do a cardiac arrest, which is our bread and butter [and Peer Support calls us] "Are you Ok?" "Yeaaah!" (laugh) "The patient died" "Yeaaah! And … my job is dealing with people dying. Yeaaah! Bye! (Int. 13).*

6.3.1.2 Acutely demanding jobs

Despite being so called 'bread and butter jobs', cardiac arrests and major trauma situations also constitute jobs that are acutely challenging, which anecdotally cause a rush of adrenaline to meet the challenge, and inevitably a dip when the challenge has passed. The following paramedics explained this phenomenon:

I know it sounds truly awful, but it's ... not ... I want those good jobs, they do push me, they do extend me, it is the reason that you do what you do, you ... it's those moments you know that you can truly make a difference, and it is good application for me, so you want everyone ... it sounds awful, you want everyone to be fine, but sometimes the shit does need to hit the fan, so you can test yourself (Int. 6).

Like some of the jobs that are perceived to be bad by others are always perceived to be interesting or good by us. Like one of the most gruesome jobs I've been to is probably my most interesting, and the one that I've done the most case audits on of recent (Int. 17).

Your cardiac arrests and your traumas are always those ones that sort of stand out a little bit as being acutely demanding, and then there's a sudden drop off of adrenaline (Int. 1).

If I have a 'good crash', we get quite excited by that, and we did this and did that, and they needed this and that and [the medical retrieval team] did this and helicopter that – that was great. That's not – I don't think that's stressful to a lot of ambos … They don't seem to be upset by it, they seem to be quite thrilled by it (Int. 20).

One paramedic described the experience quite comprehensively:

It's like those jobs ... it's kind of like saying "Grand Final", so you know there's nerves, there's excitement, it's either going to go well, or it's not going to go so well and ... proud of ... a lot of that is going to be about how you performed yourself, so it would be like "I did everything that I could, I left everything on the field, … I can walk away with my head held high ... like even though I lost, I can walk away with my head held high. If you go "FUUUCK", you know if you start doubting yourself going "Ah, you know played poorly here, I missed that, that was my fault", then you come away from it feeling not so great about it. But it is like a Grand Final, so ... that's probably how I would describe the big jobs (Int. 6).

6.3.2 What is considered stressful

There are certain issues and situations that paramedics acknowledge are stressful aspects of their job or working environment. They include both obvious and unexpected scenarios. The following section highlights nine areas that paramedics have voiced as difficulties: dealing with receiving information from the call centre, managing the unknown, the monotony, jobs that become personally threatening, making mistakes, identifying with certain patients, psychiatric patients, paediatric patients, and being with relatives who are expressing their own grief.

6.3.2.1 Issues with communications

Most paramedics recognise the challenges and sympathise with their colleagues who receive the calls for the general public via the triple 0 calls. Call-taker staff within the communications room are not required to be paramedics and do not always have the associated medical knowledge. Their protocols and checklists appear to be rigid and they are not permitted to use knowledge of the context of the situation to re-evaluate the priority attributed to individual jobs. They are also responsible for the management of all the cars that are on the road that day. Despite the paramedics understanding the communications role, and often attempting to be tolerant, this is still the first contact they have with the job and often the quantity and legitimacy of the information is problematic, making for uncertainty:

> *Road ambos tend to have ... give comms ambos a really raw deal. They really think comms have just got no idea what they are doing and what have you, but comms have got it pretty hard. If you are interviewing people in a stressful work environment ...! ... if you've got a person on there ... from the call taker who's got the person on the phone, and you've got to give instructions to and stay on the phone with on a regular basis. They've got to work out where the nearest ambulances are, "Ok, have I got enough ambulances, where am I going to put my ambulances, do I need one for that and one for that or something else has come in." Along with all that is the policies and procedures that say you must do A, B, & C, & D, and you know if you don't, explain why. The stress levels up there are ridiculous, so you really need a certain personality to survive in that environment (Int. 3).*

> *I rarely, very, very rarely get cross with the coordinators because they've got a bloody hard job, and I certainly wouldn't like to be up there. No way on earth. I would like to be trying to keep on where everybody is at any one time and they're on the way back and I've got … and that's got this and that. I don't know (Int. 14).*

However, the paramedics also know that, metaphorically speaking, the communications personnel have their hands tied in that they are required to respond in a certain manner when certain details are given:

> *Yeah, it's definitely a frustration that we, just because of the way phone calls are often triaged that we're – those jobs become a higher priority (Int. 20).*

> *All of the priority 2's are probably priority 3's or 4's, but because they've mentioned one or two key words, they will actually get bumped up and a lot of priority 3's and 4's probably should have been 2's. So, you sort of treat every job with an air of, Ok, we've been told this but one or two words in that might go ... well it could also be this or it could also be this, it could also be this (Int. 1).*

So, when the call comes in, you've got call takers who must, although at risk of losing their jobs, follow a flowchart because they're not medically trained, and they have to follow this flowchart, and if they don't follow the flowchart, they're audited and then they're in trouble. So, regardless whether or not things don't seem right, they have to follow the – they say yes to a question, they have to go down this side and then they ask those questions. So, there's plenty of avenue, but it all has to go through this flowchart. It's quite strict. So, with that then, because that comes out, someone's called us we have to get an ambulance because a base has called. So well, okay, so that then gets sent over to the coordinator because it's blood and a child, it's automatically a priority 2 – because it's paediatric upgrade … Priority 2 and you turn up and Mum takes you into the kid's bedroom and says that kids got blood around its nose. Is there any blood on the bed, is there any blood, no, no, no, no? Just a little bit. Well, it's been picking its nose I think it's alright, it's asleep (Int. 14).

There are also functions that crews wish that the communications personnel managed in a more consistent manner, particularly to do with load sharing, where one crew is not given a break when another crew is under-worked, or a single crew has received a run of the same job:

Yeah, it's almost like, do comms not realise that part of their role is to spread the load out a little bit. If everyone is really busy and you've been flogged and you're now 6 hours past your crib break, you don't care. I don't find that stressful because everyone's busy. It's when you've been out all night, say Christmas Eve one year as an example. Our other crew that started an hour after us, had been on station for 9 hours and had slept all night. We hadn't had, we hadn't even had our breaks. It was just ridiculous tasking, and that is something I think a lot of ambo's will probably talk about (Int. 14).

The Coordinator gets stuff on his screen, he sends it out or she sends it out, but they've not thought about, hang on a minute, they've actually done 4 hangings this week. How about we just send out another crew for the – but they can't possibly keep all that in their heads ... They['ve] done 9 … hospital transfers today, they're probably sick of that. How about I just give that to somebody else? That sort of thing, but that's, it's not once again, that's not personal, that's procedural (Int. 14).

6.3.2.2 The unknown

One of the issues that extends from difficulties originating with communications is the fact that the information received does not necessarily accurately reflect the situation that the paramedics encounter when they arrive on the scene. Whether the address was incorrect, or the caller was unable to state the important information, the unknown factor can become a source of occupational stress. The following paramedics spoke about how they

are unable to prepare, or if they do, it is often at best a waste of time and at worst a distraction:

> *It's just the unpredictable nature of the job that keeps you a little bit on edge ... So, there is definitely a difference to the type of pages you get, and you sort of go into a job not expecting but contemplating what ... ok, we've been told this, but from force of habit and from jobs in the past, you know that it could be this, this or, this, and you know the progression of where some jobs can go. So, you sort of have in the back of your mind, OK, if it goes down this way, this is what I'm going to need to do, so you have 6 or 7 different pathways that you're thinking of at the same time (Int. 1).*

> *I work out, oh if it's an arrest only when I get there and it's a confirmed arrest, because there's so many jobs you get there and it's like he's dead, he's dead, and you find he's having a drink in the corner, but then the other is you'll walk in and they'll say, oh he's a little unwell and you find he's been dead for 2 days. So, it's that, you don't know (Int. 16).*

> *[I] have a belief really that you don't really know what you are going to until you get there, so unless you actually really know what's going, you can't prepare for it. Because generally, when you get there, it's not what it is. Last job, an adult male that was slowly going unconscious from a motor vehicle accident; OK, off we go. It turns out to be a 2-year-old that's been actively resuscitated by the CFS. So, your whole perception of the problem is … AHh! Which causes confusion because you go "Hang on, isn't there a big car accident?" "No, it's just one child in cardiac arrest", and you go "Oh, OK!" So that changes, so you really can't prepare for it too much (Int. 2).*

The issue revolves around the ability to be prepared. The unknown is not confronted with an absence of thought. More usually, a plan has been developed in preparation, and when confronted with the actual situation, the plan may have to be completely altered:

> *So, you have that all set up in your head. Then you walk in there, and it's something completely different ... it really throws you, and it really does put a spanner in the works when it's not what it's supposed to be (Int. 3).*

With this possibility in mind, several paramedics deliberately try not to predict a situation:

> *We may just routinely say, "Ah, we may use this or that, or we may need so and so." But you probably don't try to pre-empt too much, because it could very well be you're letting your mind race ahead of yourself. So, it's probably better to go into a job ... you don't go in blind. You know that you're going to need certain equipment and if they're walking around, then fine. If not and they're trapped, then ... it just needs a little bit more care in whatever you can do. Things unfold as they unfold, that's the nature of the job (Int. 4).*

There are also the situations where the unknown revolves around a lack of any available clinical knowledge about the patient whatsoever:

I suppose that the jobs that probably may cause you stress, if someone's in front of you unconscious, and you have to work out what's going on, and there's nobody there to give you a history, or whatever. That makes it difficult, but you do it (Int. 8).

This negative sentiment associated with the unknown does not hold true with all paramedics, because there are a number that enjoy the challenge of the unpredictable, to the extent that rather than being a negative aspect, it is considered to be a positive aspect of the job:

I love the not knowing what's going to happen and the variation, and the unknown to a degree (Int. 7).

… and it's just the uncertainty ... the diversity which is just fantastic (Int. 5).

6.3.2.3 Monotony

The other side to the unknown aspects of the work is the fact that even the unknown nature is predictable. A number of paramedics find the repetitive nature of the job boring:

But it is repetitive ... all the other things we do are a normal part of what we do. But as I say, it's not unlike any other profession. You do what you do every day. It's just in ours, you don't know what's going to happen (Int. 4).

Otherwise, they know that we pretty much bring the patients in here gift wrapped and stabilised, so even those minor jobs have that little ... "Yep ... nothing happened with that patient in transit. We managed to get them to the next best place that they needed to go to." That's a tick. We did our job. Nothing happened, but we did our job (Int. 1).

One component of this monotony is the unproductive time spent between jobs. Whether at the station, at a medical pick-up, or waiting to hand a patient over into the care of an emergency medical department (known as ramping), the frustration of wasting time is often wearing:

Ahh ... I think that the biggest stress in this job is sitting around waiting. Yeah ... for something to happen. Like ... I would rather come to work, and my shifts go from 7 till 7, I would rather come to work and be busy all day, like we have today. Ok. As opposed to coming to work and sitting here from 7 o'clock until 7 o'clock in the evening and not doing anything. That's a stressful day (Int. 8).

I think the down time for me, like when you're waiting around, a lot of the times you've got to wait outside of someone's house until the police get there (Int. 23).

6.3.2.4 Personally threatening jobs

One aspect that a number of participants related as stressful were the jobs during which they were threatened either verbally or potentially threatened physically:

> *I think if I was to be asked what jobs I didn't like, because obviously I don't like being threatened; I was attacked by a bloke with a kitchen knife last year, and he only got so far and then he stopped. Now that did shake me, because it's been years since I've been hit or anything, so ... every now and then, someone may do some silly thing: try to push you, grab you, whatever … those sort of cases can leave a bit of an uneasy feeling, bit of nervousness (Int. 4).*

> *Another contributor to stress would be those taskings where I feel as though I may be exposed to that worst part of the job that I mentioned. We might cop abuse or a hard time or some sort of hindrance in just doing our job … Last night for example, I got verbally abused (Int. 20).*

This threat of physical harm does not necessarily come from a patient. Some paramedics referred to the number of emergency vehicle accidents that occur and which are part of the work:

> *Ambulances get crashed, cars get crashed, we are very frequently … factors in vehicle accidents because of operating under emergency driving conditions … Yeah and going further out into the country where the roads aren't so good, visibility is not so good, we're tired, middle of the night, we should be asleep, our brains telling us to go to sleep, can't see too well, kangaroo might jump out, and swerve – things like that go through your mind (Int. 20).*

To enter an uncertain situation and feel unprotected or insecure was also noted to cause anxiety. The paramedic below was caught in a situation where they were attending to a patient who had been injured by a weapon. As the incident was ongoing because the police had not yet located the perpetrator, they were left without police protection at an insecure location in an ongoing threatening incident:

> *Just to be there and not have anyone and just feel like you're a sitting duck. It's just – you know when you know that people can see in and you can't … see anything. Like it was just our reflections. Then, when my team leader got there, I just couldn't even see him, and I was just like – and then he got really close and he's like it's okay, it's okay. It's just me, it's just me. [We] were like "get us out of here", it was so scary. So that's the other emotional (Int. 22).*

6.3.2.5 Jobs that didn't go right

One of the situations that can cause considerable difficulty occurs when a job "didn't go right." There are four potential circumstances in this category. The first stems from the technical side of the job. Because all paramedics are trained to focus on the technical side of the conditions, some can experience emotional discomfort when technical expectations are not realised. This is not only associated with equipment that may malfunction, but general knowledge or teamwork breakdown:

> *Yeah, there are things that just didn't ... it didn't flow the way it should have flowed, and I feel I've taken a lot of the responsibility of that. So that sort of thing (Int. 3).*

> *The stuff that gets to you is the stuff that didn't go well, whether you fell apart, team members fell apart, just nothing felt like it was working. It's not ... "Oh her head's missing" kind of thing, it's "I can't get my cannula in. I can't get the adrenaline in that she needs. It's delaying treatment", so your lack of ability to perform a skill on time or someone else's lack of ability to perform a skill on time ... you know what you need to do, but the hindrance is when people aren't doing it when you expect them to, or sometimes when you're not doing it when you expect it of yourself. You have expectations of yourself and you have expectations of others and when things don't go well is when those expectations aren't met (Int. 6).*

Another manifestation occurs when the job progression is as expected and the paramedic performance is comprehensive and competent; however, the outcome is not satisfactory:

> *There's always that … some people would just say something but, um, I think there's always that concern in the back of your mind that you are going to go to a job where you, um … No matter what you do, it's not going to make a difference. You know, there's always those ones where you think, you've got to put it in its place and think "I did do everything I could to the best of my ability and the outcome was still not good (Int. 10).*

> *I think the ones that stick with me for the longest are the ones where you go to and you get to the end, and you feel like you could have done something slightly different. If you look at it and go hmm, I wonder if I had done this would it have changed the outcome slightly and sometimes I've lost a bit of sleep over things like that, but the ones where I mean you obviously losing people is part of the job, but if you feel like you have done everything in your power and it's just the way it happens sometimes (Int. 11).*

The third reason for a job to go wrong is when the paramedic either feels like they have, or they actually have, performed a task incorrectly.

I would probably have seen as much as anyone else has as far as gore and trauma ... but I can't say I'm ... nothing's ever ... Ah, you get upset if you do something wrong and say that was a bit of a silly job (Int. 12).

So, things that did stress me out in the early stages was when something stops the shit, my part of it flowing smoothly. Things, like you want to do something and something gets in the way of what you think is appropriate. That still always upsets me a little bit because that means I wasn't doing my aspect of that work. So, I think you'll find that with a lot of ambo's, things that get them initially more … is when something doubts their performance (Int. 16).

The only times I do get stressed is where I think I've done the wrong thing, and usually by talking it over with one of my senior officers and going through the case and going, "well, you did the best you could in the circumstances" or "no, you did the wrong thing", that stresses me (Int. 13).

Finally, jobs are also stressful from a technical point of view when they are not followed up correctly, or people are taken to task for what occurred. This is when industrial procedures and management can contribute to the stress experienced:

What it is … more stressing is when you have … the case I would think about the most is the case that's been inappropriately followed up from a clinical incident point of view, of poor performance (Int. 2).

Suddenly, you feel like you're left hanging on a cliff. Hang on, balance your evidence, accept if it was wrong, accept if it was right. If it's right under what the evidence says you're doing well, then they just have to get over it and come up with an alternative. That's what we do as a group. We do get challenged quite a lot. If you're going to get challenged, fine be challenged. There's nothing wrong with being challenged as long as their thought about what you're doing and acceptance of right, wrong, or indifferent, and that's where people find that blurriness scary (Int. 16).

Misinterpretation of what's actually gone on and not addressing the process of … report analysis I guess, of what has happened, and not doing established norms for example after a major incident, having a debrief, that debrief straight after the job and then they have the debrief afterwards. And they say "How did we go? What did we do?" bang, bang. And then you can answer questions quite quickly while it's still fresh in people's minds. So you'll look at me and you'll go "You didn't do this and you didn't do that, and that affected the patient", but then when you bring it out and you talk about it, then you hear why it didn't hurt that it occurred, and a lot of the times it does occur for a particular reason. "Ah, that makes sense", because you're looking at it from a different camera angle, and then there's someone looking at it from a different camera angle, and so forth. And then when you get everybody together, you generally get quite a good picture, because everyone has a different view absolutely, and then you get a bigger build-up of picture and you go "Ah, OK, this is where we went wrong, this is where we did really well, this is where we just did normally, and these are the lessons learned (Int. 2).

6.3.2.6 Identifying with a patient

Jobs that appear to have the greatest potential for stress are those in which the paramedic identifies with the patient in some manner. Whether the patient resembles a family member or a friend from any age group, or whether the patient's circumstances are similar to those of a loved one, the resonance seems to affect the level of emotional/ psychological impact experienced by the paramedic. In the country towns where populations are low, there is also the real possibility that paramedics are acquainted with the patient in some manner, which diminishes their ability to compartmentalise their emotional responses from their clinical judgement. They are required to suppress (whether consciously or unconsciously) the traumatic thoughts, so that they can continue performing the tasks they are required to complete.

> *I think anything that strikes a chord, so whether it's someone of a similar age to myself, or a similar age to a child, or anything like that is obviously more stressful than other jobs (Int. 17).*
>
> *It worries me a bit that nothing worries me. I can, um … even a dead patient's no more than a bag of wheat to me really,* ***as long as I'm not related of course*** *(Int. 9).*
>
> *[I don't like going to] the ones that are – that remind me of my family. I've got grandchildren as well, so you know young kids … but yeah, it's more of the direct link rather than just the general, oh, it's a two-year-old (Int. 21).*

Another form of identification is when the paramedic becomes lost in attempting to understand the set of circumstances that lead a patient to the position in life that they find themselves in. Whether merely isolation, or a culmination of difficult life occurrences leading to irreversible consequences, has placed a patient in their current compromising position, a paramedic can find themselves ruminating on unanswerable questions, such as what life circumstances lead a person to suicide or how someone's social network deteriorates so much, they become victims of elder neglect:

> *I sometimes find people's circumstances quite distressing. I'd probably go to a fatality and not be bothered about it, as if I go to somebody who has perhaps had a stroke, been on the floor for days because nobody comes to visit them or anything, nobody's known about it and they're still alive, they're still … And I think that is really sad (Int. 10).*

Again, there was nothing we did at the job ... nothing we could do at the job. But it was still grizzly enough that ... you knew someone died. Didn't know the circumstances behind it. Don't need to know the circumstances behind it. I think we found out afterwards from the police that it was more than probable suicide just purely from the fact that there were no brake marks anywhere on the road and you could see he'd actually veered off the road and then kept a straight line towards the tree. But the police told us that afterwards. We're not there looking for it. So again, you sort of think "It's a bit sad" and you don't know what drove him to that extreme of doing it (Int. 1).

6.3.2.7 Psychological jobs

Some paramedics find patients with acute or chronic mental health issues unpleasantly demanding, particularly if the patient is violent. Whether it be due to a psychological condition culminating in a psychotic episode, or the systemic effects of the consumption of illicit drugs, the levels of aggression displayed by the patient often lead to unpredictable outcomes that can potentially place the paramedic in a physically threatening situation:

I don't do psychiatric patients very well. I've been abused one too many times in the city I think, and I'm just over that. So, I just don't take on any aggression or psychiatric issues very well. Especially, if it's nasty obvious behavioural, they just want to be nasty people, and to me, there's no apparent reason for it. I think you can tell the difference between someone who's psychologically nasty (anger) versus someone who's just "I'm wanting to give someone a hard time", and that's the person I can't deal with very well, so that's my big thing. Dealing with psych patients (Int. 3).

There's also the mental health side of things is actually growing. And because of ice, there's a lot of ice related ... drug related ... so, that isn't going to change and it's only going to get worse, and the amount of cases that we see now that are drug induced psychosis is huge (Int. 5).

It was a nursing-based thing, so it was like if you have this person in the ward, this is what you do, then you call security. And we're like … yeah great, so what do I do when I'm in the back of a tin box with someone who's in a drug induced psychosis going off their nut, like what do I do about that? (Int. 19).

6.3.2.8 Paediatric jobs

The jobs most consistently mentioned as stressful are those involving children. This is not simply due to a child's vulnerability, but also to the paramedic's sense of lack of skills in caring for children. Most jobs performed by paramedics involve adults, and proportionately most of their training and education also revolves around adult cases. Some paramedics said they felt less equipped to care for a sick child than an adult. Their negative emotional

response comes from a perceived lack of technical knowledge, as well as the vulnerability of the child.

Paramedics indicated they also enjoyed attending an imminent birth; to be present at the beginning of a new life instead of at the end of a life. However, others did not feel this joy and considered these jobs particularly challenging.

> *We don't get a lot of them, but then there's the maternity cases, where you get to help bring a life into the world. That's another thing that adds that little ..., assuming it goes right (Int. 1).*

> *I guess for me, the high stress jobs are newborns, because they're so emotive; they can either go so good or they can go so bad, and they are so emotional, so they're probably the most stressful dealing with (Int. 13).*

Another part of the experience that was repeatedly mentioned was the innocence of children, which does indeed motivate some paramedics to become more shielding or protective which, in turn, intensifies the emotional response. Sometimes, it is the social injustice that strikes a chord, or even cases that involve abuse or neglect:

> *I think it's because they're children, and they're a bit precious aren't they? You're always a lot more protective, that's a natural thing I think. You're always a bit more naturally protective of small children (Int. 14).*

> *For someone who's not responsible for what they've done, but they're paying the price for it and sometimes that can be ... I don't know if you'd say upsetting, but [I] certainly sort of think about it (Int. 18).*

The majority of paramedics that indicated paediatric cases to be the most emotionally challenging, referred specifically to that of death of a child.

> *Upsetting, any unexpected death is upsetting. You do not expect, no-one expects a 4-year-old or a 6-month-old to die (Int. 16).*

> *So, that's probably the worst bit, stress, stress-wise what would personally stress me is a … any child death they upset me, probably upset the most or if I have a run of death (Int. 15).*

But the most difficult of paediatric cases are those children that remind the attending officer of their own children. The participants that have felt this often still have vivid memories of the situation, location, and what they thought and felt:

The one that's probably upset me the most was a young kid who died, but I can still remember having to manage his airway on the way to hospital and looking at him and he was the spitting image of my youngest son. And it obviously still upsets me a bit – but yeah, it's the things that relate to family (Int. 21).

6.3.2.9 Family expressing grief

Finally, the heightened level of emotion present is also evident in the reactions of parents, family members, friends, and bystanders. The powerlessness to really improve the situation, but to do what is necessary, and to metaphorically be an ear or a shoulder for someone without absorbing the emotion themselves can be a substantial challenge for some paramedics.

I think that's ... for me, that's probably the hardest thing to deal with is other people's grief is difficult to deal with, and there's not much you can do about it. There's nothing you can do about it generally. And it's not necessarily a problem that needs solving. But that's certainly ... can be a stress (Int. 7).

Hate dealing with the family … I go right, I'm going to have to do this. I go in, and you're also told that what you say to these people something they're going to remember for the rest of their life – there's a bit of pressure, so I've become quite serious with myself. I'll, we'll be working on someone or we'll be doing something, and I'll take a bit of a step back and I'll think about what I'm going to say. It might just be for 30 seconds or whatever and then I'll go in and say what I've got to say and sometimes I've cried too (Int. 14).

Where they get stressful is the reaction of everyone around it … but stress is dealing with families who start punching on with each other or the stress or the blame and all the rest of it, and then it comes down, did I do what I did right and all the rest of it and then you start that self-doubt which will make things stressful (Int. 16).

The worst thing that happened today … was the little kid crying cause granddad broke his leg and that was more emotional than the guy who shot his head off or something (Int. 18).

The following quote demonstrates the full sequence of processes that one paramedic follows to minimise distress on the job, to compartmentalise the work from the emotion, detailing several contextual difficulties that can be encountered at various scenes, but that all efforts can unravel if emotion is allowed to find a way behind the 'game face':

Umm. I focus on what I'm going to do. I don't think about like that. The important time is being about to prepare on the way. There's a big difference between seeing something happen and going "Fuck, you know we've got potentially a very sick child or the person could be dead", so you do have that time to put in process like if you go to a pedestrian versus a car you go, "Ohh, we've got a high mechanism

here … could have a few injuries" rather than turning around on the street and seeing it in front of you, so you do have that time to go "right, airway, breathing. I'm going to grab this kit" and I start putting together a plan if I'm attending of how I'm to approach ... go "Mate can you get this kit, I'm going to get this, this and this. We might need [the Emergency Retrieval Team] here". And I focus on what I've got to do. And it's not a person when I get there, it's a job. So these are my issues, this is what I need to fix, this is the job, this is what I'm going to do about it, and then it stays a job to me. And I don't ... what I find hard in these situations is ... like, I remember the first time I ever went to a cardiac arrest as a student … It was a woman who had a massive heart attack at her husband's 70th birthday surrounded by all of her family and friends, and it was on the second story of a 2 story building with a single spiral staircase. And she'd collapsed on the balcony. So it was an increbibly difficult extracation, and I remember, it was my first placement as a student, so 2nd year, first hour in an emergency ambulance, and it's like "Ok, so this is what ribs feel like when they crack or what fixed and dilated pupils look like …", and that was all cool, but the son started crying, like he was in the room and became incredibly emotional, and I'm the kind of person that will cry in Disney movies. So, that was the moment where it all became kind of real, where we go "Ahh, hang on, this is ...", and when I stopped compressing the heart stopped and ... that was ... so, I find it much harder to deal with loved ones' emotions, rather than the body or the injuries or the death in itself, because they just become a job to me (Int. 6).

6.4 Summary

This chapter has demonstrated the paramedic working environment from the paramedic perspective and categorised the potential stressors encountered due to the role in the organisation in which they work. It has also described the jobs that are not considered stressful and highlights those that could conceivably cause a negative cycle of traumatic thoughts. In the next chapter, we move into the culture of coping as it is apparent to the paramedics at the moment. It also describes how the paramedics believe it should be in order to protect the members. This was uncovered by exploring the advice they would give a new recruit on how they can best protect their mental health wellbeing.

In the further findings chapters, the differences found in the current culture of coping will be exposed in various groups in relation to the location of their primary workstation, their generation of birth (essentially how old they are), and how affected they are by societal evolution in how they continue to use humour as a coping mechanism in a time of political correctness.

CHAPTER 7: THE CURRENT CULTURE AND FUTURE DIRECTIONS

7.1 Introduction

This chapter discusses what paramedics perceive their current culture of coping to be. It explores the positive, neutral, and negative perceptions that were elicited about the culture of coping that paramedics believe they are living with at this time, and their observations of how effective the organisationally provided formal coping structure, known as peer support, is regarded.

The chapter will also look at what the paramedics view as important information that they need to be provided with to enable them to protect their mental health wellbeing. They discuss what they believe is important by indicating what they would advise a new recruit to understand or develop to arm themselves with the best coping strategies. The extension of this concept is that the paramedics are reviewing their cultural preferences.

7.2 Awareness of culture

As stated previously, the term *culture* refers to a set of expectations or assumptions that can be viewed as standards or guidelines relating to what people believe, how they perceive and evaluate different situations, and how they communicate and act towards one another (Steen et al., 1997). Basically, culture is everything that a group of people collectively learn or produce (Fetterman, 2010; Spradley & McCurdy, 1972), and is inherent in everything that an individual believes or does when connected to a group of people with similar interests, experiences, or environments. When the culture of interest is between a group of people working together in a particular industry, it becomes the organisational culture, where the shared assumptions identify individuals as part of the same group, and this group can be identified as a collective by others. Specific terms and jargon used between members of a single cultural group sound foreign to outsiders, and several researchers believe it to be the 'glue' that holds an organisation together, either through shared meanings or degrees of commitment leading to shared responsibility for performance outcomes (Jaskyte, 2010; van den Berg & Wilderom, 2004). Paramedic culture is the set of assumptions and language that

paramedics assimilate that helps them identify what they need to do, think, feel, and value as a paramedic within this organisation.

Paramedics make a distinction between the culture they see and what they think would be ideal or at least beneficial. The participants provided their views on the current culture by answering the following direct question: “What is the culture?” All participants who were able to complete the interview gave a response to the question “What would you say about the overall culture of coping?” When asked to describe what they thought the culture was, many paramedics simply stated that it is the way we do things, or perhaps the way the organisation would like us to do things. The task or attribute focus was not uncommon, and the inclusion of humour as one of the foundation cornerstones of their culture was a conventional opinion:

> *It’s a combination I think of black humour, clinical skills and ability, [and] general humour, not just black humour, but general humour (Int. 14).*

Several members understood that culture is what is not written down, and that the paramedic culture continues to evolve. As the following paramedic suggested, initially the smallness of the organisation may have influenced how their culture of coping operated, but that the increasing size of the service has an impact on how this culture progresses:

> *I don't know, I guess it's just a cultural thing, somehow, we've evolved in a manner that allows us to cope with issues more, and maybe just the fact do we have peer support, we do tend to look out for each other, maybe it's because of not a very big service and maybe being a bit smaller has allowed people closer relationships with each other (Int. 18).*

7.2.1 Positive culture of coping

The extent of the positive perceptions of culture also ranged from good to fantastic. The ‘matter-of-fact’ manner in which paramedic 19 just said “good”, with no elaboration or further description, gave the impression that she perhaps took it for granted that supports were there if they were needed. Others were more expansive when explaining their appreciation for the efforts that the organisation has undertaken to provide the formal processes, believing that individuals are valued and protected:

"There are systems and people in place and people that are trained, and they'll bend over backwards ... because they want paramedics on the ground … that are mentally and physically ready to work, and so they've put the infrastructure in place to make sure that everyone's 100% switched on, and if they're not, well that's fine. You can have time off, you know and, yep not a problem (Int. 2).

I think, generally speaking, it's very good. I think ... we build an expectation with the Peer Support Program that you would be supported, and we would actively seek you out and make sure that you were supported and that you felt supported (Int. 7).

Compared to Nursing, I think that the ambulance service is fantastic. They're very supportive, and that um, if you need to, there are systems and people in place and people that are trained, and they'll bend over backwards to ... because they want paramedics on the ground that are ready to … that are mentally and physically ready to work, and so they've put the infrastructure in place to make sure that everyone's 100% switched on, and if they're not, well that's fine. You can have time off, you know and, yep not a problem. So, yeah, so yeah, it's … compared to what I was used to, I've felt like, you know I've felt like a king, you know, like I've thought "really? Awh!" you know, warm fuzzies, you know, and yep really good, really good! (Int. 5).

It is evident that there are still perceptual issues relating to the cost/benefit analysis, which shows up in the appearance of differences in the outlook of team leaders. There is always the pressure to perform as a business in this economic climate, and although the paramedics do not like it, they understand this stress on the manager, as indicated in the quote below. But when the team leaders are viewed as individual human beings, without the constrictions of their role as an organisational voice or administrative conduit, they are viewed in a different light:

I mean, they're under enormous pressure to justify everything that they spend, that they're going to spend … but on an individual basis, I don't think there's an individual manager here who doesn't care about people. I've certainly never met one (Int. 7).

7.2.2 Neutral perceptions around the culture of coping

Other participants were more apathetic or neutral in their perceptions of the current culture of coping within the service. The prevailing attitude seemed to be, 'It must be okay because most of us are alright'. This set of participants focused more on the individual paramedic and non-service-related strategies, which lead to three concepts: the accumulation of stress, no-one is immune, and you need a good network supporting you when necessary.

The first prevailing concept is a general acknowledgement that stress can accumulate and is dealt with, but that most will deal with it in their own way. Paramedic 20 was more an advocate of people using their own strategies. Even though he was part of Generation Y, he had been in the service for a decade. He did not feel that there was a culture at all, and that people are generally left to their own devices, despite knowing that there are formal options provided by the organisation to help them cope. Other paramedics had similar opinions:

> *I think everyone seems to have their own methods and I certainly don't talk to many people that are caving under it and can't deal with it anymore, so I guess it must be working to a certain extent (Int. 11).*

The second view is to recognise that no-one is 'invincible'. The problem is not feeling the stress, it is understanding the effects of stress, recognising when it may be beyond limitations within oneself, and actually obtaining suitable help. Finally, another common strategy that the neutral proponents advised was the importance of maintaining a social network or interests outside of the organisation.

7.2.3 Negative culture

A number of participants focused on the difficulties they perceived in the culture, or more specifically, the barriers to the culture protecting them to the extent that they believed it could, or even did in the past. Occasionally, it was inferred that it was non-existent:

> *Oh dear. Unfortunately, I think you're left on your own … Look, there are people here who struggle to cope with certain issues ... um ... I hate being put under pressure, but I cope, that's what I do. I don't think the organisation does it very well. We're not taught to, it just comes ... it's something that just comes through time (Int. 8).*

> *I don't feel as though there is one, I feel that there's a couple of options that are offered formally for us to cope with it, and people either use them or don't, or people use their own means (Int. 20).*

Only one participant failed to mention the peer support network positively, but several raised issues that hindered its success. Organisational factors included the support from higher levels of management and the differences in this support that have occurred over time. The impression is that it has been done well in the past, but top-level managerial support for the program may have diminished. One participant reflected on the fact that

this decline is due to initial supporters leaving the service and now the incumbent management does not prioritise peer support as much:

> *But I don't think it's been kind of wilfully neglected, I think it's just kind of fallen off the radar and because it's not being actively pushed, it's just starting to wane a little bit (Int. 7).*

Paramedics indicated that they did not like the cultural direction in which management was taking the organisation, but did not identify specific issues.

> *His ideal for a paramedic is 7 years, so recruit a paramedic, use them, burn them, abuse them, use them up, 7 years if you don't become stressed, and you are turning over new staff to bring in new ideas (Int. 12).*

The 'peer' component of the peer support program is guided by a set of informal rules that govern behaviour. The paramedics should talk about how they feel about a job with people at their own level or higher, but not with someone at a lower level. This is seen as inappropriate, whether the person is lower in rank or age:

> *An intern, you're not a peer, you are a pleb, you are the lowest, no-one's ever going to turn to you. So, it's other interns that's going to support me (Int. 6).*

A point of concern for some paramedics is the perception that there has been a shift in support from their peers as a result of the increased competitiveness and an atmosphere where one must prove their skill. Int. 23 liked the collegial culture, but felt that the environment was leading to an increase in judgemental appraisals:

> *That makes it more of a performance environment than a learning environment, and I think they need to somehow foster a more learning environment, which we had recently at the internship. Because prior to our group they were rated, so each person was rated in order of how good they were clinically, and so the best one would be offered the first job, but they've stopped doing it now, which made for a much better learning environment, we were all … completely, "Yeah, let's make loads of mistakes so we can remember those mistakes and learn from them (Int. 23).*

Finally, a lack of training in understanding stress levels and being aware of the symptoms of not coping was also noted. As Int. 8 noted, individuals are left to their own devices:

> *Unfortunately, I think you're left on your own. It's individual thing, and it's not something that they teach you to do as we've just discussed, it's something that you have to ... you have to take on board over time ... and ... and truly, it's just something that just comes with experience (Int. 8).*

7.3 Perceptions of the Peer Support Program

When asked about the culture, the majority of participants automatically defaulted to mentioning the organisation's instigated mechanisms/formal process regarding mental health protection, being the Peer Support Program. Whether it is viewed with favour or contempt with respect for its effectiveness in stress mitigation, or whether its presence is merely tolerated, it is at the very least widely known and seen as a part of the culture of coping.

Some of the paramedics suggested that their more seasoned colleagues retained aspects of values and beliefs that were in vogue prior to the introduction of the Peer Support Program. This was seen as detrimental to them:

> *These people probably have got some form of probably PTSD or depression or something from a job that they've been to. And they just go, it's not for me. And as horrible as it sounds, obviously culture has changed since then, that they put it down to being a poofter or something like that. Because, that's how they grew up and that was the culture when they were here, and as far as they're concerned, culture hasn't changed because they haven't had the talks about peer support (Int. 22).*

Several quotes indicate that paramedics regard the Peer Support Program as unprofessional, and there is a general view that it is dysfunctional:

> *Yeah. It's a bit mickey mouse I believe now. It got to the stage where ... and probably still is ... they have a list ... a proforma of accidents where Peer Support will contact you, automatically. If [a colleague's] gone to a VA where a kid's got killed, and I'm [the colleague's] Peer supporter, "Are you Ok" "Yeah" "Good Bye." You just going through the motions. I think it's lost its way, it's lost its impact, and I would rather not be contacted in those regards, because it doesn't have the impact that it should have (Int. 12).*

> *Um, I really don't … can't think of … I think we do talk about it, we do have processes in place, we have structures in place like peer support, psychologist, team leaders who are sort of told to look out for our troops. I don't think we have things in place for major incident strategies 'cos we forget to do them sometimes, and that shouldn't occur. We do have a thing, or we use to, I think it's gone now, whenever we went to a death you were rung up about it, which a lot of people appreciated, and a lot of people didn't care really (Int. 2).*

On the other hand, there are individuals that, although they tend not to utilise their peers, would rather not discuss any stressful feelings they are experiencing; however, they have come to expect the receipt of a telephone call, and become annoyed if they are not

contacted. Whether it was an intentional strategy or a positive accidental side-effect, the policy to call **EVERYONE** after attending specific jobs, managed to desensitise the actual event of receiving a call. Calls were not only made to paramedics who were believed to be more vulnerable, whereby the mere occasion of receiving a call labelled them as being weaker than their colleagues. Experienced or novice, old or young, metro or country; every paramedic is contacted if exposed to a certain type of job, so no-one is stigmatised if they receive a call. In fact, now it seems apparent that one has somehow fallen through the cracks if they do not receive a call!

> *I think now they do so even the older ones now ... so if you don't call for something that they think they should have been called for, then you'll get a comment "Why didn't you call?" That wouldn't have happened 20 years ago! And then you'll say, "How are you going with it?" "I'm fine. I just wanted the call." So, they do expect the question to be asked. Even if they know they're fine, they expect the question to be asked. And I think that's a healthy and good thing because normalising asking the question helps to normalise a range of responses (Int. 7).*

Finally, there is the view that the organisation is not advocating for the program as they once did:

> *There were a couple of drivers behind the Peer Support Program that have left the service altogether now, and so it's lost a bit of its managerial clout (Int. 7).*

> *I think there is the reference to peer support made periodically ... not so much as it used to be. I think the culture of peer support has probably declined. I don't think it's as … advanced as it used to be. I'd like to see more focus on it, especially now that we've got younger people in the job. I'd like to see them reiterate to groups about it. I don't think they do enough of that either (Int. 4).*

This section has summarised the perceptions of what the paramedics believe the current culture of coping is. In the next section, the direction turns to what the culture should be. This is done by revealing what these paramedics think should be taught before they commence employment, in order to help protect their mental health wellbeing.

7.4 What the Culture of Coping Should Be

Asking participants about how they would advise a new paramedic in relation to the preservation of their mental health and wellbeing in the event of traumatic circumstances and emotional situations was designed to elicit whether the common beliefs about what paramedics regarded beneficial information and practices should actually be part of their

culture of coping. Six themes emerged that the paramedics believed were beneficial strategies in their mental health protective toolbox.

7.4.1 Self-awareness - know yourself

Several participants acknowledged the value of truly understanding their own strengths and weaknesses, particularly recognising what type of situations, issues, or concepts might stress them and what strategies they have available to overcome the stress. If they understand these mechanisms, they will be able to recognise signs in themselves that they are not coping, and hopefully, be prompt in acting to provide the kind of assistance they know is most beneficial for them:

> *Know what stresses you and – so this is a bit of self-insight required. Know what stressed you and know what ways you've got to fix it, and if you don't know necessarily what stresses you and you don't know ways of fixing it, then perhaps start talking to the people that you're working with about their methods (Int. 14).*

7.4.2 Non-avoidant communication - talk to people

Next is the recommendation to talk about stress and discuss how to minimise the deleterious effects when it becomes overwhelming. There was no preference about who to talk to, rather the suggestion was to understand what works for the individual in each situation. Whether it be social networks, family members, partners, peers or professionals, the key was to vocalise the issues and discuss the implications. No-one is alone, and everyone has weaknesses and vulnerabilities that they may feel uncomfortable about revealing in a public forum, but private and confidential support is available from several sources. The overwhelming factor was to deal with it rather than ignore the issues and allow them to become overwhelming:

> *Don't try and deal with it yourself, like try and get help, like just always use your partner, always, if the jobs affecting you and you've spoken to your partner and it's still affecting you, go and speak to [the organisational psychologist]. Use the services. They're there, use them, and they're good services, excellent (Int. 15).*

> *Find what it is that makes it okay in your own head what you've done. Find it – whether it's talking to a loved one, whether it's using the formal services, whether it's – yeah, so I guess there's the informal mechanisms which are your own, which is talking to friends and family, or … psychologists, peer support, team leaders, etc, find what it is, don't let it get on top of you I guess (Int. 20).*

Share things, don't bottle things up inside 'cause whatever you're feeling, the guy sitting next to you has probably felt the same thing at some point (Int. 18).

It was also mentioned that people fluctuate in mood and that it is to be expected that people may need extra support at certain times and not at other times. Just as it is beneficial to understand their own needs, it is equally valuable to have an understanding of other people:

I think it's in part ... I think understand that people will fluctuate, and that peaks and troughs are normal for everybody. And I guess to be accepting of that and to support people in the troughs (Int. 7).

7.4.3 Priorities - it's not everything in life

One of the factors that several participants reflected on was the necessity of developing a good work / life balance; making sure that social networks are maintained and that outside interests pursued. This was seen to ensure that an individual does not ruminate over a job in a self-destructive manner because attention is redirected towards different and generally more positive outlets. This does appear to be a factor that new paramedics are informed about early in their career. It is reasonable to be enthusiastic about work, but there is also a need to have other outlets as well. In this way, the balance keeps one's perspective realistic:

It takes a specific kind of person to be able to do the job well for a short time, but then there's just something ... that extra something in someone that can last in the job. It's not an industry of plusses, so you've sort of got to know that going into it, and maybe have other things in life that are polar opposites (Int. 1).

I think I'm coping better now because I've got a broader perspective of, yes I'm passionate about this, but it's not the be all and end all of life. And I think, and they always say that "Make sure you keep your social life happening outside of work", … Yeah, keep your social life and other things in perspective, like yes, the paramedic thing does take up a massive amount of time, but really, plan other things so that it's not everything (Int. 23).

7.4.4 Responsibility - you didn't cause the situation

An important factor in maintaining mental health was for the paramedics to develop the ability to look at their professional understanding that they did not cause the traumatic situations they found themselves attending. Such perspective comes from reviewing the level of responsibility they might absorb, or even unconsciously adopt, in these difficult situations where they are feeling empathetic or sympathetic towards their patients.

It has to do with understanding that the paramedic did not cause the situation. They did not put the patient in the difficult position they found themselves in, but they were going to attempt to help improve the situation and the outcome if possible, but importantly, to not be drawn into someone else's emotional state:

> *So, perspective, realising that ... yes, it is a case of life and death sometimes, but it's not your life and death and it's not ... it does not define your life (Int. 6).*

7.4.5 Confidence - be happy knowing you did your best

Similar to recognising that the paramedic did not cause the situation is the concept that the paramedic also cannot fully control the outcomes of jobs. No-one intentionally approaches a job with the attitude of imminent failure; however, on many occasions, the course of a job is unpredictable as the turn of events may not follow the expected lines because of a myriad of known or unknown factors. The individual cannot accept responsibility for a job going wrong if it was not in their power to do so. On the other hand, paramedics are humans and humans are fallible, and on occasions, mistakes are made. These need to be reviewed and treated as learning opportunities rather than as a time for emotional flagellation if the paramedic is to preserve their long-term mental health wellbeing:

> *To be pragmatic, to be realistic, to be understanding that some people do die. We can't save everyone. Do your best, and as long as you can live knowing that you have done your best, you can walk away and feel good even though the outcome may have been not as you may have wanted (Int. 12).*

> *Nobody goes out there to stuff up right (Int. 8).*

7.4.6 Motivation - be in the job for the right reasons

Finally, similar to the theme of *knowing yourself*, it became apparent that most paramedics viewed their motivations for selecting this as a career as a factor that had an impact on their own mental health wellbeing. The adrenaline and excitement, the impression of heroism, or even the basic notion of needing to be called upon to utilise one of the many complex skills they fought to acquire at a high level are considered counterproductive to their mental health. When the end goal is to assist someone in need, even the benign jobs can be valued as important, because they make a difference in the lives of individuals caught in a vulnerable moment. The following lengthy quote illustrates this situation:

It's not about driving fast and sticking needles in people; it is, I think, even though you need to separate off the emotional stuff, that it is still about contributing to people's wellbeing. One of the good things about this job is that you can walk away at the end of the day knowing that you have made a difference to somebody, even if it's just pain relief or it might be saving a life or it might be just that you helped a little old lady put her cat out before you took her to hospital. So, if you're in the job for the right reasons, I think that's – that helps, because there is an end goal rather than just "oh I didn't do anything useful today" which is a complaint I hear a lot. So – "I didn't do a good job today, all I did was take people to hospital and none of them were sick; you know I didn't do the big, bad road trauma" – and that, some people tend to focus on the "I'm an intensive care paramedic and I didn't use any of my skills today, so clearly my day was a waste of time." As against, I might not have intubated somebody or cannulated somebody or cardio-verted somebody, but on the other hand, I've held a little old lady's hand because she wasn't coping at home (Int. 21).

7.5 Summary

In this chapter, paramedic perspectives relating to their current general organisational culture of coping have been displayed. These perspectives explored the support they believe is available to them when they need it, and they shared opposing views of whether the current culture is positive or negative. This opened the way for comments on their views about the Peer Support Program provided by the organisation and its usefulness (or not).

The final section categorised the themes that emerged when the paramedics described their needs in relation to supporting their mental health wellbeing. This encompassed understanding one's own aptitude in dealing with stress, and recognising that assistance is always helpful. The main strategy that came to light was that of talking about the incident and the associated emotions in depth with someone that is completely trusted. The remaining four themes are suggested approaches that the participants have found beneficial while processing the information and emotional responses of a traumatic job.

This and the previous chapter have set the scene for the conditions paramedics work in and under, and their general views about the organisational coping culture as a whole with reference to what they feel it is now and what they feel it needs to be to support them the way they would find beneficial. The next three chapters expose how this general culture changes, depending on three structural factors: the location of the paramedics' primary workplace, the generation into which they were born (their age cohort), and the

modifications they have had to consider making to a trusted coping strategy (humour) because of societal evolution.

CHAPTER 8: LOCATION

8.1 Introduction

Now that the scene has been set by becoming aware of the paramedic perspective in regards to both their occupational environment and their awareness of what their current culture seems to be compared to what they would like it to be, this research turns to explore the differences in the culture of coping in paramedics. One of the most prominent cultural differences in this issue was that of location. The themes that emerged often related to the living and working environment, as well as the population serviced. The themes centred on differences involving three factors: the occupational role and the style and pace of jobs attended, the paramedics' relationship with the community, and their relationship with other members of their station. Four specific locations were approached for recruitment purposes, all with very different occupational routines and expectations of how the working day would unfold. Potentially, the members of the different locations would also have different sets of experiences relating to exposure to various researchers and styles of research projects, which may also have influenced their interest or willingness to take part in the current study. This, in turn, altered the reception offered, which differed substantially at the different locations.

This chapter will define the population and proximity to major cities and describe the initial contact, reception, and my engagement by the paramedics in each location. It includes observations of the occupational culture and the paramedics' view of the associated town culture in relation to themselves. The three themes that will be discussed cover:

- The specific roles, routines, and shift logistics, leading to a description of the different guises that certain jobs take on, depending on where they occur. These factors may account for the differences noted in occupational stressors.
- Perceptions of the paramedic role in the community and the effect this has on both their expectations and their views on what civilians expect of them.
- Paramedic views on their own environment and its influence on their coping strategies, in contrast to their views of the methods of coping used in other locations.

All points will be illustrated by comments provided by relevantly located paramedics.

8.2 Rural/Remote:

The rural/remote area approached was a small country community with a population of approximately 5,000 people, located approximately 50km from its nearest country town and 400km from its nearest capital metropolitan city. The station was relatively old and small with kitchen and lounge facilities and a compact equipment and medication storeroom. The team leader's desk was situated in the training room among the training equipment. All areas appeared to be multi-purpose, or at least to be able to be adapted for any current need.

The paramedic team comprised of a single team leader and a small number of paramedics (approximately 10). They were mostly in their mid-forties or older and were long-time employees within the area, with more than two decades in the service. All were paramedics with no extra, or reduced, responsibility roles.

8.2.1 Interaction and engagement

The team leader of this area was very welcoming, encouraging, and extraordinarily hospitable. It was entirely due to his immediate interest in the topic of mental wellbeing and concern for all members that prompted his being the first to respond to the initial invitation email to participate in the research. As soon as the necessary alterations to the ethics application were approved, a visit to this remote area was arranged. Contact was established as soon as I arrived in the area.

Upon arrival at the station the next morning, I was greeted very warmly. Per the request of the team leader, I was to conduct the interviews on location. With this in mind, a considerable concern was the preservation of anonymity. However, as all members encountered were informed about the research prior to my arrival, had discussed the research with their team leader, and had openly indicated their interest in taking part, they all gave their assurances that they were not worried about anonymity within their station when I voiced my concerns. Between the interviews, I was taken out to cafes for coffee or lunch breaks, always with two or more officers on duty, who were used to being out interacting with people in the town while in uniform, explaining to me that the townsfolk tend to be comforted and encouraged by their presence.

8.2.2 Occupational culture

The culture appeared to be akin to that of a close-knit family. Everyone gave the impression that they knew about everyone else's business, actions, preferences, and values, and the majority liked the feeling of comfort or security that this knowledge gave them. All supported each other, regardless of age, experience, or qualification differences, although the older male paramedics stated that they tended to willingly (almost unconsciously) adopt a paternal role towards the younger staff, and the younger paramedics felt that they were insulated in the way they expected parents to protect their progeny. Staff were rotated with each other, rather than being assigned to work with just one partner, and could therefore thoroughly get to know all the other members working out of that station. As two paramedics noted:

> *All of the guys here, their youngest children are older than me, so they've kind of all filled a bit of a natural father figure role, like they come over and they'll just check my water softener and, the gas, water, the electricity. You need more power points there, that chimney needs a clean, things like that! They're great! I love it! (Int. 6: R&R).*

> *But if I need to I can ... there's 2 people at the station that I can ring up and if you need to, I can come down here to get different eyes on perspective here, and these guys are really good, and just because they're not ... I mean everyone ... I consider everyone in SAAS as part of the family, so just as I'm up there and these guys are here, I still think of these guys as family as well, so it's ... it's one big happy family! (Int. 5: R&R).*

Because the number of jobs coming in is relatively small, the focus tends to be different. There is time to evaluate their performance. The difference in workload not only influences their capacity to debrief and reflect on the state of their emotions, but also how they perceive the organisation treats staff, such as being overworked or employed with little or no regard for individual wellbeing:

> *Well, it's a fairly quiet day most of the time. Come in, do our routine stuff, our checks. Sit down, we might check emails, might have a coffee - more than likely have a coffee! And then pretty much do a lot of just sitting down and relaxing until the pager goes off. Sometimes, the pager goes off straight off the bang, but there's plenty of times when it doesn't go off at all. So, it's pretty quiet (Int. 3: R&R).*

> *I talk to some of my friends in [Metro] and it seems to be the focus is how many jobs, rather than ... because their workload is so great, and I think that's probably where we are so lucky, because we only have x amount of jobs a day, so for us, each patient's very individual, whereas they don't have that ... that nicety I guess (Int. 4: R&R).*
>
> *We had some placements down in Metro and we got to go out and attend to priority 1 and 2s and driving in the traffic and everything else so ... and that was only for a day. I've got no intention to go to metro and work and be flogged (Int. 5; R&R).*

There is, however, another interpretation of the country culture due to its isolation and the associated reluctance for metropolitan paramedics to seek employment opportunities in remote areas. The following quote is from a paramedic who had not been exposed to the remote culture for very long. Although grateful for the position, the perception of segregation and perhaps stagnation is evident:

> *I'm incredibly lucky that I do have a permanent position, but it was because I was prepared to come into the country area … I don't think a lot of people realise what it's like coming through anymore. Especially down here, because they are isolated from interns, they don't deal with interns, they don't deal with students. The last time they had a young person working here was ... no-one comes down from Metro anymore, so it's kind of like this tiny, festering, little oozy pimple kind of thing that's on the middle of your back … it's a little bit painful, and you know it's there, but you can't actually see it (Int. 6: R&R).*

8.2.3 Role, routine, and jobs

Officers/paramedics arrive at the beginning of the shift and perform all organisational requirements, such as checking medications and conducting other vehicle checks. On the completion of this task, they relax with a coffee, check emails, read a book, watch television, or chat with their partner. The rate of jobs allocated to the area is understandably low in comparison to more populated areas. Because of this, it is not uncommon for a team to travel together to one or other's property to complete minor livestock care tasks while awaiting a call-out. Teams are generally always together and therefore they spend a significant time in each other's company. The working logistics also differ due to location. Shifts do not necessarily end at the official end of a shift. Members are required to do hours "on call" where they take a vehicle to their residence and respond when necessary from their home, because it takes less time to mobilise a crew under these circumstances than it does to redirect a crew from the next nearest station. The effect of this is that officers are unable to completely disengage from work: sleep patterns are altered, social life is

compromised, and it is possible that their consciousness is continually in the sphere of jobs that have been recently performed.

> *Come 6 o'clock, we change our call signs to our on-call signs, and we trundle off home with a vehicle each to be on-call for the remainder of the night. Again, even with that, we've got restrictions as we can't go anywhere without the vehicle, we either have to be in uniform or have a uniform with us if we want to go out to tea, so a majority of the time, most of us just have tea at home … [And] being on-call at home, you just sleep very lightly because you know that you've got to respond in a time, so you mentally force yourself not to go into a deep sleep because you don't want to miss that pager going off. And I ... even though the wife could pretty much remember every time the pager has gone off, each time she's said I've pretty much grabbed it within 3 seconds of it going off because you are ready just to grab that pager, you read it when you're half asleep, you get dressed, you read it again and make sure that it actually was your pager going off and what the job is and what the requirements are and all of the rest of it, and then you're up and out (Int. 1: R&R).*

8.2.3.1 Jobs

8.2.3.1.1 Style/kind/type of jobs

The location that the paramedic works from can have an impact on how a scene appears or how the factors at play caused an incident. For example, the physical environment may differ from that of the city or suburbs, making the scene more dangerous, particularly for motor vehicle accidents; however, as the paramedic below noted, rural areas do not have the same difficulties with drugs and violence, and the associated difficulties with drug-taking are not as extreme as they are in the metro area:

> *We need education on the new drugs that are coming into town; what their side-effects are so that we know how to treat them, because the violence in Metro, the violence with the drugs has been worse and we're not so bad with the violence. We haven't really been attacked, but you hear a lot more ... so [we are getting] ready for, if we know that it's on, we have extra crews and extra police if we need to (Int. 5: R&R).*

> *City guys might attend more MVAs in the city, but they're predominantly lower speeds ... there are a lot of 60kms an hour ones, 80kms an hour ones. If we have anything down here, 9 times out of 10, its 110km an hour one way, head-ons. The combined speed that you get ... it's also dirt roads, it's difficult conditions where they might have gone off the side of the road down into a ditch ... there's plenty of drainage ditches around. Plenty of trees being a country area on the side of the road. So, there's a whole case of different environmental factors that we have more experience in than what some city guys would. And just the fact that back-up isn't 5 minutes away (Int. 1: R&R).*

This area is very quiet at night. Like you could quite easily have bowling down the main street at 2 o'clock in the morning and have no fear of hitting anyone or anything. And it's got the normal small-town lighting, so you don't always have the best lighting, so you use everything you've got illumination-wise on the vehicle, and you're constantly checking peripheries and all that as you walk in (Int. 1: R&R).

8.2.3.1.2 Time with patients

The remoteness also affects the manner in which a paramedic approaches a job and the period of time that a patient is in their care. Transportation is not a transient process, as the distances travelled can be vast, and a patient with an unstable medical condition can be challenging and confronting over time:

The difference between city and one of the things I like about rural practice in particular, and I've really, really enjoyed over the years … is the length of time that you're responsible or part of the team that's responsible for a critically unwell patient. So, in town, you might have someone for 20 minutes, or maybe a little bit longer, but in town, you may not be the responsible person, you might have the retrieval team, or you may have some other ICP. So, you may be a little bit superfluous, or you may just be working collaboratively for a very short period of time. Whereas here … we can have patients for, you know, many hours, who are critically unwell and deteriorating in front of you, and that's some of the best work that you get, I think. I really quite enjoy that … the workload was down, but the trauma or the interesting patients medically, and how long you had them were just dramatic, and so you really were with people for a long time when they were seriously unwell (Int. 2: R&R).

Country is very different … You've got 40-50 odd minutes with that patient, so you get to put in practice your different treatment pathways, and if one thing doesn't work, then that's when your troubleshooting and your lateral thinking comes in, going "Right, how about we try this", or if that's not working, we go "OK, need to ring someone up" and go and share the problem … And if I had less time with that patient, we wouldn't have been able to do that, to try it. So, it's having that more time in with the patient to be able to find out what works and what doesn't work (Int. 1: R&R).

The impact of location on increased time not only makes for longer periods with the patients, but also on the duration of sole responsibility for the patient's wellbeing. Where there are reduced resources or capacity for any reason, or the patients' symptoms are broader than the paramedic's experience has given them confidence to address without question, extra physical assistance may be quite a distance away:

Whereas a big prang here, it's 35 minutes for a [country town] crew to come down on a priority one, lights and sirens. Maybe 25 minutes if they're really pushing the speed and the traffic is allowing them to do that. If we've got something happening down east, sport or something like that's further away ... we know that it's actually quicker to recall people who live in and near the station to pick up a vehicle and just go straight out (Int. 1: R&R).

8.2.4 Relationship with the community

The paramedics interviewed indicated that their interactions with the community were more personal than they would be in the city. This impacts on the likelihood of the paramedic personally knowing the patients, the community's level of trust, and their expectations and views of the role. As the quotes below indicate, knowledge of the community leads to heightened trust:

*So, it's different in the community, there's more of the personal approach here and what I've enjoyed … I found that when I was volunteering there I would ... not get protective a little bit, but I just kind of **cared** a little bit more about what happened … like I found myself advocating a little bit more … a bit more invested (Int. 6: R&R).*

So, at times, we get to throw on a uniform, other times, we just throw the jacket on or a vest on because everyone knows us within the town and know once we're in the vehicle, we're off. There's none of that "because you're not in uniform, we don't trust you (Int. 1: R&R).

However, this increased trust comes at a cost. The remote paramedic is known by the community not just as a person, but as a paramedic. Whether they have a uniform on or not, they are identified as having that pre-hospital medical knowledge and skill set, so this detracts from their sense of individuality:

And you're always a paramedic, it doesn't matter where you are, aren't you? It's hard to be individual, especially in a town. It's hard to be an individual because you're the paramedics (Int. 6: R&R).

8.2.4.1 The possibility of knowing patients

In the previous chapter, it was noted that one of the jobs seen as psychologically difficult were those in which patients were known to the paramedic, or reminded them of a friend, or more traumatically, a member of their own family. As one paramedic noted:

They've both been here for nearly 30 years. So, they're part of the community, the town knows them very well. They know most patients we go to (Int. 3: R&R).

You'll see the same patient multiple times, you'll probably transport them again and if they're really crook, you'll take them [to the larger town]. You'll see their family in the supermarket, you'll see their family at the post office, you'll ... the nurse will be a second cousin! There are connections to the patient, and I really enjoy that (Int. 6: R&R).

And because they've been here a long time and it's a small community, they know everyone, know their injuries, know the family, and there is that kind of connection (Int. 6: R&R).

8.2.5 Relationship with other members at their station

The culture of the small community shapes the professional identity of the paramedic. The shared knowledge of the work and the situations they encounter together produces a solidarity akin to family. This is also enhanced by the small number of officers who rotate through the shifts and the fact that each paramedic has worked with all staff at some period of time, so they all know each other. This is unlike city paramedics, who can be rostered on with one partner for up to six months at a time. If there are personality clashes, paramedics in remote towns are not rostered with this partner all the time. Interestingly, no remote paramedic mentioned personality clashes.

You've always got to be pretty much with each other. It's got a little more strict in the last few years - we used to stretch our elastic band between ourselves a little bit more, perhaps one of us would go for coffee and one might not. But they've said enough of that, so we don't tend to do that anymore. We tend to do most of our things ... if one of us needs to go home to check pets or feed stock or whatever, we do that. But we are still very casual place to work. So, I can't complain (Int. 3: R&R).

You cover for each other. Yeah. And that's something that's definitely doesn't happen that much in the city (Int. 1: R&R).

8.2.5.1 Scope of practice

The community spirit seemed more instinctive in the remote area and is an expected part of the culture. It is known that resources and personnel are scarce, so skill sets overlap between organisations, and back-up assistance is given from other sources such as the police, firefighters, or other emergency responders. Because of this more integrated approach, these remote paramedics interviewed saw their scope of practice as greater than that of their metropolitan peers. The two quotes below demonstrate this integration and collaboration, as well as their broader scope of practice:

You have much more autonomy over what you need to do and what you have to prioritise in doing before you get back up, and we're lucky that the CFS down here are also the fire rescue units, so we actually work and train with them quite regularly. They're first-aid trained, they've all done up A3 posters of the layout of the ambulances so that they can use that, and with our training sections, know where our equipment is so that they then become sort of vollies, the equivalent to vollies or can assist us in treatment so ... yes, we might be out by ourselves for a certain period of time, but we've got other services around and everyone chips in (Int. 1: R&R).

We have a slightly more unusual setup here, that the hospital has been told that if things go pear-shaped, they can call us in as ambos to help them if they get a patient that walks in, and it happens all the time. You'll get your farmer that walks in that's drooping in having an MI just because they're too stubborn to call an ambulance, and it's stopping them doing their bloody work for the day. And they're already busy with everything else on the ward, and they can't get any additional staff in, they've been told that we're more than happy to come in and help them out. And we come in ... but we'll operate under our own guidelines and policies, just using their equipment and their facilities (Int. 1: R&R).

So, essentially we went to play doctor and then did our consult over the phone and we would look after the Accident and Emergency, and then we would progress to looking after the hostel and then progress to looking after the nursing home. And completely beyond us, but ***supported really well by the nurses, the cleaners, the dog trainers, whoever worked in the hospital*** *were really happy for us to participate, so the work environment was tremendous and very professional (Int. 2: R&R).*

So, that's another little feather in our cap, and we know that we can provide the community, and we're inherently proud of that because it's not something that a lot of other stations can do or do, so it's another skill that we have, and it's not an easy skill (Int. 1: R&R).

8.2.6 How does this influence the culture of coping?

Each of these factors alter both the coping strategies available and the culturally acceptable methods of engaging in those strategies.

8.2.6.1 Protection of the family

Firstly, the protective and supportive nature of most families gives comfort to its members, knowing that they can talk to, and trust, each other with an implied level of respect and confidentiality:

But then also there's the people in your crew who are also very supportive and it's just like one big family. I like it I mean, because I haven't got any sisters and now I've got lots of sisters and other brothers and sometimes you think, you know whatever, but overall it's really good (Int. 5: R&R).

So, and I feel ... and because of what employment like it is, quite a positive space country, because all of that negativity ... squabbling adults [in the city] ... down here, everyone is just going on their merry old way. Got your job, go to work, you have your days off, you come back to work, and it's nice. It's a nice balance, it's a nice place to be, so I think I would be a lot happier turning to my peers here and having a chat to them because it is a happy place, so I don't really ... I don't fear their judgement at all. I feel supported by them so I'm not ... I'm a lot more comfortable to talk to them and they have had those experiences and they know it happens, so I think there's that: a) there's that childlike thing with "we want to protect her", and b) I trust them to talk to them (Int. 6: R&R).

8.2.6.2 Trust

Because of the feeling of security and safety that a family environment can provide, remote paramedics appeared to be more prepared to allow themselves to become vulnerable and be brutally honest and open when discussing their concerns. They seemed to have the ability to use the audit process in the spirit for which it was intended; i.e., identification and analysis of issues or problems, so that solutions or other options can be considered.

Like, one of the things that I really appreciate about being down here is that "shit, don't know what's going on" conversation. It's like ... but it was really nice, like instead of being like, "yeah, I've got my underpants on the outside! Everything that I did was absolutely fully sick all the time, I nailed everything", it's like "Nah, fucked it, turned to shit. This is what I'm doing about it now", and I'm auditing it, and this is the learning process, so I go "Yeah. Made a mistake" (Int. 6: R&R).

8.2.6.3 Time to debrief and have closure

Because there can be considerable time between jobs, the paramedics said they had an appropriate and unhurried or unpressured amount of time to fully debrief about an incident if they felt this was necessary. There is also the opportunity to identify the outcome of their efforts by interacting with hospital staff to inquire about the patients.

The bigger teams, the metropolitan people, will probably … find it harder because they don't really have that nice routine time after the event, whereas we are ... we're here, and we've got the time to diffuse … Metro colleagues are more ... busier, but we have the nice ... being next to the hospital, and we have a good rapport with all of the hospitals in the area, so especially here and in [Country Town], so we can actually follow-up quite easily (Int. 4: R&R).

So, that's generally when we do our debrief, and normally then, we just have a big chat about it and go pop across to the hospital and see how the patient's going, chat to staff, particularly when it's quite significant and you'd been running it (Int. 2: R&R).

If we work with someone that we've work with for many years, we fall into that routine of going back to what we were doing prior to the job. And only if it was a particularly interesting job, or we are interested in the outcome of that job, would we go into it any further. Otherwise, it's a case we've done and that's it. It's finished. I'm like a carpenter who hangs the door; he doesn't go back and stare at the door for a while after, it's done. And at the end of it all, whatever the outcome is, we have no influence over it once we take the patient to hospital. It's all about ... well, we may go over and check to see how the patient's getting on. I think that's more of a country thing (Int. 4: R&R).

Whereas in the city, you just ... you might see it on the news, and if you did a good job or there was something particularly interesting about it, you might get your team leader to chase it up on [the metropolitan hospital information system] afterwards. You know, what was the outcome? What was their injuries? But that's kind of the limit of your involvement (Int. 6: R&R).

8.2.6.4 Negative aspects

Although there is more time to debrief on the job, the nature of the remote roster is that the end of one's shift is not actually the end of the shift. As part of the on-call component of their rotation, these paramedics must "take work home with them." This influences their family and social life as well as their ability to fully rid their mind from work. And finally, there is the impact of remoteness and specific personnel and resources; as many organisations broadened their skill set to back up others in need, so the remote paramedic is required to perform duties that their metropolitan counterparts would not be required to perform:

The downside of being on-call is that you don't technically do a full dump of the day because you are still working, so you don't dump until the end of the 4 days. So, there's that chance of carrying over a few jobs or a few things over those 4 days that you can sometimes take home (Int. 1: R&R).

Because I used to work in [Remote] and their ... the strange part of it ... when you're working in [Remote] you're working 4 days on and 4 days off. So, you're 24 hours is 4 days. You've got to have a 0.0 blood alcohol, so you can't drink. There are a lot of people who do drink, I don't (Int. 13: CT).

We used to remove a lot of the bodies in the old days, put 'em in the ambulance and that sort of thing. [Now], only rarely if you really need to, like if you need to get 'em out of public view, it's distressing. So, we don't take decomposed bodies, we don't take bits and pieces (Int. 2: R&R).

8.3 Country Town:

The country town visited in this study has a population of nearly 30,000 people and is located 425kms away from the nearest capital city. Considerably more integrated as a (metropolis) provincial capital than its remote neighbour, the station is noticeably larger with several private and communal areas. Only relatively newly opened, the facility was modern and incorporated more recently acquired equipment to service its much larger population.

The personnel numbers here were greater and more varied in skill set or requirement. The numbers were in the vicinity of 30-40, with a few team leaders, several paramedics, and a number of ambulance officers. The average age of the members interviewed was in the 50s.

8.3.1 Interaction and engagement

The opportunity to attend this station was organised on my behalf by the participants of the rural/remote station, who telephoned ahead and encouraged their country counterparts to consider offering their views on the topic. On arrival, the station was deserted, and when someone did return, it became apparent that my arrival had not been communicated widely and that my presence was unforeseen. However, this potential hurdle was quickly overcome as the members immediately indicated their willingness to take part. As the station was considerably larger than that in the remote area, there were more members present at any single point in time (perhaps 6 – 10). There was a general feeling of relaxed but constant productive activity. The social activities differed, in that if a group was to have coffee, the beverages would be collected and brought back to the station, rather than a group going to a local café.

8.3.2 Occupational culture

The culture was appreciably different to that experienced in the remote area. The sense of cohesiveness that characterised the remote town appeared to be absent, and loyalty, protectiveness, or connection between members only occurred on the basis of trust relationships. Sub-groups splintered or united according to age and interests. Despite this, they still exhibited a collective spirit characteristic of country towns when interacting with metro paramedics. Similar to the remote town, many of the paramedics in the country town

station had worked in the area for several years: it did not appear to be a short-term decision to come and work in the country. In addition, as the career pathway is different, it was possible to commence in the occupation much earlier in the country town than in Metro:

> *Yeah, so I did the Cadets in the country, and then you could be on ambulances really early on in the Cadets because you're in the – they thought it was appropriate to send 14 and 15-year-old kids on ambulances (Int. 16: Metro).*

However, even though there were greater numbers of personnel working in the country town compared to that in the remote station, teams often only worked and interacted with a smaller number of paramedics; after a decade attached to the one station with only 30 to 40 officers, some paramedics had never worked a shift with other paramedics on staff. Nevertheless, despite personality differences, and a lack of opportunity to work with everyone on the team, all the staff knew each other.

> *There's probably 30 people that come in and out of here, and you know all of them, and you know who's going to be here and you know who's not going to be here and you can – it is different – it's a different sort of feel – in terms of just what that actually is. I guess whether you get along with people or not get along with people, you know everyone and you know what they're about and you know what to expect and you know what the feeling is going to be like and what kind of conversations you're going to have with them or around them, whereas if you are in a large metro station or if you're sitting in the back of the ambulance at a hospital in town, you are always being a bit more careful of who's around you I think (Int. 11: CT).*

> *And country tends to work differently so we have ... you might do 2 or 3 rotations with one person and then you'll swap to someone else. So, if you don't get on with one, you likely to get on at least better with the next (Int. 7: CT).*

> *When I first started here 25 years ago, we used to go and play social tennis and we might go for meals, but that doesn't happen ... and I wouldn't, not anymore. No, we don't tend to socialise very much. It's a little bit cliquey here (Int. 8: CT).*

Another important difference between the remote and country town culture of coping is the fact that there is no on-call work. As the station is fully staffed for 24 hours a day, members are able to go home and "leave work at work" at the end of each shift. Because of this, paramedics are given the time to completely disengage their mind from the service and to use their own coping strategies if necessary.

8.3.3 Role, routine, and jobs

The style and rate of work also differs in comparison to the remote area. The rate of deployment is higher, so there is essentially less time spent in the tearoom conversing with colleagues in a relaxed atmosphere. Similar to the remote station, transfers of patients to the nearest capital city takes hours, so members spend long periods of time chatting and caring for their patients. Another factor shared by the remote and country members is the severity of the injuries sustained by patients involved in motor vehicle accidents. This was the result of the increased speeds travelled by cars involved in accidents, the reduced quality of the roads, the lack of knowledge of road conditions, usually absent lighting, the abundance of natural hazards (trees and kangaroos), and often a lack of familiarity of the techniques necessary to drive safely in rural conditions because many of the drivers are tourists. With this increase in severity, there is the possibility of an associated increase in the impact these accidents have on a paramedic's mental health wellbeing.

Another factor is the role paramedics play on the job. Country practitioners carry an increased burden of responsibility because of an increased scope of practice:

> *Yeah. Oh, country's quiet. Yeah, it's much quieter than the city and you don't, like ... when I went to that leg amputation. The ICs were the first ones to arrive, and then us, and we had [the Emergency Retrieval Team] and we had everyone on our doorstep. My partner did a leg amputation from a shark bite in [seaside country town] and it was her and her IC partner for an hour even at hospital. You know, the doctor was on the phone to [the Emergency Retrieval Team] the whole time, so he ran the Resus. Like it's just, it's viewed differently. You're way higher up the pecking order. You're the shit ... like it very much falls to you a lot of the time (Int. 17: Metro).*

8.3.3.1 Jobs

8.3.3.1.1 Style/kind/type of jobs

The country town location has similar scenes and incidents to those encountered in the remote area, except that there is a hospital situated in the country town, which necessitates more frequent patient transfers. Moreover, simply the increase in population drives the increase in the call-out rate.

8.3.3.1.2 Time with patients

Similar to remote towns, paramedics in the country are able to spend more time with their patients because of the distance travelled to the nearest hospital. Their comments are analogous to that of their remote colleagues:

> *Yeah, and that's the other thing – you do a lot of the long-distance transfers which is something you don't do any town [Metro] – or any transfers because we have got all the PTFs [Patient Transfer Officers] in town, so it's very rare that you do something like that. Yeah, you do get the rare job where you've got someone who is very sick and you're a long way away and you have … for a long period of time (Int. 11: CT).*

> *The team does about 120,000 kms a year in the one vehicle. Cos, we do quite a number of … like a really easy day, we would drive from here to [Country town] or [Country town], pick up a patient, bring them back, put them into [radiology], go and have lunch, go pick the patient up, take them back to where they came from, have our second crib, drive home, and it's basically knock-off time. 800 k's for the day perhaps (Int. 9: CT).*

> *I guess like we knew we were going to a vehicle accident. We were quite a distance away, so it probably took us at least about 40 minutes to get there (Int. 10: CT).*

8.3.4 Relationship with the community

Once again, the similarity between the remote community and the country town is apparent, with the only difference being the population, so there are many more people to know. The paramedic below noted:

> *And I knew these people and I was just, that's one of the problems with working in the country 'cos you know everyone, and so that made it harder as well. I didn't know them well, but I knew them enough that this kid recognised me and knew me, so of course, he was quite clingy to me (Int. 10: CT).*

> *Well, we had a case, years ago, in [remote] where a police officer accidentally shot his wife and killed her, and we knew the family, we knew the wife, we knew the kids and everything (Int. 13: CT).*

8.3.5 Relationship with other members at their station

The composition of the station is more varied due to the increase in staff numbers at the centre. However, there is still a paramedic perception of a general country/remote feel of closeness.

The atmosphere is pretty good, and everyone is quite relaxed and you get along with everyone quite well and you have a reasonable amount in common I think, but yeah, I could come into work today and I am working and there is 4-5 on the station I have nothing in common with, and then the next day, there could be four people that I get along really well with. It just depends what day you come in I think, but I think the general – if you're going to average it out, the general atmosphere is quite laid back, which is good (Int. 11: CT).

Look, we've got a really good station here. I do hear some horror stories as far as that goes in the city, whereas here, I think it's a little bit more balanced. I think it has got … we do have a lot more time probably to sit around, chat, and get to know each other and stuff, and you're not just ... it's not just a work … like it's yeah, they're not just your colleagues, they're also your friends (Int. 10: CT).

It certainly helps to create a team, because you haven't got little dyads working, and you know being quite insular, it is a team-based thing (Int. 7: CT).

We have three married couples here, and a father and daughter and a father and son, all on our team (Int. 10: CT).

On the other hand, the reliance on other members within the organisation is a concept not easily adopted by their metropolitan counterparts, as discussed in more detail in the next section. The reliance on other paramedics solely for support and friendship can be a foreign idea. The following quote is from a country town paramedic who recently relocated from the metropolitan area, and demonstrates that support and friendship in this area comes from within the profession, not from school and family:

I think one thing I've noticed being in this small town, because I've never lived outside of [Capital city] before, the last 8 months or whatever, it's been, most people – it seems like most or all of their friends in the town are from work, whereas I found like I mean in [Capital city], I mean you've got your school group of friends; your work group of friends; your sport friends – this that and the other, and you hang out with different people at different times, but around here, everyone just seems to come to work with work people and then go home and they hang out with work people (Int. 11: CT).

8.3.6 How does this influence the culture of coping?

The coping strategies available and the culturally acceptable methods of engaging in those strategies differ between the country town and the remote area. There is less of the taken-for-granted support, particularly between the different age groups, and a skill set disparity between experience and qualifications; therefore, the protection of the family is not a foregone conclusion. Trust is also not as quick to come by.

I've had good support from the senior ambos here on the station, but I couldn't say I've had much support from [a team leader]. He's ... I'll put it to you this way, I regard my peers as people who are either my equals or my seniors. I don't regard [the team leader] as my peer. He's only been in the job for 5 minutes (Int. 8: CT).

8.3.6.1 Time to debrief and have closure

Less downtime naturally means less time to talk about jobs and to process stressful information. The passage of time and the changes that occur due to this (which are discussed in a later chapter) can alter how paramedics cope. The next paramedic explained that their debriefing was not usually conducted in-house:

Most of my experience is in [Remote] and our debrief was probably "How are you feeling?" "Ah well, you know, bit stressed." "OK, well, I'll see you down the bar and we'll have a couple of beers." And that's basically what we did (Int. 9: CT).

8.4 Metro (outskirts):

The metropolitan area studied has a population of approximately 1.3 million people. This city is serviced by just over 20 stations of varying sizes, with only a few designated as true industry hubs (referred to as Metro (hub)). The station attended was a similar size to the country town station, again with several private and communal areas, but also with more workstations for managers and team leaders. It also had the advantage of being located close to one of the major public hospitals. The station occupants were far more transient, with crews from all over the metropolitan area dropping in for various logistical reasons.

There were many more paramedics moving through this station. It was not like the situation in the country or the remote area, even though there were dedicated paramedics assigned to that area. It was considered more of a base from which to start and finish a shift. For the majority of the hours at work, these crew members were in, or near, their vehicle. Also, because Metro deals with larger populations, there are more specialist paramedics (ICPs and ECPs) available when necessary. This is generally a younger workforce than in the other areas, which is implied by the average age of the members interviewed being less than 40 years.

8.4.1 Interaction and engagement

Interest in my non-clinical research seemed to reduce correspondingly to the station's proximity to the city centre. Again, contact was achieved via a team leader who was interested in mental health wellbeing, and the members of his team were encouraged to take part. Paramedics became involved after reading the information left on the tearoom table, chatting with me while I was at the stations about the topic, hearing others' experiences of the interview process, or just spontaneously deciding that the timing was right.

8.4.2 Occupational culture

The social nature of this station was unlike that at either the remote or country locations. Several teams worked at this station. There was a constant flow of paramedics coming and going between jobs; both members connected specifically to that station or others for whom the station was the closest at the time, or who were sent there to fulfil some administrative or logistical task. The perception of a consciousness of a connectedness to one place was absent. An occupational culture was apparent, but it was more dispersed through the whole of the organisation rather than in an isolated area. Identity was generalised across the whole metro area. The focus seemed to be more on getting the work done than on the wellbeing of individuals. It felt like the individual was absent and when wearing the uniform, all members were "paramedic."

> *I love working in the city, I like the job and I like the atmosphere, but I do not miss the negativity. And that ... 'cos it's not the work, it's not the jobs, it's the people, and the attitude, and what they bring to work every day, and it's the systemic issues that are making people anxious all the time, being sick. There's just a lack of ... I don't know, personal engagement I suppose (Int. 6: R&R).*

> *A lot of the time, you can still be in a group of people and still have a discussion about whatever you want, but I think you're always just that little bit more careful about who's around and who you're talking to because it's just so much bigger group of people that you don't know and have never met that are in the exact same role as you are on the other side of town (Int. 11: CT).*

> *Metro the time and place ... you're out and about anyway. You can't travel 5 minutes in [Metro] without seeing an ambulance somewhere (Int. 1: R&R).*

The paramedics said there was less flexibility in rostering in the metro area. Shifts are usually '4 on 4 off', comprising of 2 morning/day shifts (either 10 or 12 hrs), 2 nightshifts (either 14 or 12 hrs) and then 4 days off. There may be some differences in rostering for paramedics that have attained higher qualifications/skill sets such as the Intensive Care Paramedics (ICP) or the Extended Care Paramedics (ECP), as they are required to attend shifts within the communications building to act as advisories for other paramedics around the state. However, as in the country town, members are able to leave work and not think about it, or be prepared to jump into the role at any unexpected moment.

The other factor that is more apparent in the Metro area is the utilisation of more ECPs and ICPs. In upskilling, the role differs which, in turn, affects how they fit into the established culture:

> *It's also because of the role that we do. We have a central location and we tend to wander around. So, interactions on stations aren't … So, we're not as in the station teams evolved. We're only CP's, so we're overpaid and underworked compared to what they're doing. So, there's a little bit of "they're ECP's" and we say no, and we can direct clinically a little bit where they go or what they do on the job over the phone. So, you're part of that, they think you're management, not think you're management. So, we're in a bit of a mixed bag. So, some people really love you and you get on, and others don't because they've got a gripe with it and they don't – it's just that cross and that's always going to be in any organisation. It's not, when you have different clinical practicing groups, it doesn't mean one's more skilled than the other, but obviously on a pay scale, I'm above what they're getting, but that doesn't mean that it would be better if it was different. Theoretically, I'm supposed to be more knowledgeable because we have to give them directions (Int. 16: Metro).*

There are also many other roles for the paramedic in the metropolitan area; for example, single occupant cars are used as they can respond quicker to an emergency than mobilising a full crew:

> *You're trying to just get a bit of treatment initiated till an ambulance can get there. One person helping is better than, if the resource is here and the jobs over there and … your next cruiser out of the [nearest Emergency/Public Hospital] we'll send that car there, if it's an asthma attack, well they can certainly dish out a lot of treatment before the crew comes (Int. 15: Metro).*

8.4.3 Role, routine, and jobs

The rate of jobs assigned in any shift in the metro area was far greater than that in the country areas; however, the distances travelled to arrive at a specific destination and then to transit to the nearest appropriately resourced hospital was shorter. More patients, but less time with each was the usual pattern. Metropolitan paramedics do not often spend hours stabilising and talking to patients; therefore, they are able to focus more completely on the task rather than the person, the technical issues faced, and the medical mechanisms of action at play. In addition, extra resources such as more experienced or qualified personnel are much closer at hand, so a paramedic is not long without required assistance. However, the relentless nature of the callouts can lead to both physical and mental fatigue.

> *We were at [suburb] and before you knew it, we'd had ... well, the ICs were the first ones to arrive, and then us, and we had [the Emergency Retrieval Team] and we had everyone on our doorstep (Int. 17: Metro).*

> *It's busier – in town it's certainly busier, and I think I don't know if anyone has talked about the general mood and vibe of everyone is down. I haven't been here for very long, so I don't think so as much – I haven't got much to compare it to, but I think everyone at the moment in [Metro] is just trying to take any second they can to just take a breather and just relax, because it's pretty much go, go, go, all day in town. In terms of the work you do, I think it's all the same really. I mean they talk about coming out in the country and doing all your … agency stuff – I've probably done less than half a dozen and apart from that, all the work is the same. I mean, a slightly different process in terms of treatment and hospitals and stuff, but technically, it's all pretty similar. Probably – no actually, I was going to say, it's more mental health out here, but there's heaps in town (Int. 11: CT).*

> *The shift no, the shift, the combination of not enough night resources, being fatigued, not having breaks, or having a very late break. So, you've got this tiredness, tired, grumpy person that can't eat and you put that combination together and at 4:30am in the morning and then you get your adrenaline. Your tolerance level is zero and then they give you another job or they give you a break and then they break your break and because it's so busy, and then and so then that, that tired, grumpy, hungry person becomes, becomes some sort of a vampire or something at that hour of the night (Int. 15: Metro).*

8.4.3.1 Jobs

8.4.3.1.1 Style/kind/type of jobs

Injuries sustained in motor vehicle accidents are generally more minor than those encountered in the country because of the reduced speed limits in force within the city; however, the possibility of encountering mental health issues or acute psychological

episodes is heightened. Another perception is of the nature of illness that warrants a call to the paramedics for assistance. Although in the country, paramedics say that the patients believe a heart attack will be annoying because it reduces the amount of work a farmer can do that day, the attitude of a metropolitan patient can be quite the reverse:

> *There's a bit of an unwritten rule that in the country, people will call you because they're quite unwell, whereas in the metro, people call you when they're not unwell. Do you know what I mean? In the city, people will call you because they've been bitten by an ant (Int. 14: Metro).*

> *They rang him and said seriously what's wrong? "Oh" he said, "I've stubbed my toe" and I can't get home. So, and he couldn't talk to his mum because he'd run out of credit - so he gave me the number and I rang his mum and I explained, and she called him a princess and told me she'd sort him out and I cancelled the ambulance. Or the 15-year-old who woke up at 2am in the morning shaking, and I rang her back and said to her "Why do you need an ambulance?" "I'm shaking, I'm upset." "So, what were you doing?" she said, "Oh I was asleep." "And is there something that happened to make you shiver?" "I had a bad dream?" And it turned out she was in a house, and I said, "So is anybody else there?" she said, "My 18-year-old brother, should I wake him up?" I almost said "Yes", because I'm pretty sure if she did, he would have slapped her – which is exactly what she needed. But I didn't, I was very professional, I gave her a little bit of empathy and said, "Why don't you just go back to bed, and go to sleep, you'll be fine, it'll all be better in the morning (Int. 21: Metro).*

Because of the rate of jobs coming through on any given shift, the metropolitan paramedic receives a greater variety of jobs than their country colleagues. This means that they can have a run of similar jobs.

> *The coordinator gets stuff on his screen, he sends it out or she sends it out, but they've not thought about, hang on a minute, they've actually done 4 hangings this week. How about we just send out another crew for the – but they can't possibly keep all that in their heads but, actually that's probably not a good example. They done 9 [minor metro] hospital transfers today, they're probably sick of that. How about I just give that to somebody else. That sort of thing, but that's, it's not once again, that's not personal, that's procedural (Int. 14: Metro).*

This also means that the paramedic can encounter situations that may be considered traumatic, but have no time to focus on processing them:

> *In the service, you do the cardiac arrest, you wait for the police to come, then you give them your paperwork, you go in the truck, you get another job, there's no time to worry about it. So, all of a sudden, you've done 10 jobs and the cardiac arrest was job number 10, you've now done 8 more jobs, you're now fatigued, and you've almost forgotten that you did a cardiac arrest at the beginning of the day (Int. 15: Metro).*

8.4.3.1.2 Time with patients

One of the most noticeable differences between Metro and country/remote paramedics is the amount of time spent with an individual patient. This is markedly reduced because travel distances are far shorter.

> *Total patient time would be 15 minutes from the time you rocked up on scene to the time you dropped them off at Emerg. You had very little time to troubleshoot and work out ... "Is what I'm doing the right ... am I going down the right pathway?" So, there'd be probably more of those jobs in the city … So, even just in minor bread and butter jobs ... picking up the chest pain from the medical clinic to take to hospital ... it's a 5-minute job. You're barely starting the paperwork and you're already at the hospital (Int. 1: RR).*

8.4.4 Relationship with the community

In the metropolitan area, paramedics do not have such an intimate relationship with their community. They are considered to be a service. Here, they are known simply as a paramedic because they wear the uniform. Paramedics do not have individual identities and are potentially treated with less respect accordingly. This is reflected in the statements made by metropolitan paramedics in relation to interactions with civilians or non-paramedics. Positive general community interaction opportunities are rare, so when the Metro paramedic talks about members of the public, they comment more on their non-medical friends and patients' misperceptions, interpretations, and remarks:

> *When you tell people that you're a paramedic and they go "Oh, you must see some terrible things", it's almost the generic response, greater than 90% of respondents and they're expecting you to say that "Oh yeah, I see people's brains and blah, blah, blah." No – when people say that I'm thinking – yeah, I went to this real bitch last night that told me that I was worthless and blah, blah, blah. That's what bothers me (Int. 20: Metro).*

> *Infrequently, it does happen, but not as frequently as you get verbally abused. Last night for example, I got verbally abused. A lot of the time, the people that are verbally abusing us, they don't really have a physical presence, they can be quite intoxicated and if they were to throw a punch or swing a knife … and would probably fall over. To go to someone who's probably just drunk and doesn't want us anyway because some do-gooders called us, and then is going to hell abuse us when we get there (Int. 20: Metro).*

Other issues that do not tend to come into play as much in the metropolitan area as in the country include the possibility of knowing one's patients and the increase in the scope of practice. The likelihood of a metropolitan paramedic personally knowing a patient is low

considering the size of the population. The scope of practice, on the other hand, could be considered to be as broad as in the country; however, each role has been specifically designed with labels, training, and pay rates, and an individual paramedic becomes a specialist in one role, rather than being able to perform a range of tasks, or any role required that falls within the overall guidelines.

8.4.5 Relationship with other members at their station

As in the country areas, the metropolitan area paramedics are also grouped into teams; however, they feel more like collections of people that have the same supervisor or team leader. Some groups are more cohesive than others, and this also seems to be, in part, driven by the attitude of the team leader. Team building exercises are attempted by some, but there is not much time allocated to such organisational cultural concerns compared to the maintenance of clinical skills during the rare professional development days.

Staffing rosters are managed differently in the metro area. Paramedics are scheduled to work with a single individual for a substantial period of time. Although annual and sick leave, along with other spontaneous personal events, will change the actual number of shifts that are conducted together, six months is quite extensive, and this situation comes with its own challenges:

> *I was only up there for about 9 months. I think one perhaps major factor that's different is the way rosters are worked. So, Metro works ... basically work with the same person for 6 months and then someone else for 6 months. I know people at Metro that have worked with someone that they haven't got on with, and it is a nightmare for them. It's very ... that becomes the greatest stress in the working day (Int. 7: CT).*

> *But it's still, it's difficult, you're so saturated with that person's personality, it's hard to not pick up traits from them, especially in a mentor/student relationship, because there's always someone who's more senior on the ambulance, that relationship tends to show, I feel. Yeah, it's like, you're in a confined space with them, this tiny cabin for 48 hours a week. Quite often, we don't spend that much time with our loved ones during the week unless you live with them. So, it's a significant relationship (Int. 20: Metro).*

Finally, ranking or qualifications seem to play a role in trust relationships. The recent interns in the metropolitan area seemed to cope with their situation by supporting one another as a collective, rather than defaulting to the over-competitive nature that they developed on their way to this level of their career.

> *It was if they could – the ranking was, it was in other places, but not with us. We were all pretty good that you'd all work together, and if you found an interesting article, you'd send it to people and be like, I found this, this is really interesting, or I went to this job, I've done this audit, have a read of it, like we were all pretty happy to share our whatever we had, and which is good, yeah. It's just what we did (Int. 19: Metro).*

8.4.6 How does this influence the culture of coping?

Each of the factors that differ across the three locations alters both the informal coping strategies available and the culturally acceptable methods of engaging in those strategies. There is no 'protection of the family' perception in the metro area as experienced by the remote paramedics. There is rarely time to fully debrief at the time of an incident, with back-to-back jobs making the processing of an individual situation difficult, closure is not generally contemplated, and trust is only given to others who have been known for some time, have become closer, and who have proven themselves trustworthy. There are usually a number of people around at any one time, especially at shift changes and an individual cannot know everybody:

> *So, say you're at [Metro (hub)] on any day, and it's your crew that's there, but 100 other crews plus two … managers plus three PSOs plus a couple of team leaders, and unless you're sitting in a room with the door shut, you've always got your ears pricked up of who's around you and you're very aware of what you're talking about and you probably get very political at certain times … politically correct I guess in the way – just talking because you've always got to be careful that you're not saying the wrong things, but then you go to a station where it's just a one crew station and it's a lot more lay back I think and the vibe is a bit different (Int. 11: CT).*

8.4.6.1 Negative aspects

The predominant aspects that emerge in relation to the difficulties that metropolitan paramedics face when trying to consider their mental health wellbeing, is that they do not get enough time to process emotional information in between jobs, the clinical information that they receive is not reliably accurate, the decreasing amounts of time on the job means

they have no ability to progress the situation positively (e.g. ramping), and the various threats to physical wellbeing:

> *It is another job, after doing job after job after job it's another job, you're going to another job, you're not going to Mr Smith that's bleeding to death on the floor, you're going to another job. We don't look too much at the job at times, it's more like, "Okay it's priority 2, we're going lights and sirens." Priority 1, yeah, it's more ... probably a cardiac arrest, then you might sit down ... oh well, it's a 90-year-old male, oh no, you know what, it's a 10-year-old. And then, you've got a completely different hat on. That's, that's probably the only time that we would go, "Whoa shit, you get this, I'll get that, we'll go straight in, who's, who's who else is coming to help us? where are they?" (Int. 15: Metro).*

> *I think the downtime for me, like when you're waiting around, a lot of the times you've got to wait outside of someone's house until the police get there. Or you have to wait with the patient until we can get a lifter to come in and lift them up, and it can be hours at the scene. And then at the hospital, you can be waiting in the ambulance, like ramping, waiting, waiting, waiting, and you just want your patient to get taken care of, but you've just got to sit there and wait, or even like being triaged, you know "I'll be back in a minute", and then something will happen and they're still in there half an hour later waiting to go through. So, I think waiting is the worst bit in all different areas (Int. 23: Metro).*

> *Ambulances get crashed, cars get crashed, we are very frequently … factors in vehicle accidents because of operating under emergency driving conditions. Yeah, and going further out into the country where the roads aren't so good, visibility is not so good, we're tired, middle of the night, we should be asleep, our brains telling us to go to sleep, can't see too well, kangaroo might jump out, and swerve – things like that go through your mind (Int. 20: Metro).*

8.5 Metro (hub):

Although still dealing with the same metropolitan population as the 'outskirts' areas, inner suburb stations (the true industry hubs discussed previously) displayed another set of unwritten rules regarding the research, or perhaps, simply a set of views relating to granting access to outsiders. The station was very much larger than the country stations and comprised numerous teams per shift. It appeared much more business-orientated, with more administrative staff present, and the hierarchical structure was practically palpable with environmental barriers such as walls and other solid structures enforcing this perception.

8.5.1 Interaction and engagement

There were more team leaders available at any time during a shift than in the remote teams. Their office workstations were located some distance from the areas in which the paramedics had their 'crib' break (any mealtime) or awaited callouts. Paramedics in this area spent far more of the shift on the road in transit, or between jobs, due to the constant stream of callouts. Communal gatherings only predictably occurred at the change of each shift.

It was not possible to explore the culture of this category of station because there was no interaction allowed with the members directly; although this in itself is evidence of a difference in culture across the various station locations. Very few team leaders appeared interested in the research on any level, and only one informed his team of the opportunity to take part. Research on anything other than clinical developments appeared to be viewed as unimportant, to the point of time-wasting. The cultural factors behind this value set are open for interpretation; have they been over-researched and are now not interested in yet another study? Are they so intensely busy that they do not want to think about work in any off time (as there was no leeway to conduct any interviews at the station)? Whatever the reasoning behind the attitude, no interviews were conducted with this group of paramedics, which unfortunately introduces another level of bias, and unfortunately, causes an absence of the rich perspective that this set of members could have provided that would have rounded out the research.

8.6 Summary

This chapter has outlined the differences in the culture of coping due to a paramedic's primary working location. The information has been structured to sequentially reveal the geography and population of the area, the reception of the researcher and of conducting research on a non-clinical subject, and the occupational culture in general. This was further teased out into differences in the roles and jobs encountered, and the relationships experienced with their wider community and their colleagues within the ambulance service. All of these factors contribute to the differences that the locations have on what a paramedic has to deal with emotionally, and what strategies are available and culturally acceptable.

The following chapter draws attention to the differences in the culture of coping due to a paramedic's age, or in particular, the generation in which they were reared and the conditions which they encountered when embarking on working life. It delineates the three generations that were working in the occupation at the time the interviews were conducted (Baby Boomers, Generation X's and Millennials), and describes how their methods of dealing with stress and their culture of coping is different.

CHAPTER 9: GENERATION

9.1 Introduction

In the previous three chapters, I have described in detail the workplace stressors that paramedics find difficult to deal with, and noted that common public misapprehensions regarding what must be stressful are counterintuitive. Details have been outlined of what the paramedics believe the culture of coping is currently, and how they would prefer it to be, as evidenced by the advice they provide to paramedic novices. In the last chapter, I outlined how the culture of coping differs by the location of a paramedic's primary workstation. In this chapter, I outline how the culture of coping is affected by generational differences in values and interaction styles. The chapter defines what is intended by the term 'generation' and breaks down the components of the three generations interviewed within the paramedic population. I examine the perceived attitudes of each generation and demonstrate how these play out within the profession: the differences in entry into the profession, ongoing attitudes towards the profession, socialisation /communication, and coping strategies.

The specific differences that are explored in this chapter include attitudes towards experience versus formal knowledge, general values and principles, entry into and ongoing attitudes towards the profession, respect for authority and company loyalty, communication preferences, and coping strategies. These attitudes are often unquestioned and taken-for-granted aspects of the culture.

9.2 Definition of a Generation

The term or concept of a 'generation' has been used extensively in common language for decades; however, sociological use of the word occurred as early as the 19th century (Pilcher, 1994). The term generally assumes certain stereotypical values held by people influenced by specific life events linked to their birth date, and their prevailing sociocultural environment. "Values are learned within a shared social context" (Lyons, Duxbury, & Higgins, 2007, p. 340), so it is not surprising that on top of occupational cultural values, there would also be differences between cohorts born generations apart. Because of these differences in how population cohorts consider the world, intergenerational workplace

conflict sometimes occurs among professional groups that operate with a broad age range of employees. A number of quantitative studies have been conducted to demonstrate these differences (Becton, Walker, & Jones-Farmer, 2014; Busch, Venkitachalam, Richards, & Debbie, 2008; Cennamo & Gardner, 2008; Lamm & Meeks, 2009; Lester, Standifer, Schultz, & Windsor, 2012; Lyons et al., 2007; Twenge & Campbell, 2008; Twenge, Keith, & Freeman, 2012; Weingarten, 2009). The presence of different generational groups within an organisation is presumed to exhibit variation across a range of values and styles. There has been an increase in research using the concept of a generation, especially when relating to differences in the workplace. The term 'generation' exists in popular culture, sociology, and biology with small variations in meaning. The kinship literature and biological terminology tend to refer to a generation as the timeframe or collective period between parents and their offspring.

In any society, individuals associate themselves with a generational group. However, individual parameters between generations can blur depending on the years of exposure to the service and the paramedic's maturity, which will lead to certain adjustments being made to their own life values, as the paramedic below noted:

> *Yeah, I guess there are a lot of different values. I feel very much caught in between the 2 groups, the younger and the older, I feel as though I'm probably starting to sound like, and progress to the older group, I feel like, that's how young they are as they're coming in now like I was when I started (Int. 20: Y).*

Generations express similar values and characteristics because they were brought up in, and exposed to, similar economic situations, parenting philosophies, and technological advances. They have also been subjected to similar perceptions of the world triggered by historical events. "A generation consists of people of a similar age in a similar location who experienced similar social, historical, and life events. … These shared experiences (e.g. industrialisation, fundamental changes, cataclysmic events, and tragedies) differentiate one generation from another because they have a profound effect on the attitudes, values, beliefs, and expectations of generational groups" (Becton et al., 2014, p. 176).

The time periods for different generations also varies. This is due to: a) the popular culture not being armed with reliable validated research and so making an estimate of when value systems appear to alter between groups; or more importantly, b) generations also have a

geographical component as different life-changing events occur at different times across the world. For example, Generation Y (or Millennials) in Athens, Greece, will grow up with different expectations regarding employment and job prospects given the high unemployment rates, than will Millennials in Austin, USA, where job prospects are very good (CGK, 2016).

9.3 Demographics of the Paramedic Population Interviewed

The dates of birth of the paramedics interviewed ranged from 1947 to 1992, which encompasses the timelines for three defined generational periods. These will be described in greater detail below under the categories of Baby Boomers (1945-1964), Generation X (1965-1980), and Generation Y (1981-1994), after the demographics of this sample have been described (see Figure 2).

Baby Boomers (Int. 2, 4, 8, 9, 12, 13, 21)

Seven paramedics (30.4%) were born between 1949 and 1962, which places them in the Baby Boomer generation. This is in keeping with the proportion of paramedics in the 50-70 year age range in the Annual Report published in the year of the interviews (27.7%) (Silent 1). All of the paramedics interviewed in this generation were male. The proportion of males employed in the service from this generation is 69.3%. All had experienced training in another industry before entering the organisation (28.6% health related), which meant that they had considerable life experience to bring into the profession. However, the majority (71.4%) had also volunteered with the ambulance service before entering the occupation, so they knew what they were getting into before they progressed to a paid position. The average length of service was 25 years.

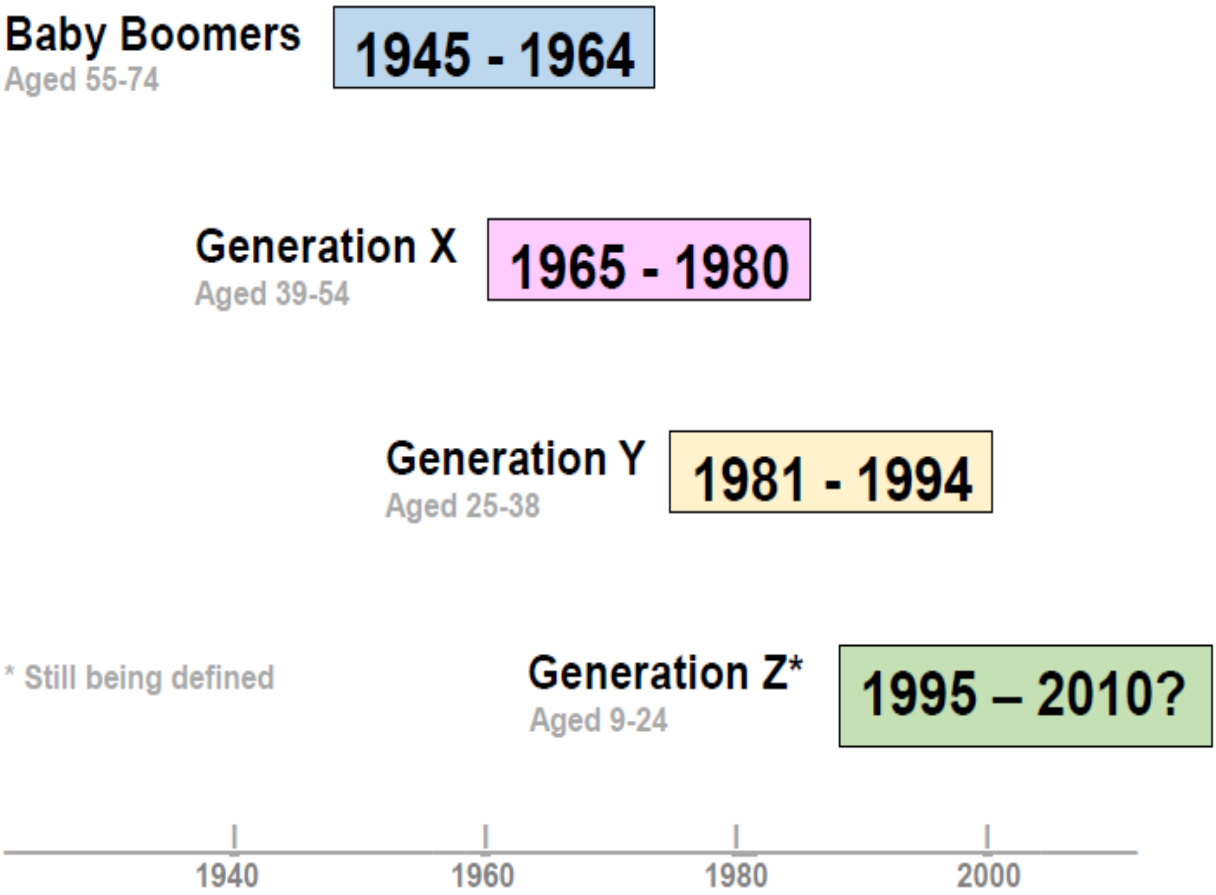


Figure 2:Timelines for Generations (Ages as of 2019)

Generation X

Ten of the paramedics (43.5%) interviewed were born between 1965 and 1972 (54% male/46% female). This reflects the exact proportion employed in the service (40%) where 54% are male and 46% female (Silent 1). Similar to the Baby Boomers, all paramedics in this generation had worked in other occupations before entering the service (20% health related), but a smaller number (40%) had worked as a volunteer before entering this profession. The average number of years of service for this generation was 15 years.

Generation Y

Only six paramedics (26.1%) were born between 1986 and 1992. This is the only generation where the proportions of representatives were much lower than in the service (32.3%). Again, the gender difference was half male and half female. This is not representative of the service, as the newly engaged workforce is predominantly female (males = 40.3%). In this generation, only one paramedic (16.6%) had worked in another occupation prior to entering the industry (born four years earlier than the other Gen Ys). Although half had indicated that they had volunteered previously, two (33.3%) had done so while undertaking their university degree, so only 16.6% had some experience of the paramedical field before committing to the occupation. The average number of years of service for this generation in this sample is 4 years.

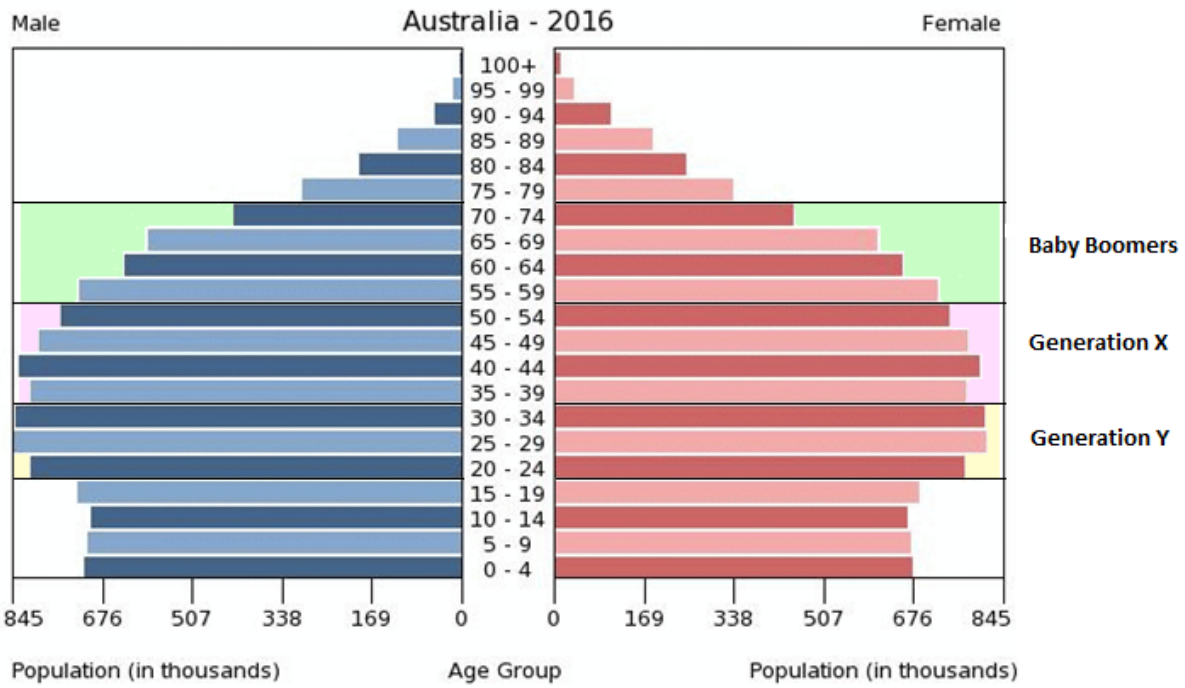


Figure 3: Population Age Group pyramid for Generations in Australia in 2016 (adapted from https://www.indexmundi.com/australia/age_structure.html)

9.4 The Generations

This section describes the three individual generations with information from both popular culture and the peer-reviewed literature, before illustrating the differences with quotes from paramedics from each generation. The discussion includes commentary on the interpretations made of each generation by the other two groups where it is relevant to paramedics. The characteristics attributed to the three generations are ideal types, and as a consequence, are one-sided exaggerations of the reality (Cheek, Shoebridge, Willis, & Zadoroznyj, 1995). For a more comprehensive, but general, overview of attitudes and values, see Figure 3 for the generational differences.

9.5 Baby Boomers (1945-1964)

The Baby Boomers are the first generation born after World War II (1939-1945), with their parents emerging from a time of poverty and restrictions experienced during the Depression (1929-1939) into an era of promising economic opportunities. They were influenced by events such as the Vietnam War and the AIDS epidemic, and accordingly, they tend to be sceptical of government, the media, and institutions in general (CGK, 2016). However, they are generally more loyal to a company, prefer working for the same company, and believe that the hard work/sacrifice/time put in leads to advancement and other rewards (Becton et al., 2014). This is probably because when they started their working life, the culture was one where it was assumed the company offered long-term security of employment. “Employees were described as not only working for organisations, but belonging to them” (Becton et al., 2014, p. 178). Formal authority and leadership are respected because of the time invested, and this leads to attitudes and attributes of competitiveness, diligence, and achievement orientation, where working is the primary priority even at the expense of family. Baby Boomers prefer working at a moderate pace, and enjoy collaboration, obtaining consensus, and “above all else, approach work with a ‘do whatever it takes’ mentality” (Lester et al., 2012, p. 342). Communication is preferred face-to-face or by phone, but they have some familiarity with technology and learning about online tools and resources.

Baby Boomer paramedics can be competitive, sceptical, and display a “do whatever it takes” attitude. They may view their work colleagues as family and appear to be more covertly

protective of their closest associates. The following younger paramedic spoke about the Baby Boomer protectiveness, particularly around their mental health:

> *I think that was more of a little baby duckling sort of thing. I was on a team with a lot of older gentleman that either had really young kids or little bit older kids or kids my age. So, I think in a way they were like, are you okay? Because they – I think some of the stuff I go to at my age, they wouldn't want their kids to see and I think to them that's why they would say, "How are you going? Are you okay? Do you want more support? Do you want this, do you want that?" Whereas, I think because there's a lot of – a lot more young people coming through, I think people are more open to the fact that young people probably shouldn't be seeing what we see or having to deal with what we deal with (Int. 22: Y).*

9.5.1 Cultural differences

Cultural differences in communication preferences and attitudes of loyalty to the group first, and the organisation second, are illustrated in the following quote:

> *The competitiveness and trying to get one up on someone else. And that's, if you've got to dob them in, dob them in. To me … you might see somebody do something wrong, I'd rather tell them to their face at the time and say "I don't think that's right. We need to look at that, we need to talk about that. Their instant thing is – report it, and it goes up the chain, then it comes down, and then it comes with punitive action. That's not moving, that's just being dobbing. And that's what we've got. That's what we're breeding into them now. They'll SLS everything. You leave your paperwork at the hospital by mistake – SLS" (Int. 13: BB).*

This Baby Boomer had an aversion to what they saw as Gen Y's comfort with reporting any misdemeanour directly to management.

Gen Y paramedics have all been exposed to the Baby Boomer generation through their own parents, families, and friends, but occupational scenarios can develop a different flavour because of the different expectations. Different age groupings also mean different perspectives on the world – the different values lead to different groups holding different views on situations as being more important/outrageous/unjust/fulfilling than others. Below are a number of comments from Gen Y paramedics on the different values or attitudes that the Baby Boomers have:

> *I like the sense of realism from the older generation that, I guess that's probably where the bulk of my black humour has come from, and the cynicism and sort of like, oh for F's sake, this person just needs a bucket and to be put to bed. I like that because it's real, it's true, in the vast majority of cases (Int. 20: Y).*

> *I think everyone comes from very different backgrounds a lot of the time and there's a lot of different age groups. So, I am the youngest here – most people by a long way. They've got different upbringings; different views on the world and just … discussing … discuss social issues and sometimes you just duck out the room (Int. 11: Y).*

There are also occupational expectations that have altered over the course of time where respect and political correctness in all interactions must be displayed. The following Baby Boomer mentioned a situation where he could be taken to task for rudeness under other circumstances, but in the middle of a job, every member is task-focused:

> *Should I say, "Please can I have the shocker this time?" You sort of just go what's happening, what's happening, what's happening. But it's never – apparently, it never comes across as rude. But they know I just want it done. And everybody wants it done, so nobody goes, "Excuse me, can you not talk to me like that?" Nobody says that. But I'm sure if I was ever rude, someone would approach me about that. So that's at least reassuring (Int. 22: BB).*

9.5.1.1 Socialisation

When Baby Boomer paramedics commenced work, commonly over two decades ago, their investment in their job, workplace, and colleagues was greater than that displayed by more recent generations. This meant that extra time was devoted to their colleagues who became more intimately associated with each other. Friendships developed and expanded outside of the immediate work sphere. The following paramedic stated that although this communal attitude was present many years ago, it is not part of the current culture:

> *I mean, when I first started here 25 years ago, we used to go and play social tennis and we might go for meals, but that doesn't happen ... and I wouldn't, not anymore (Int. 8: BB).*

9.5.2 Differences in the job

Several differences are experienced in all aspects of the profession because the generations come through at specific time periods in history where a specific amount of information is known, and particular expectations are maintained because of the prevailing societal culture of the time. As new information is acquired and assimilated, and society adapts, the expectations slowly shift. Even the performance of specific tasks will alter over time:

We used to remove a lot of the bodies in the old days, put 'em in the ambulance and that sort of thing …". ***Qu: "You don't do that now?"*** *"No. Only rarely, if you really need to, like if you need to get 'em out of public view, it's distressing. So, we don't take decomposed bodies, we don't take bits and pieces … (Int. 2, BB).*

9.5.2.1 Entry into the profession

In the view of the Baby Boomers, getting a paid position in the ambulance service prior to the 1980s was not as competitive as it is now. The service operated between 9am and 6pm, after which volunteer ambulance personnel filled the shifts. During the transition period in the late 1980s, new recruit positions were often filled by volunteers who knew and enjoyed the work enough to make it their full-time employment. The paramedics below spoke about how easy it was to enter the ambulance service when they did, but also how different their entry skill set was to that of the young recruits of today:

I was lucky that I came in at a time when we needed paramedics. You only had to sign a piece of paper and you're in [laughs], you're accepted (Int. 12, BB).

The ambulance service in 1989 did the big recruitment, and I came on board. Easy. And when you've already had the taste of what it's about, it's easier to say whether you're suitable or not (Int. 4, BB).

I think the disadvantage [now] is that you get really young people who lack the … [pointing to other members around the room] nurse, nurse, tradie, nurse. You know whatever else I did – none of us were school leavers (Int. 21: BB).

They want to take the academics. They want to take the 1% that achieve high distinctions, that's what they want, they don't want people that can do the job, they want people that can be seen to do the talk (Int. 13: BB).

9.5.2.2 Attitude to the profession

The training for Baby Boomers was not as intensive in the 1980s, and other health personnel did not consider paramedicine to be a "profession." But over time, and with the increasing competitiveness for entry pushing up the academic requirements, respect from other health professionals has increased. However, there is tension between the generations over the importance of intricate and detailed medical knowledge and the skills acquired over many years of working in the industry:

It's just a bit confronting to some of the older generation, because they're not used to [medical] people talking to them (laughs). We're very good! We interact quite well now (Int. 2, BB).

The department has actually come to the realisation that having someone like young [colleague] here is a fountain of knowledge and then going down to the [Country Town] and being involved in the Professional Development Workshops and realising that this is where the focus is now clinically. It's not just about our skills, it's about knowledge base (Int. 4: BB).

"You know, because they get told by the uni, "We're better than you because we've got uni degrees. No, the old ones are old dinosaurs" … Degree doesn't mean shit in this job. It doesn't mean you can do the job. It means I can write it down on a bit of paper and talk to somebody about it, but it doesn't mean I can do it" (Int. 13: BB).

They come back with heaps of knowledge, and truly, they do have lots of knowledge. They do. I sit in on some of these training days that we have, and I'm not interested in any of that any more truly (Int. 8: BB).

Despite the differences in knowledge base when they enter the profession, there is evidence of a clear attitude disparity about the occupational environment and the work ethic. This occurs when paramedics who 'do whatever is necessary' work with paramedics who 'will not work outside of job specifications', and was a particular issue for two paramedics interviewed. In the examples below, Baby Boomer paramedics criticised younger paramedics for their perceived value differences, specifically the laziness:

Most of them are lazy nowadays … Generation Y. Why (Y) would I do that? Why won't you do this for your patient? Why would I? I don't get paid for it. That's all they're interested in, the money. What's in it for me, and that's it. To me, that's the wrong reason to be in the job, but there you go. That's me (Int. 13: BB).

Because they take the attitude that they'll come to work ... if you could stop ... One of the biggest issues here, if you could stop the Y generation kids from walking in the door in the morning to start their shift, they look after their trucks, they'll come in and watch television, they'll watch it on their iphones or their ipad, and that's all they do. They're not interested in doing anything else. You ask them to wash the truck, "Well, it's not in my job description. Didn't learn that at uni." What a load of shit. Well that's their attitude (Int. 8: BB).

Another difference is the change in generational perceptions of longevity in a single job. Baby Boomers were brought up in an era when it was culturally the norm to invest one's whole life in the company (and be rewarded for doing so). Generation Y has the popular reputation of being 'job-hoppers' who no longer see value in staying in one position for long periods of time:

Well, most people of my generation do, the younger kids seem to ... it's a job for them, and there's every chance that they'll move on and do something else. It's not a career for them, or I don't believe it is, but for the people of my generation, it is a career. And we'll do it until such time that we retire (Int. 8: BB).

9.5.3 Differences in dealing with stress

Baby Boomers have long been considered to deal with stress in a matter of fact manner, with a 'toughen up, princess' attitude, to ignore and have a drink, or to go and get something to eat or laugh about it. Perceptions and the actual coping strategies have altered over the course of time, which has left a diverse imprint on each generation. Gen Y are more conscious of political correctness and, as a consequence, find it difficult to adapt to the glib or dismissive manner that the older generations engage in to deal with stress. This inhibits them from using the Baby Boomer coping strategy of black humour, which has an impact on their ability to deal with their stress:

Once upon a time you could come to work and have fun. You know, I know it's a stressful ... and it is a tough job for people looking in from the outside, but ... you've also got to come to work ... it's your workplace and you come to work and relax and have some fun as well. It's like we have the fun police that meet you here at the door and it all stops … There's no fun here anymore. If someone sees that you're having fun, well ... if somebody's having fun, they'll shoot them down and bring them back to earth. It's just not right. It's nonsense (Int. 8: BB).

And there are definitely a few comments from other older ambos when I first came in like "What are you doing?", if you're a bit down in the dumps, "Snap out of it, we've got something else to do" (Int. 1: X).

After you do a big bad and brutal, I go down for a pie floater." ***Qu: Right! Tradition?*** *"Ahh absolutely! For the old school it is. You get hungry! You've had a big adrenaline push and you have two things; you have fight and flight, or feed and breed. They are your two responses. So, once you've gone through the fight and flight ... feed and breed is the opposite part, so that's your way down. That's after all the adrenaline is gone. When your fight and flight response is there, we can't flight, we can't run, so we've got to fight, so the adrenaline will be there (Int. 13: BB).*

Generational differences also have an impact on the use of the Peer Support Program. Baby Boomers tend to feel more comfortable talking to people who have at least as much experience as they have, rather than someone who has attended a short course in peer support and may not have worked in the industry for long:

Possibly, although when I think about it, the ones I've spoken to have mainly been in the old age groups. That's probably because I'm doing more country areas and a lot of them are volunteers who live in the town, and they've been doing it for years, they don't get many young volunteers. But yeah, like you're really experienced ones, they will just go, "Oh yeah, thanks for the call, appreciate it, but I've been to 7 of these", like a SIDS case for example, "I've been to 7 of these, I'm fine, I know where you are if I need you", kind of thing. But then I've had, I did, I'm not sure how long she was in the job, but I had an older lady who'd been to a paed death, and she wanted to chat about it, and she said, "She knew she wasn't right", and so we had a big chat. And then she had other things in place to look after herself, so yeah, so they're probably a lot more self-aware I guess (Int. 23, X).

I think you'd find that there's a lot of us old school who won't use it. I don't think I need to talk to one of my peers that are probably junior to me that haven't had the experience, sits there and listen to me (Int. 13: BB).

The Baby Boomers' views are mostly tolerated by the younger generation, as is evident in the following quote from a member of Generation Y, explaining what they perceive the Baby Boomers to believe and how they think that this is due to the lack of exposure to organisational peer debriefing:

These people probably have got some form of probably PTSD or depression or something from a job that they've been to. And they just go, it's not for me. And as horrible as it sounds, obviously culture has changed since then, that they put it down to being a poofter or something like that. Because that's how they grew up and that was the culture when they were here, and as far as they're concerned, culture hasn't changed because they haven't had the talks about peer support. I don't think [the organisation] has really pushed it through. They're pushing it on the younger people (Int. 22: Y).

Contrary to what the older generation of paramedics think, this younger paramedic believes that the new recruits coming through are aware of what they will face on an emotional front, and that it is the older generation that is struggling:

It's very different, and I think when we enter it now, we know what we're going into, but I think they've sort of just been pushed into it. They didn't really – so they're sort of like shit, I've been pushed into it, I can't not cope. That's my job now; I have to just deal with it." ***Qu: Okay so the job changed, but their emotional attitude hasn't changed?*** *"Yeah …, because I think a lot of the older people, that's all they have. And they're the people that I think haven't really evolved with the service in terms of you get thrown into a role and it changes, and you just have to go with that. It's – to them, I think some of them think it's not okay to not be okay (Int. 22: Y).*

The Baby Boomer generation believe they cope adequately with stress, using their internal support network of trustworthy colleagues usually from the same generation. They use

humour and other diversionary techniques. The other two generations perceive these in a negative light. The next generation, Generation X, followed the Baby Boomers into the workforce, and initially they absorbed their coping strategies and practices.

9.6 Generation X (1965 – 1980)

Generation X grew up in a society that was less stable than the previous generation. They were exposed to several issues (e.g. recessions and increasing expenses, social forces, the feminist movement, the pill, 'no fault' divorce, etc). Increasing pressures, including corporate downsizing and unemployment, contributed to the high divorce rate and a growing need for children to be in care, or to just take care of themselves until their parents got home from work (CGK, 2016). Because of this, they can be considered more "individualistic, distrustful of corporations, lacking in loyalty, focused on balancing their work and personal lives, financially self-reliant, and entrepreneurial risk-takers" (Becton et al., 2014, p. 177). As organisational loyalty no longer equated to job security, Generation X was not as concerned about changing jobs, as they were more motivated by intangible incentives such as seeking work that was interesting, flexible, and autonomous, as well as higher salaries and improved benefits (Lester et al., 2012).

As members of this generation are considered to be highly sceptical of power and institutions, they are acknowledged to consistently challenge authority. They tend to be the children of compulsive workers; a fact that has considerably affected their outlook on their work/life balance, which is a primary motivating factor. They are also known to "prefer a relatively informal work social climate and have a weaker work ethic than previous generations, crave autonomy and independence" (Lester et al., 2012). Generation Xers appreciate direct communication and detailed, constructive feedback from supervisors. They are also known to be outcome-focused, blunt and direct, and prefer communication via email, or face-to-face when it is not going to waste time. But they also recognise the necessity of acquiring a diverse set of skills. "Generation X is said to have pioneered the 'free agent' workforce, focusing on keeping skills current to improve their security" (Becton et al., 2014, p. 178). The paramedics in this generational cohort tend to bridge the gap between the Baby Boomers and Generation Y and try to maintain a comfortable work/life balance.

9.6.1 Cultural differences

Bridging the generation gap is not easy for Generation X. They have found themselves accepting the Baby Boomer values as they assimilated these attitudes when they were first exposed to the paramedic workplace culture. They have seen the gradual change of culture, and almost mourn the fact that many of the social support behaviours and traditions no longer seem appropriate.

9.6.1.1 Socialisation

The differences in how Generation X socialises within the services is illustrated below. Generation X appears to be similar to the Baby Boomers in their relationship to the ambulance service; many of their close personal relationships come from within the service, and much of their social time is spent with work colleagues. As one of the participants noted, even when they have spent 8 weeks together as a team, they will still meet on a Friday night for drinks. In the first quote below, a Generation Y participant bemoans the loss of this culture, attributing it to the increased bureaucratic culture of the service, while the second participant attributes the shift to the increased size of the organisation. This contrasts with the comment from a Gen X who believes this generation initially developed strong workplace relationships consistent with the way the Baby Boomers operated; however, the newer recruits from Generation Y tend to already have strong social ties developed during their university years with outsiders, and do not seek strong social ties from within the service.

> *There's a lot more red-tape now than when I started, there's a lot more policy and procedure, and it used to be we'd have a team meeting up in – I mean this could be a country thing as well – but we had a team meeting and talk about ambulance stuff and station stuff for an hour and then we'd go down the pub and jugs of beer would be put on the table, in uniform, and that didn't matter, it didn't matter, and now it's like well … actually doing that? (Int. 20: Y).*

> *Yeah, there's a big life outside that's a lot more interesting for me, and I think that's an older thing there rather than the new, because as I said before, they've all gone to uni together, they've all … the rest of it so, they all married each other, god there's – there's a lot of people, they've all got relationships within [this ambulance service] because the demographics are 55, 40. They're the same age group, same interests, same … so eventually, they're going to form relationships. Good on them, but it's nice having something outside of it (Int. 16: X).*

I think the size has something to do with it. Like to me when I was only new in the job, our rosters would work around 8-week rotations, so at the end of the 8 weeks, everyone would get together after a night shift and we'd have breakfast together so that we'd all meet in one of the clubs in the city or something and have like a close shift breakfast. Whereas now, that doesn't happen (Int. 18: X).

9.6.2 Differences in the job

Generation Xers have also seen the increase in work intensity from a time when there was enough down-time between jobs to debrief with one's partner if necessary, to now where they are often pressured to attend another job, immediately following a case. Also, ambulance officers were originally skilled enough to perform any required task, whereas now, the tasks are more specialised, so the training and protocols have become equally specialised.

You didn't have a high workload. What there was, was a greater emphasis on emergency work … and it did have a breakdown. We did a lot of very low acuity work, so it wasn't specialised as it is now. It's not, it wasn't differentiated. You were one week running clinics, so you're talking all the oldies to their OPD appointments and then the next week you're on an ambulance, and when you're on an ambulance you did everything. So, there was emerg, transfer, emerg, transfer. You could, so it wasn't as differentiated is the word that I can just think of (Int. 16: X).

9.6.2.1 Entry into the profession

Similar to the Baby Boomers, Generation Xers transitioned into the profession with either knowledge of the work, or at least life experience obtained from working in a previous occupation that required interaction with the public. This meant that they came to the job with life skills, maturity, and extra-occupational knowledge.

Bedside manner I don't feel can really be taught to an extent, any more than you can sort of just have a functional level of it that can be taught. Beyond that, the ones that have an exceptional bedside manner, it seems to be innate with them, and you can tell within the first few hours of a placement for example, and just using a student as an example, what their bedside manner's like and what their ability to have a conversation with a person is like, it seems to be getting rarer and rarer, and I notice the more mature-aged students are more able to do it. So, it's perhaps more liking to life skills and life experience rather than anything else (Int. 20: Y).

There was a tighter sense of community amongst staff I think, and it was a different make-up of people, I think most, it was very male dominant and most of us had a trade before becoming a paramedic (Int. 18: X).

I was a cadet with St John, and I saw the old guys in it and sort of thinking, it's okay, but it's a bit boring and then it just changed, and I just applied (Int. 16: X).

9.6.2.2 Attitude to the profession

Originally, this generation was trained within an industry-based diploma course before this changed to a university degree at the turn of the last century. As the training has gradually increased in academic intensity, Generation Xers have worked to adapt, also understanding the importance of maintaining as many skills as possible to improve their applicability in the workforce.

They've got a lot of ambo stuff down pat, it just takes, sometimes you kind of think you're a bit of an old dinosaur, and because things that have changed part of you, I think also should try and keep up with the younger ones which is part of the reason I wanted to do the IC course as well, so that you can kind of remain up-to-date because it's important that you do, otherwise you lose respect, and I don't want to be in the position where I'm one of these old dinosaurs who just hides somewhere out lying so that no-one knows that they're really shit at their job in order so they can just see out their time. I don't want to be one of those people (Int. 14: X).

When it comes to longevity in the service, Generation Xers have similar values to that of the Baby Boomers. Those who mentioned occupational duration indicated that they intended to remain loyal to the job.

But I can see myself retiring in this job (Int. 5: X).

I thought, yeah, that would be alright for a couple of years, 25 years later, I'm still here (Int. 10: X).

There's a lot that have got their 25-year clasp and stuff like that. I'm not sure because physically it's, it's not the job that I think that people can do until retirement age. It's a, it's a heavy job, it's mentally can be quite challenging I guess as you get older, because there's so much knowledge (Int. 15: X).

9.6.3 Differences in dealing with stress

Generation Xers share with the Baby Boomers similar strategies when dealing with stress. They were adaptable in the past, and absorbed the Baby Boomer culture, but now this culture is changing as a result of an influx of paramedics from Generation Y, and the shift in educational requirements for paramedic practice. They understand the need to change and adapt to the new culture, but also mourn the old culture.

Yeah the culture has changed. It's changed. Certainly changed. I've been in the job for 10 years, so it's changed a lot in that 10 years. There was a lot more jocularity before. I remember a time when I've chased [a colleague] around an ambulance station with a fire hose squirting him (Int. 14: X).

Well, some people still, some of the uni students have never been exposed to it do complain and have complained in the past … They obviously they get away, I don't tend to care as much, so I still have black humour but, and that aspect of it I think I'm old school (Int. 16: X).

I have faith in my own knowledge to know that if I'm not right, I'm going to get help. I'm old enough to know that, but no-one's invincible (Int. 15: X).

Generation Xers use similar coping strategies to Baby Boomers in terms of the Peer Support Program. This means they rarely use it. They do tend to put themselves last and are traditionally sceptical, so it is not surprising that they are reluctant to expose their vulnerability to a peer support counsellor.

I think that if I'm struggling, I will go and see [occupational psychologist], before I spoke to another ambo, I'd just to speak to [him] (Int. 15: X).

I do it, I research it, I do all the rest of it, I read all about it and sort of, or even that professional development, but I don't want to relive every fucken job I've done. To talk about it, it seems like we're a bunch of heroes with another bunch of heroes (Int. 16: X).

The Generation Xers seem very much caught in the middle of the generations. They use the older coping styles, but understand the advantages of converting to the more recent set of attitudes, values, and practices. Generation Y has been exposed to far more information relating to the preservation of mental health wellbeing and are not afraid to use it.

9.7 Generation Y or Millennials (1981 – 1994)

Generation Y, also commonly referred to as the Millennials (or Generation Me), are the children of the Baby Boomer generation. Although they have been brought up with terrorist attacks being a common scenario, it is a time of greater economic prosperity, but they are often children of divorced, blended, or merged families. The parents of this generation were extremely child-focused and protective, determined to nurture their children's self-esteem. Despite the best intentions, the main effect of this was to increase the levels of narcissism in this cohort to heights not previously recorded (CGK, 2016). There has also been a decline in civic engagement and community concern, with ideals such as 'being a leader in my

community' having more to do with narcissism and fame than community investment and care for others (Twenge et al., 2012). Due to this, the Millennials have less loyalty for organisations and brands, and are flexible in all areas that change as quickly as the prevailing Internet speed (CGK, 2016). This, in turn, has an impact on their view of longevity, as "Millennials are thought to be comfortable with change and less likely to view job security as an important factor in their careers" (Becton et al., 2014, p. 178).

As this generation has grown up with mobile phones and computers, they are reputed to be extremely sophisticated and technologically adept. The global connectivity and speed of change that is part of their culture also makes this generation more similar across the world than previous generations. This multi-tasking, fast-paced group enjoy working in teams with peers, and prefer their bosses to be personable, to value employee input, and to provide instant and continuous feedback. Racial and ethnic diversity is much more common and valued, and Generation Y is dedicated to cultural sensitivity in the workplace. "Stereotypes for this generation include being distrustful of organisations, having a strong desire for meaningful work, holding lifelong learning as a high priority, and viewing family as the key to happiness" (Becton et al., 2014, p. 178). Because of this, Millennials have been known to appreciate the worth of leisure more than previous generations. "With regard to work-life balance, members of Generation Y are seen as desiring a lifestyle that allows them to balance play with work in a manner that prioritises engagements with family and friends over work commitments" (Lester et al., 2012, p. 342).

Generation Y paramedics are just as confident and self-aware as their stereotypical description alludes. They are also competitive, do not expect to spend their whole life as a paramedic, and are thought to prioritise leisure over work.

9.7.1 Cultural differences

The other two generations believe that Gen Y see themselves as equal in importance to anyone they encounter. The paramedic below indicated that this attitude has an impact on how they address patients and bystanders and that, as a consequence, can be a risk to their physical and mental health:

> *"And also, the other fact is young female paramedics are the ones getting, having violence against them on the roads, and I think that's potentially because they're just not handling the situation properly, they're not communicating and de-escalating properly, they think "You shouldn't be talking to me about that because I'm Gen Y or a bit precious or whatever, and again I'm generalising" (Int. 23: X).*

But the most obvious difference, in the view of the other two generations, is the competitiveness required to actually obtain a job in this profession and the impact this and other cultural factors has on the behaviour of Gen Y paramedics. The quote below clearly explains the impact of this competitiveness and the organisational recruitment processes on Gen Y. What it does not explain is why the older paramedics who supervise them encourage this competitiveness, while other Baby Boomer paramedics complain about their lack of collegiality and failure to become team players:

> *So, as a result, there's no jobs, which is just increasing that competitive business. It is at the point that during your internship, your mentors, your clinical instructors are telling you not to share information and help your peers in your internship group because at the end of the day you know your ranking will dictate whether you get a job or not, and if you help someone else, you are potentially shooting yourself in the foot, which is just awful, and I don't think that contributes to ... it promotes a very 'me' orientated mindset, which is awful because you don't feel like you can turn to others for help. And you don't know whether they're going to be helping you ... you do, what kind of information you need to be getting, who to trust, who not to trust, and I think [the organisation] doesn't really know what they're doing yet either. They've got all these interns coming through, and they know that they're going to need jobs in the future, but there's no jobs right now. So, they're kind of working it out as they go along, so they only put in short-term solutions and there's no long-term plan, so people are trying to make decisions that will affect their lives based on shonky information that is constantly changing underneath them. That creates a level of stress and anxiety that has become an endemic culture amongst all these people who are scraping for a job. Which kind of creates a lot of negativity and they'll be on station, and they'll be complaining, and we have a right to complain (Int. 6: Y).*

The constant uncertainty in terms of employment also means that these new recruits are more attuned to the desires of the management, and strive to follow the rules they deem most important:

> *So, when things happen I'm sure ... like people who've been in the organisation a long time they kind of have this ... "No, like I will get paid, I will do this, and it will be this way, and no you have to do this" ... and we're kind of like "Ah ... you've done this ... um that's fine ... but ... "like very hesitant about standing up for our rights where I think maybe people in the generation ... kind of more towards the retiring spectrum kind of ... not untouchable but ... they don't care, where as we come from an environment ... we've had to do absolutely everything we can just to get a job, so when the organisation says jump, we say how high! (Int. 6: Y).*

Some of this generation are already seeing the impact that their attitudes have on the service as a whole, and are concerned about the direction the organisation is heading:

> *I worry about when we become the leaders of the organisation, because eventually that will happen. Our behaviour now and this is ... if we're forced to fight and scratch. What are we going to in turn expect the next generation will treat their peers and students and other professions? What do we think is a legitimate way to solve a problem and how are we going to do that? … Looking down the track, I kind of go "How are we going to change this and what is going to happen if we don't change, because I don't think it'll be good. No, it'd be very, very interesting so. Yeah. So, if anyone else needs a study about a really anxious group of people ... (Int. 6: Y).*

9.7.2 Differences in the job

The most obvious difference in attitude for this generation comes from their novice status. Almost everything they encounter is new, fresh, and interesting. They are hungry for knowledge:

> *Pros of the younger culture is that they're fresh and they're enthusiastic and I like to feed off that which is, it's been really good. I was working with someone who's only been out on the road for a year or two just recently, and she was quite eager and enthusiastic, and it made me feel more energised and more able to do my job. So that was good. And they can refresh your knowledge when you go, "Oh, what's so and so. I've forgotten?" the name of this drug or how it works or something else and they're like blah, blah, blah (Int. 20: Y).*

9.7.2.1 Entry into the profession

The ease and method of entry into the profession is one of the greatest differences between the generations. Previously, the Baby Boomers and even the Generation Xers were given jobs to fill a void in the paramedic numbers when it was a vocational course and the service reduced its dependence on volunteers. The Millennials' situation is completely different. The number of students enrolled by the various universities across the country do not work to quotas linked to labour market demand, and consequently, the market is flooded with educated, talented paramedics with too few positions for all to be employed. They understand when they enter the profession that they must demonstrate a high level of performance and academic ability in order to gain employment.

I've worked my arse off to be here and I'm lucky. I went to uni with 208 or 180 kids. Of that 180, about 50 of us have actually been given the chance to do internship, and about 40 of us have been given jobs, so I can't really complain, and like I don't ... every day I think I've had a bad day, I think about that and I could be still pouring beers with a $30,000 HECS debt and all these skills to do these amazing things and not have an opportunity to do it (Int. 17: Y).

I was on my internship, so you were kind of stressed all the time because our whole internship was "are you going to get a job at the end of it? Am I not going to get a job at the end of it? Who am I impressing now? Who's writing my reports? Who's doing this? Who's doing that? What kind of image am I putting across at different times?" You're always worried about what other people are thinking about (Int. 11: Y).

All three generations have strong opinions about the current recruiting strategy that generates high levels of competition:

There's not too many that aren't straight from school. They're quite determined, headstrong, confident, often from private schools, yeah, who are very good in their practice. The university seems to be churning out some really good students, really good para's and yeah good with their technical skills, good with the way that they are with patients as well. [However], some of these ones straight out of school don't know how to talk to a 90-year-old that's had a fall (Int. 14: X).

"Yeah, I mean we haven't got groups that do the fight, and that sense of entitlement is quite bizarre when it's taken away from them ... Because these are the rich kids coming through … you know a lot of them, and I know it's a generalisation, but a lot of them are private school, reasonably well off compared to people like when I joined … apprentices, they were doing the rest of it and they had an industrial background and the whole … thing and … will get the job and the money. These kids have struggled, and they've got huge HECS debts and they want the job and all the rest of it but when they get it, cruisy! Hang on, what do you mean I've got to do this now, that's not fair, that's not right … Because Dad's told them to stand up for themselves and all the rest of it, so yeah, a lot of that sense of entitlement goes wrong and they do fire up (Int. 16: X).

Certainly, having life experience helps, but also, you had people who were experienced at working in other environments who appreciate … what [the ambulance service] did for them. Not many other employers would give you a big screen TV and a recliner chair. I'm not knocking the guy coming out of uni now, but they don't know any different [than] the chair and the TV (Int. 18: X).

9.7.2.2 Attitude to the profession

With a competitive attitude, the Millennials expect improvements and for the organisation to listen to them. They expect their opinions to make a difference in ways that differ from previous generations:

*I mean, they all think they're bloody special; they all think that – and there's no – the other thing, the one thing I do notice about it is that there's no degree of automatic respect, and I understand respect needs to be earned, but there's no degree of respect given to people just because [**they are older, more experienced, any reason?**] That's right, yep. I'm getting sick of being called [first name] by five-year-olds, and yet if I said I'm Mr [last name], I'd get looked at as if I was some sort of weird paedophile. But I, there's no titles at all, and not that that's the be all and end all, but often there's no respect that goes with it because somebody has experience or whatever … a parents' pride – a teenager should go out and get a job while they still know everything (Int. 21: BB).*

We certainly have an industrial culture that's certainly pushing for change still, and we have a workforce that is highly educated now and motivated. So, they all constantly start pushing and agitating for change. So, those things will happen because the group of people coming through will obviously want their profession to evolve (Int. 16: X).

Baby Boomers with their 'do what is necessary' attitude, and the Gen Xers who have adopted similar values, also question the commitment of Gen Y. They also resent their confidence in their knowledge to be able to dictate what needs to be done:

I think to use a physical example, we have a lot of young people on WorkCover. And I think it's because they get it drummed into them so much that they – you've only got one back; you don't want to wreck your back, and they get a twinge and they go on WorkCover instead of saying, oh okay, I've got four days off, I'll take care of myself and it'll be fine. And the result of that is that we now have people who are not prepared to do anything on the job that might risk injury and that pisses me off – you know when you have a cardiac arrest, you need to do a dirty lift to get them out and get them going, rather than saying, oh no, well we need to wait for this piece of equipment and that piece of equipment and ten other people and oh well, if they die, they die. I don't think that's the right way to approach it, so I think we probably do need to teach people how to manage their stress and identify their stress, but it would be nice to do that without making them so concerned that everything becomes a stressor and all of a sudden they go "Oh, I can't cope" (Int. 21: BB).

The newer ones are teaching us stuff. Yeah, I think we're all probably a little bit resistant to it because we've been in the job for so long, and we know what we're doing, and you've been in the job for 10 minutes, you can't tell me what to do (Int. 14, X).

Yeah. And usually they ask ... what really annoys me is that these people ask questions, but they know the answer before they ask them, ok. Do you understand that? They know the answer before they ask it, so I sit down and I think why did you do that? You know full well what the answer is, but you're waiting for somebody else to slip up, so you can bounce in and give them the correct answer. Ahhh ... No. I think Gen Y's would love the audits. And they're the ones that do it. Yeah, but the older generation probably can't stand them, and they sit back, and they just watch. Because we get taken over by the Y generation (Int. 8: BB).

> *Most of them are lazy nowadays … Generation Y. Why (Y) would I do that? Why won't you do this for your patient? Why would I? I don't get paid for it. That's all they're interested in, the money. What's in it for me, and that's it. To me, that's the wrong reason to be in the job, but there you go. That's me (Int. 13: BB).*

Generation Y are also perceived to have a different attitude to work. They appear to value their leisure over care for their colleagues, which is a factor that the other generations have not come to terms with. One paramedic was particularly concerned about this attitude:

> *One of the other issues that we've got, which is becoming a real problem, is because they've got a lot of young people now, there's no real sense of community I don't think, and no sense of, we're losing some of our team behaviours. So, things like long weekends, you're down 22 crews on a weekend because they've all called in sick at the last minute. So, if you know that you're going to work that night and you're already that many crews down on Saturday night on a long weekend, you are going to get absolutely slammed and I find that frustrating (Int. 14: X).*

Another generational factor that particularly disturbs Baby Boomers is the Gen Y attitude to authority and the chain of command. Previous generations respected the hierarchical order, but Gen Y are seen to have an attitude of being heard and respected in their own right; they have circumvented the traditional order and processes for managing conflict:

> *If [our manager] came out and told you off, hypothetically, well you'd sit and listen. But if you didn't like what he told you, you'd go straight in the office down here where he wasn't watching you, you'd get on the phone and ring up the union and say, "Right well [the team leader]'s done this, this, and this, I'm not happy about it. What are you going to do about it?" That's what you would do (Int. 8: BB).*

> *I think the young people who want to do that actually stand up for themselves and they will question and criticise. It can be a little annoying because they … you are wondering whether the boundaries are understood, about what is work, what is leadership, what is clinical, and what is safety, patient safety (Int. 2: BB).*

Another factor that irks Baby Boomers and Gen X is the attitude of Gen Ys to the longevity of their career. Previous generations have seen this as a loss of loyalty, even while appreciating that it results from the actions of management:

> *But, it's the way things are moving too I think, there's not many permanent jobs left anymore, everything's casual and, so therefore, the loyalty's not there from the employers, because the employers aren't giving loyalty, so it's all different now. I think they don't owe anyone anything, so they'll do it for as long as it suits them, and then they'll do something else or, and people are changing careers more often too … I think that's just, not just in our industry, I think that's across the board (Int. 23: X).*

I don't reckon the young ones do, because I've heard a few of them go, "Oh yeah, however long I'm doing this for" or, you know they have other plans and it's not that important to them, to have a career, it's just that "Yeah, heard about it at school, thought it'd be good to do for a bit" (Int. 23: X).

I think it has become a lot more competitive, I don't feel that there is the same comradery between ambos as there was. It's very much now, it's a profession, it is really ah, probably yeah, people coming into the ambulance service now are certainly a lot more ambitious, it's just a, it's a stepping stone onto something different. It's um, well, they say that the life expectancy now of a paramedic is about 7 years. For want of a better word are coming through because they're getting high TER scores to get into the degree. They are very academic based, um, and they're fiercely competitive. They know what they want and they're just going to get it (Int. 10: X).

And what's going to happen in the future is you're going to have an ambo that comes out of uni at a young age with X amount of training, they're going to do their internship, they're going to have a lifespan of 7 years we'll say, and in that 7 years, hopefully, they're going to do their IC course and then leave before they hurt their back or sue us for psychological trauma (Int. 20: Y).

9.7.3 Differences in dealing with stress

Paramedics from Gen X were of the view that Gen Y knew how to look after their mental health, but also saw that they were criticised for not having the necessary work ethic:

I think the younger ones, even though they get criticised for being a bit soft, will protect themselves mentally and physically by having a day off. They're not as, I think they, like us oldies are kind of a bit, that oh, it's … and we can cope and 'bull at the gate' kind of 'toughen up princess' kind of attitude … which also has a negativity in that it's not self-protective, whereas the younger ones are more self-protective (Int. 14: X).

I think they are better at looking after themselves as a whole, that's how they've been brought up, it's about them, you know, you look after yourself, your family and your friends come first and then work second. In my generation, work ethic was, you'd put everything into your work … so, that's what I found, that yeah that's their focus, so their family and their friends, and work is lower down the list, so they're much better at looking after themselves and their needs through having those interactions with family and friends (Int. 23: X).

I think the young ones seem to be quite good actually at maintaining their fitness and their health. That is generational I think, because not too many of the older ones do it. It's mainly the younger ones that do, they're actually quite fit and healthy, and they all bring in food rather than eat junk food, whereas I'd rather just go and get Maccas and be done with it. But that's just me. I'm not the healthiest person in the world (Int. 14: X).

Conversely, when Gen Y talk about their protective strategies, they realise the importance of their mental health and have established processes in place:

Apart from writing a personal journal about my feelings on the job and stuff like that, I do walks, I go for walks, and I meditate. That's just my 'me' time. I always make sure I have 'me' time, and then if I find in my meditation or the time that I have for myself those jobs in particular are creeping into my mind, then I go, I'm not okay with that. And that's sort of like a bit of a red flag for me to go, hang on a minute, I can't shut down enough to push this job out that I'm not okay. But, I think I've worked with a lot of older people, more so - people at my age in my internship, I didn't really get a lot of time to work with. Because they don't really talk about coping mechanisms, they probably just do that when you do a job, you just get on with it. There's no – still a bit taboo I think, for some older people to recognize that it's okay to be emotionally not okay after a job (Int. 22: Y).

You can always ask, like you can always just walk up to someone and be like, are you okay? And it's either like a, yep, like I'm fine, I can do this, or they'll walk away, and you just tap in and take over the job, and that's fine – like its, yeah. And it doesn't happen often, but again, that's all the stuff of like, you know, keeping an eye on your partner and making sure that everything's okay with them as well. Like we sit in a tin box for 48 hours, you get to know them pretty well, and read their cues and things like that, so you can sort of tell when something's up and you're just like, are you okay, or you just – I don't know, sometimes like the guy I was working with before, … you know, you just have a look and you're like, oh okay. Or you'll just be like, I'm just going to go get the stretcher ready, can you take over for a minute, and you sort of know like something's not right, but like I need to stay here, and they just need a minute and they'll come back in when they're ready. And that's fine, and people are happy to take over jobs and do whatever if their partner's struggling, or they need time out, then yeah, that's fine (Int. 19: Y).

Generation Y use the Peer Support Program more effectively, as they have received more information and education about protecting their mental health, and throughout their degree training and internship, were made aware of the need to reduce the stigma linked to mental illness:

Qu: This generation uses it more, peer support? *A: 100%.* ***Qu: Because it's really the done thing now isn't it?*** *Yeah, and I think they make it really open and acceptable. Like when you come in through internship in your first block, you meet – they say this is so-and-so, they're from peer support. And a lot of the time, they're your colleagues. So, your first point of call are your colleagues (Int. 22: Y).*

I think now with the group, like interns before me and my group, and the interns after us that are coming through, we've had it drilled into us about professionalism and that this is the way it is and these are the proper ways for, you know, like there are specific channels now for if you want to contact peer support, if you need some support with your mental health, like there's more generally accepted ways of going through it (Int. 19: Y).

I did have one younger one, a younger volunteer, a uni student, and he, yeah, he didn't know what was right and wrong, and how to cope and he asked for a follow-up, yeah (Int. 23: X – A Peer Support Officer).

An interesting feature of this cultural shift is that it is not a conscious effort. Resources are provided, but are not necessarily used. It is more the fact that these new recruits have been exposed to the concepts and are aware of the resources, so they know where to start when they need assistance. Otherwise, they appear content to wait and see what the prevailing norms and values are when dealing with stress.

> *I think it's certainly important knowing how to manage it yourself. Like I said, in terms of what we specifically did, I can't particularly remember – it's a fair few years ago, but it certainly wasn't like – I don't remember going into a lecture that was specifically on dealing with that kind of thing. Like, I said we might have touched on it from time to time. I think it's more something you have to learn out on the job anyway. It's hard to prepare yourself with just someone telling you about it anyway really (Int. 11, Y).*
>
> *Yeah, so you think that people are watching you all the time. You have to try and make a really good impression, because if you don't, like that's your career, and it's sort of drilled into you from day one that you've got to do everything you can to, you know, keep your head up, and like if you're having a rough day, then you know you talk to your CI about it and that's it, like no, not that we were … the intention never cut off from peer support or anything like that, and they don't – no-one else knows if you've accessed peer support, it's all confidential, but as an intern, you still don't want to do it.* ***Qu: So, as an intern it's frowned on, but once you're through the process it's acceptable?*** *"Yes. I don't know if it's actually frowned upon, or if that's just the perception that interns have" (Int. 19: Y).*
>
> *There is a book about coping with mental health and like with your family and support and stuff like that, there is one. I didn't read it, but there is one.* ***Qu: So, you had the resources and chose not to …*** *"A: Yeah …".* ***Qu: Did any of your friends read it"*** *"A: I doubt it" (Int. 19: Y).*

9.8 Summary

This chapter has outlined the differences in the culture of coping taking the perspective of the different generations. The definition of a generation used for this context was described as an ideal type (CGK, 2016), or a set of ideal types, prior to providing an overview of the demographic characteristics of the paramedics who were interviewed. The three different generational periods were then considered in detail, with a breakdown of the social influences on them while growing up, their attitudes to work/career, their characteristics displayed while working, preferred methods of communication, and their desired forms of feedback. Finally, in this chapter, the generational attributes that were most apparent in the current sample of paramedics (Baby Boomers, Generation X, and Generation Y) were described.

The differences noted by the paramedics themselves as members of each generation, or as noted by their peers in the other generations, were reported. This touched on the details of the cultural differences, differences in access to the profession, and the differences that came to light in dealing with workplace stress. The next chapter continues to highlight the factors that affect the culture of coping. The focus turns to how old coping strategies have adapted to societal evolution, in light of the wave of political correctness. This shift has had a profound effect on the use of humour, especially black humour, as a traditional paramedic (and other health and emergency professional) coping strategy.

CHAPTER 10: SOCIETAL EVOLUTION/HUMOUR

10.1 Introduction

The previous two chapters have focused on factors that were found to influence the culture of coping, namely the location of their primary station and the generation that they are categorised in. The culture of coping in paramedicine, and indeed all the health professions, has also been affected by societal, and by extension, occupational evolution. Some practices that were once acceptable methods of de-escalating an emotionally traumatic situation may eventually become socially and politically incorrect. This is the case with humour as a coping strategy for dealing with stressful situations. Despite its long history as a strategy for assisting in the processing of traumatic information, humour, and particularly black or gallows humour, is now branded in some quarters as being socially unacceptable and, as a consequence, has become limited in its use. Older paramedics understand the protective nature of humour and use it as a primary strategy to mitigate emotionally intensive situations. Although they recognise the changing societal norms and expectations, they are almost at a loss to adapt to a more socially acceptable strategy. Hence, their current method of choice is to limit the use of such humour with certain colleagues, especially younger paramedics who have been brought up with the newer expectations. Younger paramedics are presumed to view humour as inappropriate and, as such, have different sensibilities, specifically around maintaining a culturally sensitive work environment. Although the use of humour is still enculturated early in a paramedic's education via interaction with their peers with similar interests, and their exposure to older paramedics in the field on placements, it is understood that it needs to be expressed with caution, and only in front of an accepting audience.

This chapter reviews these ideas starting out with a discussion of what is meant by the term 'humour', the distinctiveness of Australian humour, and how it is used in the workplace. The chapter then explores the benefits of humour to the user, its use as a strategy for coping with traumatic incidents, its potential disadvantages, and how black humour differs from general humour. Following this, the chapter outlines the nature of paramedics' use of humour, including black humour, despite its political incorrectness. Finally, the chapter reports on paramedic perspectives on the limitations they have imposed on themselves as a

result of policies on political correctness, and the way they have attempted to alter their use of humour in line with this shifting culture so that it can be maintained as a coping strategy.

10.2 Humour

The Cambridge Dictionary defines humour as "the ability to find things funny, the way in which people see that some things are funny, or the quality of being funny." This definition easily incorporates the cultural component of humour, which is learning from the people one interacts with to appreciate when something is funny to that group. Some authors break humour down into factors such as non-seriousness, social context, or incongruity, while others believe it is more of an elaboration or reinterpretation of contexts (Iidaka, 2017). It can be clever, ridiculous, or surprising, and often requires an understanding of minor nuances presented out of their expected context (De Groen & Kirkpatrick, 2009, p. xvi). It is also apparent that there are cultural differences in the appreciation of humour across different countries, and this needs to be taken into account when unpacking the meanings and uses of humour in this context.

10.2.1 Australian humour

Appreciation of humour is different in every culture. For example, Australian humour is said to have its origins in our convict background, due to the social and environmental difficulties encountered during the early years of establishing the colony. Terms such as 'dry', 'extreme', irreverent, and anti-authoritarian are used to describe this humour, specifically masculine humour, for "it's richly inventive range of metaphor and word-play as a form of abuse, particularly against people in authority" (Davis, 2009, p. 34). But, given that it is humour, it is not considered a serious challenge or threat to authority. In their book ***Australian Humour***, Dorothy Jones and Barry Andrews suggested that the irony of Australian humour is more related to the individual's understanding that their current circumstances are not of their own making and their future is equally out of their control, so they accept the status quo and sarcastically accept the fact that they are powerless (De Groen & Kirkpatrick, 2009). "Many Australians, whether city or country dwellers, found in their national humour of sardonic pessimism an antidote for despair, a substitute for tears" (Willey, 1984, p. xi).

As far as the content of Australian humour is concerned, it is culturally recognised that anyone is eligible to be the target, and positive recognition is achieved if the offering is high on the colourful and creative scales. Australians enjoy reducing people who have developed a superior opinion of themselves, because deflation punctures pretensions. No-one is allowed to escape derision in Australia, no matter who they are, and "while witty is good, crude will also pass" (Davis, 2009, p. 41; De Groen & Kirkpatrick, 2009).

Australia is one of the few cultures in the world where making fun of someone can actually be a sign of friendship. "Australians can make fun of someone's bad habits, like being late or being messy, they might even play a few practical jokes on really good friends. It's all a part of building rapport and showing trust … being comfortable enough with someone to make a joke at their expense is in itself, a signal of mutual respect, equality and closeness" (Insider Guides, 2018). The following quote from a paramedic playing practical jokes illustrates this point:

> *I remember a time when I've chased [colleague] around an ambulance station with a fire hose squirting him. I've broken his bottom with one of those air horns by putting it on his bot, we've hoisted someone's uniform pants up a flagpole out the front. We've poured water on people, I've had a yoghurt fight on station, we've had water fights and water bomb fights, and we've been chasing each other around and, oh, taping up the ambulance doors so that you can't open the doors up. You can eventually, but it's not expected. You can eventually open the doors or filling up the foot well with a bag full of water and it used to be a bit of a challenge to try and think of something new … Yeah, it enhances your creativity and you go, oh, that was good. You'd be impressed (Int. 14).*

One of the functions of humour is to relieve tension, and in Davis' 2009 book entitled, ***'Aussie' humour and laughter: Joking as an acculturating ritual,*** she stated that Australians still use humour as part of their survival process, writing that "For Australians, using and appreciating (or at least tolerating) humour is not so much permitted as compulsory. This is a culture that deploys humour openly as a weapon to identify those who are truly 'at home', in both the land and the society. In this sense, it is the style and conventions of the 'jok(e)-ing', rather than those of the jokes, that indicate 'Australian-ness" – that is, how Australians *use* humour, rather than the nature of the humour used" is the important factor (Davis, 2009, p. 38).

There are several sources of information that try to educate people from other countries about the nuances of Australian humour, because experiencing the irreverence and perhaps insensitivity for the first time can be alarming: “Australians joke about all kinds of things that might be considered in bad taste in other countries including death, illness, accidents, sex, bodily functions, the list goes on. If you’re ever feeling confronted by an Aussie’s dark humour, remember that it’s probably just an effort to relieve the tension surrounding a subject and to look on the brighter side of things” (Insider Guides, 2018). It is because of this tendency that Australians seem to fall naturally into using darker humour. It leaves one with the feeling that they have some control over a situation that they have no control over whatsoever. “Our sense of humour allows us to blow a raspberry at the fates, to defy the nemesis we cannot escape” (De Groen & Kirkpatrick, 2009, p. xvi).

10.2.2 Occupational humour

In the organisational context, humour has many guises and functions. It is used to reinforce the cultural norms and mores of the group, and to punish those who do not adhere to them. Terrion and Ashforth (2002), referring to police officers, noted that humour is used to define a situation and to build cohesion. They argued that, “Through humorous stories and jokes, definitions of normal and appropriate attitudes, feelings and behaviours (are) ... transmitted to new recruits and reinforced … Humor helps define situations and normative expectations as well as express latent tensions in a relatively non-threatening manner. As such, humor helps foster and negotiate a shared understanding of organizational reality” (Terrion & Ashforth, 2002, pp. 58-59). Research on the use of humour used by other first responders, such as firefighters, reinforces this theme. For example, Thurnell-Read and Parker (2008) wrote: “Inferences of this nature are delivered via informal repartee … making (it) clear that there are informal expectations and norms in play with regard to the level of physical strength and resilience amongst male firefighters, and that it is simply unacceptable for watch members to be anything other than competent in this area” (Thurnell-Read & Parker, 2008, p. 131). Parallels can obviously be drawn between police, firefighters, and paramedics as far as stress and trauma exposure and their common use of humour in the workplace.

In order to dispense this style of humour, a perceived weakness will be identified and besieged, but it is solidly understood by all players that the delivery occurs in a ‘playful

frame' and that the context is in no way serious (Terrion & Ashforth, 2002). One commonly used method of humour delivery is the process of 'piss taking'[3]. This is described as "a 'test' of one's ability to withstand verbal castigation from others whilst maintaining peer group credibility" (Thurnell-Read & Parker, 2008, p. 130). Proving that an individual can withstand personal derision serves to solidify a member's inclusion in the group, but also exposes the person to mildly challenging situations which, when satisfactorily weathered, builds a level of emotional resilience. Thurnell-Read and Parker (2008) believe it to be an essential component in certain occupations building a level of emotional control and restraint while doing the job, "which allows those concerned to cope, not only with the day-to-day interactional aspects of working life but, in turn, to function competently amidst a range of other psychological tensions and distractions" (Thurnell-Read & Parker, 2008, p. 131). Paramedicine as an occupation that is exposed to psychologically intense and emotionally challenging situations, has understandably drawn on humour as a coping strategy for a major part of its history.

Humour, in any of its forms, finds a place in most industries and occupations. It is particularly relied upon in the medical and emergency service occupations, as will be described in more detail below; however, the following paramedic saw equivalent scenarios elsewhere; for example, in other industries that work at night where the employees are confronted with similar clientele:

> *You hear that in the media, and you hear that from the public that we have this black humour and that's how we cope. I don't specifically think we're any different to any organisation that's anywhere else, and I think you'd find the lady that runs the video shop, with the druggies coming out at 9 o'clock at night, and being destructive and bad behaviour. They would probably be in nasty situations and do exactly the same thing. 'Cos that's what I hear from other people that I've worked with (Int. 2).*

[3] In rhyming slang, the variants *mike bliss* and *mickey bliss* both stood for *piss*, and Partridge defined the (United Kingdom) meaning of 'to take the mike/mickey [bliss]' as 'to take the piss', 'to make a fool of someone; to pull someone's leg'. He explained that 'TO PISS and hence deflate a bladder gives the central idea of deflation, in this case by making a fool of; perhaps coincidentally an inflated bladder (on a stick) is the mediaeval comedy prop associated with a fool' [Partridge 2006: 1439] (Davis, 2009, p. 23).

Lee and Kleiner (2005) stated that “the positive effects of humour at work include: higher on-time attendance at meetings, a greater spirit of harmony, higher productivity, increased morale, high level of enthusiasm and energy, and diminished interpersonal conflicts.” It is for these reasons that humour is beneficial in a workplace and should be encouraged by team leaders and management alike.

10.3 Humour: What it Does

The use of humour has been observed in the emergency services, the military, in health, and in other first responder occupations that are exposed to increased levels of stress. These occupational groups use humour to de-intensify the stress, which enables them to continue performing their duty or role. Therefore, it is important to decipher what humour does and how it is used in stressful situations (Davis, 2009; Samson & Gross, 2012).

The use of humour in the workplace can be categorised into four types: physical, psychological, social, and cognitive. The physical benefits of laughter include enhancing oxygen intake, releasing tension-reducing endorphins (Davis, 2009), and temporarily increasing but then decreasing both heart rate and blood pressure to less than baseline rates (Harries, 1995; Lee & Kleiner, 2005). As the paramedic respondents noted, it has a depressurising capability:

> *It dehumanises, it de-stresses the situation. You can turn it into something you can laugh at, and by laughing of course, you’re relieving stress … so you’ve turned it from something that’s internalised to externalised, and it’s all very funny” (Int. 16).*

> *I think it's just like a bit of a defuse, like a valve, release valve kind of thing. You know if you just had a good laugh, then you’ve got endorphins going around (Int. 23).*

Humour also has psychological value. It assists in the venting of potentially destructive emotions such as anger and frustration; for example, joking about difficult patients rather than challenging or antagonising them can be helpful in the maintenance of anger, panic, and anxiety levels (Besser & Zeigler-Hill, 2011; Lee & Kleiner, 2005; Lyttle, 2007).

> *But you know there are some things, sometimes even if you just go to a really hard patient who is just a piece of shit, and you make comments like aarrgh [with eyes rolling], like because you can’t be rude to your patient. You’ve got to be very professional and things like that. Maybe in handover or talking to other crews, like oh yeah, this guy needs some 'Tontine' [toilet paper] therapy, or just another*

> *waste of oxygen or things like that, because you can't say to them, "Lift your game. You're a piece of shit. You are literally wasting my time." You can't say that. So, things like humour comes across not only in the really stressful situations, but you say it just because you're stressed. I'd say it's a coping mechanism because instead of punching a patient in the face, you say something to someone, just based on comments that you wouldn't want your patient to hear. But you just feel like it's so appropriate (Int. 22).*

The social advantages of humour include allowing a paramedic to 'save face' when a mistake needs to be corrected, which is essentially "verbalising serious concerns in a more relaxed manner" (Caudill & Woodzicka, 2017, p. 45), or reducing the risk of a negative consequence or counter-argument (Becker & Giora, 2018). It also allows a group to build a collective identity by including or excluding others (De Groen & Kirkpatrick, 2009). It can work as a light-hearted mechanism for enforcing cultural expectations. Making fun of someone's level of fitness if they have lost form, when the occupational expectation is that fitness and strength is essential to perform the tasks well, is a method of reminding them of what is important and where they need to be to fit within the group (Thurnell-Read & Parker, 2008).

Several paramedics provided examples of cognitive redefinition of the situation. Usually this came in the form of identifying a simple, ordinarily harmless detail and focusing all attention solely on that:

> *Oh, it is, it is distasteful at times, but how do you get, how do you do a job like that without an outlet? You can't … I think … it's just to have a laugh ... I think it's just a way of ambos altogether having a laugh after a shit job and nothing ever goes perfect, and [laughing] there's jobs when I've tripped over and you don't, it's not funny, but it is funny because, the job's an awful job, the person's really sick, and in the middle of that, they're over … And so, instead of taking away from the fact that, oh my god, that guy nearly died, that old man nearly died, did you see the way that she went blonk over, on that cord? (Int. 15).*

> *A job that one of the guys and I went to, a head on into a tree ... this guy had hit the biggest or thickest gum tree I have ever seen on the side of the road, it would take 4 people to get their arms around it, it was massive, he'd managed to knock off all the small dead branches from the top of the tree. The whole scene was littered with dead branches and it was just the fact that I made a comment on the way back going "Maybe we should go back and pick up some of that timber", and it wasn't that humorous, it was more just a ... it was more an observational comment that got turned into ..., I guess got turned into humour, but it wasn't actually meant as something humorous to break the cycle (Int. 1).*

In the next two examples, the paramedics did not attempt to shift the focus away from the complexity or gravity of the medical issue the patient was facing. Instead, they needed to maintain a professional façade while attending to someone they believed to be undeserving.

> *I don't know, I guess just – I guess it is a coping mechanism, and I guess it is a way of – what does it do – maybe it's a way of normalising what we do because sometimes we go – why are we going to this, why – it's like the drunk person, this person doesn't need an ambulance, they're probably this, that, and the other, and I guess it's a way of saying this, what we're doing right now isn't normal, we're speeding across the city in the middle of the night for someone who just needs to be put to bed with a bucket. I guess that's an example of black humour right there, and then, that normalises it, that makes it okay in a way I guess (Int. 20).*

> *So, you'd be driving along and, oh for God sake, this is ridiculous and blah, blah, blah. You get to your job and my game face on, get out, all professional. Hi, how are you, whoever comes out and meets you, and you go through that process and then you might ANR them, so Ambulance Not Required, you get back in the ambulance, you don't laugh hysterically as soon as you get in because people often watch you out the window (Int. 14).*

10.4 Humour as a Coping Strategy

Humour can be used in a diverse set of approaches to assist in coping with stressful situations and dealing with adversity. It can act directly on one's physical or emotional state, or buffer the often deleterious effects of stress. It can enhance social support, ease tension, promote objectivity, create distance from threat, and alter perspectives so that the focus is not on taking problems or issues too seriously (Abel, 2002; Overholser, 1992). The following paramedics suggested that it brings the group together, and that this is a positive coping mechanism:

> *It might diffuse the tension that's going on at a scene … and it sometimes ... Let's say you've just finished a job and you're all standing at the back of the ambulance at the hospital, and we're talking about the job, and a little bit of black humour comes into it ... I hate to say it, but people immediately feel comfortable, and then they'll start talking ... especially the ... the timid ones might say something and then ... and that's incorporated in a very informal way of having a debrief (Int. 8).*

> *Yeah, but I mean that is one of the things I do love about the job, is when you're sitting back at the station, you know in the recliners, everyone's bantering and making really crude jokes and you're just like, yeah, it's pretty awesome to be with that many like-minded people, and just to be that open and free with what you say, like it's pretty good (Int. 23).*

> *I love black humour myself, so when I get used to the little stories that always amuses me, and as I said before, it's the one – what's the right word, it just brings a unifying type thing; it doesn't matter who people are, as soon as you say black humour, there's this smirk, a wry smile, a twinkle in the eye! [It's the same on night shift] but from the people who are working, we're the ones who are now of the tribe of people who are awake, so I think that the discussions that go on in hospital or between us and the cops, or - not the firies, because they are asleep! – but people who are awake at 2am in the morning and working, not just out there partying, there is a sense of camaraderie that isn't the same during the day and they get the black humour the same; there's that connection because it's sort of, it's the in-joke of, you know, if you make a comment about something along those lines to a doctor or a nurse, there's a connection. Whereas, if you said that to the person waiting in the taxi line to go home, they would have no idea what you were talking about. So, in a different way, it's those relationships as well, so you know, and that in itself is probably part of the coping mechanism (Int. 21).*

It is also used in most workplaces, but emergency workers and emergency medicine have a perceived particularity for using this humour (Christopher, 2015). These paramedics refer to this connection across health occupations:

> *It is a coping strategy. We do. It is. It is. Truly it is. Some of us ... if you weren't in the medical profession ... It becomes part of your vocabulary if you're actually talking about it. We do it here all the time, and some of it's not pretty. And nurses are just as bad. Yeah. So that is a coping mechanism (Int. 8).*

> *It's just something that we find funny because of the industry we're in. And nurses again will probably be the closest one that can relate to that, purely because of the similar workload, visitors, patients, whatever. But, it's probably one of the more powerful tools" (Int. 1).*

> *I think it's cultural because it goes across ambulance services, and it goes across police forces - and I have seen it. I've got friends as consultants and I've watched them in action, so I've seen their black humour and we've all done it. I mean, as I said, we deal with pal care specialists and pain specialists, and then you can still occasionally after everyone's been formal, someone will say something how long is the garden and you'll hear the black humour joke will slip out (Int. 16).*

The emotional stress encountered by paramedics, especially when the situation is still unfolding, is certainly something that would feel temporarily inescapable; therefore, the differences in use and meaning between general humour and black humour needs to be established, but are often blurred. The following quote gives a good example of humour that was used to break the tension of a job:

Yeah, I guess that's a really good coping strategy as well, like … oh okay, we went to an arrest and one of the oxygen cylinders was out. And I was working with a new intern and she goes, oh, can you just pass me the dead one, as in like the dead oxygen cylinder, not the dead man that was lying next to the oxygen cylinder. Well, we all wet ourselves, and then went, oh, we shouldn't say that. And like, so there's a few things like that you're like, oh shit, that was funny, but really inappropriate. But yeah, I guess it's just part of the job, and it sort of does take the human element away from things, like particularly with things like arrests and deaths and things like that (Int. 19).

10.4.1 The disadvantage/harm in using humour

Humour is not always considered to be 'healthy' and does not always lead to a positive effect on the individual's long-term wellbeing. The predominant danger of using humour in the workplace is that it may cause offense, and this possibility increases as the workplace becomes more diversified, as is the case with the ambulance service, as more of the younger Generation Y enter the workforce (Becton et al., 2014; Lyttle, 2007).

Humour is also sometimes used by people to put down others, in order to "elevate themselves at the target's expense, and that the targets are not well liked." This might be directed towards workers who are culturally different in some way. For example, Terrion and Ashforth (2002) reported on a study conducted in the 1970s in which "male police officers used putdown humour to disparage female officers, presumably because the males were uncomfortable with females working in a stereotypically male occupation" (Terrion & Ashforth, 2002, p. 59). The potential parallels between the police service and the ambulance service are clear in the next quote, where a paramedic refers to this situation, but from a more recent time.

I haven't really come across it I don't think. I mean, there's been a bit recently of sexist, excuse me, comments being made, and I think a lot of the old school boys are like, "Oh, I'd give you a hug, but I'm not allowed to anymore." Which is a bit sad, because everyone is very friendly and … But on the other hand, I think it's probably a good thing, and it's probably about time that it got brought to the surface, because it's like, "Yeah, that used to be funny, but not really funny anymore, you actually are being sexist, so you need to have a look at yourself. Doesn't mean you're a bad person, you just need to stop and have a look, you know." Yeah well, there's a lot of young females coming through who aren't used to [those] old school comments, and even me being old school, I'm still a feminist, so sometimes I'm just like, "Yeah, you better watch it buddy, because I'm not going to be taking that" (laughing). But you know, you kind of recognise that that's what they're used to. Doesn't mean they're a bad person, it just means they're a bit behind the times (Int. 23).

10.4.2 A black sense of humour

Black humour or 'gallows humour' has the same positive effects or benefits as described for general humour, but an added intention is evident where an aspect of power has been retrieved by the powerless. Force (2016) stated that "Gallows humor is often viewed as an expression of resilience and hope that has the power to soothe suffering. When a minority has a few tools to combat an oppressive majority, gallows humor can be used as a sort of secret, subversive weapon" (Force, 2016).

Australians can have a very black sense of humour. While in many cultures, it is considered poor taste to find humour in difficult circumstances, Australians tend to look for this lighter side, and this is the way it is used as a means of coping with a bad situation. An example of this is the naming of the Harold Holt Memorial Swimming Pool in Melbourne after a Prime Minister who disappeared while swimming in the ocean in 1967. The following paramedic commented on how ingrained and natural black humour is in their way of life:

> *I don't think it's more than situational. I don't think it's any different to the day the space shuttle blew up and people died in it, you know, the jokes that came around that. September 11 jokes. It's just a natural part of life, and humour overcomes … I don't know. I think it's just a natural, a morbid thing we have (Int. 2).*

However, there is the criticism that black humour is completely disrespectful to the sufferer. The paramedics below understand that one of the mechanisms of humour is to dehumanise the situation, but that it is not intended to be disrespectful or insensitive to a patient in need:

> *I don't think anybody would … and that article I mentioned seemed to indicate that black humour was somehow a bad thing because what it did was it dehumanised all our patients and made us just laugh at them, and that's not what it does at all. Nobody, I don't think anyone would go to a patient in pain and be laughing even inside. They'd be dealing with the situation as best they could and all that, but later on, there is some aspect that allows them to diffuse the stress because they can laugh at the fact that they were actually flopping around. Didn't laugh at the time (Int. 21).*

> *That's what I think the public don't get, especially if it's done at a time when they can either overhear it or they see it, is that they don't understand that it's not a … it's not done out of malice, or it's not done out of any form of degradation. It's just something that we find funny because of the industry we're in (Int. 1).*

10.5 Humour in Paramedicine

This section will identify details regarding the connection between humour and paramedicine. It will demonstrate the cultural development within the paramedics in the service and then their caution around its use. It recognises some of the functions that humour has as a coping technique, which is its ability to dehumanise and diffuse tension. Issues relating to an outsider's view of paramedics' use of humour are also exposed, and finally, this section will explore how paramedics use humour with their patients and bystanders to ensure a more comfortable environment.

Humour, and particularly black humour, is possibly the most culturally influenced of all the coping strategies used by paramedics. The process begins in the training facilities as collections of like-minded individuals with similar clinical interests endure communal challenges that set them apart from other individuals and occupational groups. Then, if they are fortunate enough to enter into service, they discover the unwritten rules from more seasoned practitioners in action during specific situations. The paramedics interviewed indicated that black humour was a fundamental element in the ambulance service. The first quote demonstrates that this use of humour is possibly an international phenomenon, and the following quotes indicate that it cannot be taught, but is picked up through observation and other cultural mechanisms:

> *It's a movie …, it's a must watch. So, it's about 3 different ambulance services, one's Mexican, there's a Mexican one, there's one in Italy, I can't remember where the 2nd one was, but in poor countries, in poor areas. And just the way they do things clinically is completely different, but their humour is the same, their sense of humour it's, it's so much the same (Int. 15).*

> *Umm. Yes. I think we're a very unique bunch. When I did time ... like enough starts in uni, like even then I found ... like moving back home after being in [Metro] being surrounded by paramedic students and paramedics, and then coming home and doing [work outside of paramedicine], it was really hard because no-one got my sense of humour and my jokes, and I couldn't ... and you'd be like ... "Ah, check this out!" and it'd be like this mangled arm or anything like that, 'cos no-one else is kind of like "Ah, that's cool!" kind of thing ... (Int. 6).*

> *I don't know, I guess it just sort of crept in over the years, it was so gradual that I didn't even notice I was doing it until one day you realised, I don't know, I guess there's always an edge of cynicism to it, and someone will say "you're too cynical for your age", or they'll just make the joke and that's so cynical or something, and you're like, okay I'm officially an ambo now (Int. 20).*

> *Well, they didn't teach me. You just listen to other people. And you pick it up from nurses, you pick it up from other people in this job. We do need black humour to get us through jobs (Int. 8).*

Once it has become a subconscious part of their identity, the paramedics then realise that this aspect really does set them apart from civilians, and they start being careful with their use of humour. The following paramedics mentioned situations that started with an initial openness and ended with an almost apologetic qualification:

> *Oh my! Some of the funniest things I've ever done have been with dead people. And I don't mean that in an unprofessional way (Int. 2).*

> *I think we're a little bit careful, I mean there's black humour and there ... There's humour that's funny and there's humour that's probably, I would say, it's a bit too sensitive (Int. 4).*

> *To relieve the stress of the thing. You sort of say nasty things."* ***Qu: Is it nasty?*** *I don't know if it's nasty, but it's yeah, black humour. Its things that are funny that I think if I told people that didn't work in this job, they would say I was a terrible human being (Int. 22).*

Another component of the use of humour to cope is its ability to take the 'humanness', and therefore, the deep emotional investment out of a job. The utility of the technique is understood but, as mentioned by Paramedic 21, there is also a slight feeling of guilt that it is automatically used, rather than viewing the situation holistically:

> *I guess it de-personalises ... yeah, it de-personalises it. It takes something terrible and makes light of it. Stops it being a real thing and it becomes just humour (Int. 7).*

> *But yeah, I guess we do – we tend to laugh about that; I suppose we also tend to isolate stuff you know – maybe in the ambulance service as well as in health, we'll talk about – I went to a fracture today or I went to a cardiac arrest, not a human being with a fractured leg and a resulting pain, but I went to a fracture. We do tend to get a bit trapped into what I can do to the patient rather than what I can do for them (Int. 21).*

For paramedics, the effectiveness of humour comes from its use in breaking the potential for a psychologically negative cycle to perpetuate from one job to the next. Black humour is used to diffuse the tension arising from a job to ensure they move onto the next job with a fresh attitude and clarity, and do not take the negative emotions into the new situation. The following paramedics demonstrated the importance of this factor in their ongoing performance:

You'll find something about it that was ... you sort of make it into a bit of humour, so you just diffuse it a little bit, so you can hopefully not be constantly thinking about it … That humour does tend to ***break that cycle****. So, it might be something as completely mundane as what the patient was wearing or wasn't wearing at the time you got called, or it would be something completely innocuous, or it could be something blatantly obvious … but it's that spark that we need to almost diffuse that case****, close it off so that we CAN move on to the next one and not be distracted,*** *because that's the one thing that we don't want to be doing, it's getting distracted for that next patient that needs us. So yeah, humour ... it's the quickest way of diffusing something (Int. 1).*

If you focus so much on your professionalism, and you focus so much on what's going through your head, then I think what you do is you become a time bomb for emotions, whereas if you bring some outlet, if that outlet's a little bit of humour or a little bit of lightness, then I think that diffuses that, whereas people who are would be more vulnerable are those who go in there with an ultra-serious attitude all the way through and there's no way of diffusing (Int. 4).

I guess, like I said, it takes away that human element of everything where you can have a good laugh at everybody and each other around you; be like, well that was a really stupid thing that you did, wasn't it? And you're like, yeah, I know. But like, we went to a bariatric arrest, and after the job, we did the good debrief and we went through everything, and the very last question was, and did everybody see the box of Krispy Cremes next to the patient, and we all said, yeah I did – like it's just, I don't know, I guess it's that way of sort of de-stressing everything and making sure that you can go along with the next job, because people don't know that you've just been to a four year old … when you go to the next, like next patient was like a nanna that's having chest pain or whatever, like they don't know what you've been through before, so you can't take all of that emotional baggage into your next job because, or else you'd never get anywhere. But yeah, I guess black humour's a really important part of debriefing cases and of [the] culture, I suppose (Int. 19).

The previous quote also highlights the need for the paramedic to be aware of their surroundings and the people who are around them, both within earshot and in view. The following paramedics did realise when they needed to be careful to not have their efforts at de-stressing witnessed by others.

And it's just that one little spark that we use to then have a giggle or a chuckle in the back of the truck, and obviously, we try and do that out of the public's eye, because they just don't understand why we do it, when we do it, and what we're doing it for (Int. 1).

You've got to be careful where you use that - because general public don't actually really get that … Only other ambo's get that, and those that don't get it won't get it because they're not really of the culture that's going to be right for this, and I think even some nurses don't have it either. There seems to be, the A&E nurses I think do (Int. 14).

The other side of the issue is when the paramedic uses humour to help de-stress the patient or family, to lessen the severity of the situation. The following paramedics detailed how they use a sense of humour to ease the tension and lift the anxiety:

> *I go into a family and if it's serious, we concentrate on what we're doing, but there is a point where you can actually relax the people around you, including the patient, and you can use just a little bit of levity or a little bit of deference ... Beautiful pictures of your grandchildren and all that, and that's what I try and instil in them (Int. 4).*
>
> *Sometimes you can joke along with the patient and you can judge their ... how they're going to receive, whether they're going to be, "Oh my God" shocked or whether they're going to go along with it, and so sometimes it will just be ... you can judge and there won't be anything too much there to draw" (Int. 5).*
>
> *I think a level of, what's it called, emotional intelligence is required. I think a sense of humour. So, you need to be able to also go, "this is a stressful situation, how do we calm everybody down or how do we take this down a level", and for me, humour is the way that I do that. That, I don't know how … but I'm pretty sure that plenty of others do it ... The humour, it's the black humour, it's the able to say something to a nanna that you just go, my God, I could never get away with that and it's received well. So, it's not about being rude to anybody. It's the delivery and the personality. I've worked with people [and] they've gone, oh my God, I can't believe you've just said that and the nannas' think it's gorgeous, but if I delivered the same thing, they'd be horrified. It's all timing and delivery (Int. 14).*

This final quote for the section summarises the who, what, and why of humour use among medical personnel:

> *Ambos are renown for having probably one of the more darker [senses of] humour as a coping mechanism. It's the only thing that we've got to diffuse any stressors that we've got going on, either from the job or from the environmental influences. Nine times out of ten, it's done in the vehicle when you've finished the job. There might be the one time where you need to diffuse the situation when you've got a number of crews there, out of earshot of everyone else, just so that you can sort of break that cycle and refocus. But yeah, it's definitely there, and I would say other than other health personnel, you know, your nurses, your doctors, probably the top 2, but there's definitely others that would probably use it as a diffuser. But it's only in those other two professions that they really use it in the same way that we do. It's just enough to break the cycle of thoughts, break the adrenaline rush, so you can actually allow yourself just to relax and stop being attentive, stop that heightened awareness so that you can actually recharge your batteries for the next job (Int. 1).*

While this section has clearly outlined the positive contribution that humour, including black humour, makes to defusing stressful situations and allowing paramedics to move from one job to another without carrying the emotional trauma with them, they are also aware of the

shifts in cultural appropriateness around humour. In the next section, the shifts that have occurred in how paramedics use humour are explored as are the impacts these changes have had on its function as a coping mechanism.

10.6 Political Correctness

The Oxford Dictionary defines political correctness to mean "the avoidance of forms of expression or action that are perceived to exclude, marginalise, or insult groups of people who are socially disadvantaged or discriminated against" (Oxford English Dictionary). For example, political correctness shifts language so that the use of a pre-modified noun (such as 'disabled person') is replaced by a post-modified noun (such as 'person with a disability') (Halmari, 2011). Political correctness is designed to be absorbed into the culture by influencing the assumptions made about what is appropriate or inappropriate to say. Goddard (2009) talked about cultural scripts as these assumptions: "Any given speech community has such shared assumptions, and although not everyone necessarily agrees with them, everyone is familiar with them because they are reflected in the language" (Goddard, 2009, p. 38).

However, as stated previously, Australians are known for their irreverent humour. "The practice is an enduring feature of Australian public and private life, and even in these latter days of legislation designed to outlaw sedition, vilification and defamation, most Australians would agree that it is their democratic right to challenge in this way their elders, their betters, their enemies, their friends, and of course themselves" (Davis, 2009, p. 24). Despite the changing sensibilities, even certain authorities still protect the use of disrespectful and impertinent humour: "When the country's chief law officer identifies 'Australia's fine tradition of satire' as something worth protecting and being proud of, adding that 'Australians have always had an irreverent streak', then surely an important blow has been struck for freedom and happiness and we can hold our heads a little higher as we enjoy our jokes" (Davis, 2009, p. 20)

Humour can be hazardous when not used lightly with sensitivity. That this may be hurtful, or even deeply offensive, does not seem to concern a number of people in this culture. "Australia lacks many restrictive conventions or taboos on joking (until the advent of

political correctness, a movement that sparked its own counter-revolution as comedians protested limitations on their work)" (Matte, 1995, p. 56). However, the adoption of political correctness was intended to inhibit or restrict the telling of savage, uncivilised, derogatory, bigoted, blasphemous, or phobic jokes about any group of people that were deemed foreign or alien (other cultures or races).

The effect of political correctness on the use of humour in paramedic circles has been overly restrictive in their perspective. Black humour is not always directed at disadvantaged minorities. Nevertheless, there are members that have increased sensibilities that do become offended. Certain paramedics are upset about the institutional crackdown on their use of humour, and the effects this will have on their ability to cope with trauma.

> *So, I mean, and as you say, the jocularity is one of the biggest coping mechanisms, they've lost it (Int. 14).*
>
> *Oh dear! Such a cynical bastard! Oh, that would be black humour. We're not allowed to use black humour … Oh, we've been told no … As part of our respectful behaviour."* ***Qu: You have actually been told?*** *"Um Hum. Yep, yep, not appropriate to use anymore, which is one of the coping mechanisms for ambos, we're not allowed to use it, so there's going to be more stressed ambos out there" (Int. 13).*
>
> ***Qu: Is political correctness going to just …?*** *"Kill everything? Yeah … You know [the humour] can be quite blatant, as you probably know. It can be terribly inappropriate. These days, politically correctness is hitting the ambulance service as well, so they've got to be a bit careful about what you say and who you say it to, and all that sort of thing (Int. 21).*
>
> *My interpretation is they're trying to clamp down on gossiping and they're trying to clamp down on bullying and harassment. There's always been a problem with gossiping, and there's been ... Some people that have been accused of different things, and then the gossiping has taken over what's really happened. So, there's been a big clamp down on that, there's also been a big, big clamp down on I guess, I don't think it's the black humour, I think it's more of the inappropriate gestures. So that stuff … something that could be misconstrued as a sexual harassment comment or something like that … I know that they've clamped down on that, which is fair enough, it should be too, if there's people doing stuff like that, it should be stopped. Black humour? I guess it's the degree of black humour maybe they're trying to clamp down on. I'm not sure, but I haven't been told what's … But then, if it's just you and your partner in a car, they're not going to stop you from having a joke (Int. 15).*

There was also a resentment among the members that the institution was required to go down this track. Added to the institutional restrictions against black humour, some older

paramedics believe that the new recruits come in with a heightened set of sensibilities and do not yet understand the benefit of humour as a technique for coping with stress:

> *It came because the … university students took offense to some things that people said … and they couldn't deal with it, and so they ... they complained ... about various things, it wasn't just that, but that was part of it, so ... so basically, the implications of it are you are not allowed to say anything that is out of place, you are not allowed to do anything, I mean our coping is, you know our black humour is just typical of ambulance, police, fire, it's pretty normal for us, but you wouldn't use it outside … But we are not allowed to use it at all. It doesn't matter [that it helps], it doesn't matter. We're not allowed to use it because somebody took offense to it and complained (Int. 13).*

> *No, it's always the management, and you get … we've had people that come up that don't understand the humour and usually it's like 1st year degree students and all the rest of it, and some of them think "oh, that was a very inappropriate joke", and they make a comment and then of course, you're in trouble because you've made an inappropriate joke. When the reality is, that's how you blow up and you do dehumanise it. That's the whole idea. It's not normal to go and help someone stuck … and put them back on a thing and help clean up. Don't know anyone that says that that's fucken normal. So, you make a joke about it. But when you first start, they think "oh, we've got to respect the whole body, the whole person." Yes, you do, but you don't. You do while you're there, but if you don't blow up and change it to something else, it's always going to be … every person is going to be someone personal to you and you can't do that. You know how I said I tend to dehumanise things, that's what I mean, and I've always, why would I be doing it.* ***It would be like dealing with my fucken Mum every day. You can't do that****" (Int. 16).*

The new difficulty now in using this coping strategy is knowing where, but more importantly, in front of whom you can use it. A paramedic must now have a deep trust in the colleagues around them in order to feel safe to de-stress a situation in this manner. The next few quotes explain how they continue using this coping strategy:

> *I think certainly, you would say other ambos … would make other people cringe ... I still think that there are certain people that take it to different levels. There are some ambos that say certain things that make me cringe a little bit still, and they probably think I wouldn't say that … different ambos, so I think you've got to be careful who you are talking to, but like … going back to your friends that you have gone through uni with and are now working with, they're the ones that you feel most comfortable. I think you need someone that you can talk to that you know you can say whatever you want, and it's not going to be pushed … and you can have a laugh about it and you just need to have that someone to confide in. I mean, there is certain people around here that you can have a joke with, but you go, oh wonder if they are going to pass it onto someone else, and you have to be a bit careful, but I think if you didn't have someone where you can have that absolute confidence, you would go insane probably (Int. 11).*

Qu: Where do people do it? *"Umm. Normally in private with only appropriate people present."* ***Qu: Who's appropriate?*** *"Peers and even then, it needs to be selected peers ... I think if it's done right, then yeah, because you need to have some relationship with the person you're talking to, which means you need to know something about them, and you know ... What I would think of as black humour, someone else may actually be offended by it ... Maybe it's really close to their personal circumstances. If you don't know them, you don't know that, and it's not black humour if you do that, it's just offensive" (Int. 7).*

Yeah well, we've kind of been reigned in I suppose, but once again, I think you've just got to pick your audience. And I think you'd have to be, if you're in a large room for instance, say at [Metro: hub] and you had lots of different people in that room, you would have to speak like you're in an office environment. You'd have to really curb the black humour, you'd have to really curb that sort of stuff, but then once you're in an ambulance with your partner, and it's only the two of you in there … you can still get out that black humour. You just have to pick and choose who you say it to (Int. 14).

I remember like as a new intern going to a few jobs and being like, that was a really inappropriate thing to say. But, you know – and I guess it's choosing your audience, as well, like for some people that you can't, like you know you can't do any sort of … like for some people, they'll just take it the wrong way and you'll end up with file notes and SLS's and all that sort of stuff. You know, you've got to pick your audience and make sure that what you're saying is like still appropriate to the people that you're around, as well (Int. 19).

Some paramedics do appreciate the intention of the political correctness 'crackdown' (or correction/improvement), and have not had difficulty in adapting their use of humour to the new specifications or individual sensibilities. The following quotes demonstrate that they have thought deeply about the issue:

People that struggle with that kind of humour I think are very clinically focused. And I have no problem with people that don't like it. That's fine. There are certain people I won't say things around because I know what they're like, I know what they do like and what they don't like, and I know what they consider inappropriate. And to respect them I won't say it. There are other people that do like to have a laugh, and as their way of coping or de-stressing, that's what they'll say. So, I think you can, but that's definitely a conscious choice that someone makes (Int. 22).

Everyone's different and has different coping strategies I think, yeah. It just probably happens that most of us like that coping strategy. But yeah, there's definitely other people out there that are more, like I'm probably borderline, like I enjoy it and I appreciate it, but I don't … I'm not really an instigator of it. So, I'm a little bit more reserved on the professional side, so there's probably other people like me out there as well. Like, I can think of a couple but, yeah, and maybe I just haven't been in the job long enough, maybe that will all come out the longer I'm in it (Int. 23).

There are other members that are not as comfortable adapting and are more exasperated at the organisational crackdown. The paramedic below is more concerned about how well they will cope in a traumatic situation:

> *You can't take that from job and you know what? They weren't at the job. You can't appropriately say that wasn't an appropriate time to use that kind of humour. What is that? Were you there? Did you understand the job? Did you know the precursors? Did you understand the stress of the case? Did you know we were a staff member down, and trying to do a cardiac arrest with three people is actually really hard? Or like it matters. They can't take that. I don't think that's right. Otherwise everyone will just become robots, and no-one will know how to cope, and then everyone will have a bit of a brain explosion or emotional diarrhoea I guess, I mean, no, constipation, emotional constipation. It will just get all stuck in there and then. If that's people's only way, you can't take that from them (Int. 22).*

And finally, at what point should an individual control the behaviour of the group? One paramedic encapsulated this perspective with a good analogy:

> *I understand there are some serious issues that have had to be dealt with, but essentially the message is that if you're in a group like this, and people are talking, and somebody is upset, even if you are upset on behalf of another person, that group has to stop talking about that topic. So, you know, if we're all talking about whatever it is – and I use the example of football; I hate football, so if I'm at work and there's seven people talking about football, theoretically I can say "I am feeling excluded and I'm feeling isolated and I'm feeling upset – so you people need to stop talking about football." Surely at some point, somebody needs to turn around and say "You know what? You can leave the room, it's your problem not ours", but – and the black humour's a bit like that; if there is a black humour conversation going on and one person's upset according to that concept, everybody needs to stop talking about it … And that's what political correctness sometimes seems to do. So, and you know depending on context – if it was sexual harassment, clearly that's just not right, but there are other situations where you could see that it's the group that is going to suffer because the individual says, well, I'm upset, and because – just because I'm upset doesn't mean you have the right to tell me that I shouldn't. How far do you take it?" (Int. 21).*

10.7 Summary

This chapter has considered the way the culture of coping for paramedics has been required to change because of societal evolution. Because of the insistence on political correctness, the use of one of the paramedics' most used coping strategies has had to be modified. Most have just limited their use of such humour around members with whom they are not totally familiar, and have therefore not developed a trust relationship with. The long-term impact

of this fracturing is yet to be determined. The following chapter will discuss the implications of differences in the culture of coping due to location, generation, and societal evolution.

CHAPTER 11: DISCUSSION

11.1 Introduction

The foundation question for this research is: - *What is the culture of coping in paramedics?* The previous five chapters have outlined the paramedic perceptions of their occupational and coping culture, and the three factors that were dominant in their insights in regards to how the culture of coping differed between individuals. In order to further explore this theme, the questions posed to the paramedics revolved around which coping strategies they perceived were deliberately used or not, which were perceived as being beneficial or detrimental, and which were culturally encouraged or discouraged by their peers. More specific questions asking to elicit this information dealt with understanding the common experience of what is considered traumatic, how coping strategies are learnt, and how organisationally provided strategies are perceived.

This final chapter discusses the findings in relation to the research literature by theorising, interpreting, and making meaning of the information provided in the five results chapters. This new knowledge provides a deeper understanding of paramedics' experiences and perceptions of mental health wellbeing within the Australian context. Following the interpretation of the findings, a general typology of paramedic culture is presented that conceptualises the research outcomes from a theoretical standpoint, drawing on Tönnies' concept of Gemeinschaft/Gesellschaft, which he developed to illuminate the differences between community and society (Christenson (1984); (Nilsson & Hendrikse, 2011; Slattery, 2003). In drawing on Tönnies' and Durkheim's typologies of the old and modern worlds, I explain their theories and then show how some of these ideas resonate with the way paramedics portray their informal culture of coping. Tönnies' theory was selected because it resonates with the varieties of cultures within the world of paramedics. These two opposing ideal types of culture, being one-sided exaggerations of a social fact employed to demonstrate a point (Swedberg, 2018), are presented not as two isolated extremes, but as two ends of a cultural continuum.

In the final section, I outline the limitations of Tönnies' theory and provide a more nuanced and contemporary view of community/society that sheds light on the differences found in

the paramedic culture across locations, generations, and over the passage of time. Collectively, these modifications form the basis for recommendations put forward for the ambulance services, particularly for managers wishing to provide positive strategies for understanding and supporting the informal culture of coping and enhancing paramedic mental health, while potentially improving the management and delivery of services.

11.2 The Working Environment and Stressors

In Chapter 6, I outlined the working environment and stressors that paramedics indicated influenced their culture of coping. There are, broadly speaking, two categories of stressors encountered by paramedics: critical incidents, such as the traumatic jobs they attend while at work, and organisational responses, including industrial procedures and the way management responds to critical incidents and workplace situations. As the managerial relationships within the organisation were not part of the principal research question, and were not routinely explored in this study or covered in the findings, this section will focus only on traumatic jobs as a source of occupational stress.

The different roles that are performed by each paramedic influence the form of stressors they encounter in a shift, the time available to talk between jobs, and the closeness of their relationships with peers. Paramedics in roles with higher accountability, such as team leaders, have more responsibility for their team members, and will unavoidably deal with a greater number of emotionally demanding issues, because they also get called to the difficult scenes that their team members must deal with, therefore dealing both with the extra incidents and with supporting team members in higher intensity situations. Because of this extra obligation, it is essential to have suitable personnel in these positions, and it is vital that their extra role is understood, valued, and supported by the organisation.

Although research was conducted last century on the assumption that ambulance work was intrinsically stressful (K. M. Young & Cooper, 1997, pp. 40-41), it became more apparent in this study that 'lay' preconceived notions about the kinds of jobs and situations that paramedics consider stressful are often mistaken. "Gory" or "bread and butter" jobs, pertaining to trauma and cardiac or respiratory events, are not considered particularly stressful. A good day is "*several people almost dying and not dying*" (Int. 6). For these

paramedics, a job which challenges them and makes full use of their clinical education is more exciting than stressful. Some even stated that scenes that were “upsetting” were not necessarily stressful. Over a third of respondents found it difficult to identify anything stressful about their job at all. This is comparable to the findings disclosed by Crampton (2012), who found that “the critical incidents that align more closely with the DSM-IV-TR (i.e., personal safety endangered, incidents leading to the injury of self and colleagues, or life endangerment) did not create a severe disturbance” (Crampton, 2012, p. 44). This is an unusual finding given that between 20-30% of paramedics experience enough PTSD symptomology to warrant a diagnosis (Alexander & Klein, 2001; Clohessy & Ehlers, 1999; Regehr & Goldberg, 2002), a figure far higher than for the general population. It would appear that it is not the specific job that contributes the most to chronic occupational stress, but some other factor. This could also be explained by personal perceptions of control, as identified and commented on by many researchers, as an important factor influencing the severity of experiencing a traumatic reaction (Avraham et al., 2014; Donnelly & Siebert, 2009; Mahoney, 2001; Regehr & Millar, 2007; K. M. Young & Cooper, 1997), which seems to have a greater effect in organisational situations. A lack of control would be felt in the ‘unknown’ situations where communication of facts has been transmuted prior to arrival at the scene, or patient behaviour becomes unpredictable. As one paramedic said,

> *So, you have that all set up in your head. Then you walk in there and it's something completely different ... it really throws you, and it really does put a spanner in the works when it's not what it's supposed to be” (Int. 3).*

Clinically, jobs are generally considered stressful by the majority of paramedics interviewed when they do not go the way they should, when the paramedic identified in some way with the patient, or when they were required to help family members and bystanders deal with grief. One universal concern over stress occurs when paramedics attend paediatric jobs. One of the factors that touched paramedics in this study, a point echoed in the literature when dealing with paediatric jobs, is the compassion or sensitivity experienced regarding the innocence or vulnerability of the child (Regehr & Goldberg, 2002). Paramedics also reported that they felt they had not received sufficient training for situations with children, leading them to doubt their clinical experience in dealing with paediatric patients. For this group of paramedics, stress in the paediatric space is the result of an emotional response to their own medical incompetence in the clinical skills and tasks required, coupled with their

emotional and empathetic reaction to the vulnerability of a sick or injured child. Assumptions about the forms that stressors take need to be reviewed and reassessed on a regular basis.

11.3 The Current Culture and Future Directions

Chapter 7 dealt with the current culture and future directions. It outlined the perceptions of paramedics on what their culture of coping is now, how it works for them, and how supported they feel. All paramedics in the current study noted the formal occupationally provided Peer Support Program as an integral component of the service's culture of coping and an obvious strategy, whether they used this service or not. Attitudes towards the Peer Support Program varied considerably according to the individual's perspective. Some paramedics felt supported by this initiative, valuing it greatly, while others almost considered it a hindrance. This is particularly noted between the generations, as for example, among the Baby Boomers, the common attitude was "*I think you'd find that there's a lot of us old school who won't use it. I don't think I need to talk to one of my peers that are probably junior to me that haven't had the experience, sits there and listen to me" (Int. 13: BB),* whereas for Gen Y, the prevailing attitude was closer to "*Yeah, and I think they make it really open and acceptable. Like when you come in through internship in your first block you meet – they say this is so-and-so, they're from peer support. And a lot of the time they're your colleagues. So, your first point of call are your colleagues" (Int. 22: Y).*

The research literature is divided on the influence of peer support programs. In her quantitative study of Australian operational paramedics, Brough (2005) found that the support of colleagues and supervisors had an impact on job satisfaction, but not on psychological strain. This support was not, however, part of a formal peer support program. Pitt et al. (2013) conducted a Cochrane review on RCTs conducted between 1979 and 2011 involving peer support workers and their effects on consumer outcomes. They found that there were no significant differences; however, they were also able to state that "the quality of these studies was moderate to low, with most of the studies at unclear risk of bias in terms of random sequence generation and allocation concealment, and high risk of bias for blinded outcome assessment and selective outcome reporting" (Pitt et al., 2013, p.

CD004807). It is clear that research into this area needs considerably more rigour before the results can be viewed with confidence.

One side-effect of the peer support program in this study was unexpected. Paramedics were of the view that management had compiled a list of jobs that they defined as upsetting or traumatic, and when these occurred, contact was made with them to see how they were coping or if they needed support. Because everyone is now automatically contacted after an event, individuals claimed they became desensitised to receiving the call. This was due to the fact that calls were not only made to paramedics who were believed to be more vulnerable, but to everyone in the team. When calls were targeted, the mere occasion of receiving a call labelled the individual as being more susceptible to stress than their colleagues. In this service, the peer support call is made to all paramedics in that circumstance. Ironically, despite the risk of being labelled susceptible to stress, paramedics who would previously not have wanted a call, now become annoyed if they do not get a call. They assume they have fallen through the cracks and that management has forgotten them, which appears to them to be worse than being supposedly bothered by an unwanted phone call.

Further to this, a recurring comment on the formal peer support program related to the level of backing it now received from management. The view was that for it to fully succeed, peer support needed to be visibly sanctioned by management. A number of paramedics were of the opinion that senior managers no longer promoted the program. This was considered a retrograde step given that Generation Y were believed to have embraced it more fully.

Attitudes towards the value of formal peer support programs also differed. Those who saw it of value believed the counsellors were adequately trained and that the peer support officers were competent, and that they did help paramedics work through emotionally difficult situations. Other paramedics were more neutral, did not believe that support was needed, and that people utilise their own strategies that they learned elsewhere, and these strategies must be working, because people continue to go to work. A third group know that they have the option to use the program if they need to, but felt that they are on their own, essentially isolated from assistance. They did not feel supported, stating that the formal

culture of coping in the industry is non-existent. With the literature available on peer support, and the achievable benefits being so inconclusive, it is difficult to convince members of the advantages that may be gained, or the assistance that could be attained by talking with a peer support professional (Mahlke, Krämer, Becker, & Bock, 2014; Pitt et al., 2013).

Paramedics also noted that the passage of time had affected the culture of coping within their organisation. For example, small organisations are better placed to deal with the trauma associated with the work because their staff achieve closer trusting relationships with each other. However, as the organisation grows in number, and station teams become larger, it becomes more difficult to develop strong emotional ties to other members of the team or to rely on them for emotional support. This was aptly demonstrated in statements on the levels of trust between the Rural, Remote, and Metro stations:

> *These guys are really good, and just because they're not ... I mean everyone ... I consider everyone in SAAS as part of the family, so just as I'm up there and these guys are here, I still think of these guys as family as well, so it's ... it's one big happy family! (Int. 5).*

> *A lot of the time you can still be in a group of people and still have a discussion about whatever you want, but I think you're always just that little bit more careful about who's around and who you're talking to because it's just so much bigger group of people that you don't know and have never met that are in the exact same role as you are on the other side of town (Int. 11).*

Whatever the paramedic believes the culture is or is not at this point in time, they consistently presented strategies on what needed to be done to maintain their own mental health wellbeing. Firstly, they argued that work/life balance was important, that being a paramedic was not everything in life, and that many issues can be managed by making sure that social networks are maintained and that outside interests are pursued. Because of this, attention was redirected towards other generally more positive outlets, such as sporting interests. Another important element espoused by the respondents was to know oneself (insight), to understand one's personal triggers, coping resources, strengths, and weaknesses, and to recognise within themselves when they were not doing as well as they should, and at that point, to seek professional help. Ensuing from this, a number of paramedics recommended talking to people: to find out who they were comfortable with, to cultivate their social networks, family members, partners, peers, or professionals, and

deal with the traumatic exposure by talking about it. Avoidance, or generally ignoring the need to discuss traumatic details for reprocessing, was seen by the participants as detrimental. This is in line with the current research on how avoidance can contribute to the maintenance of PTSD symptomology (Clohessy & Ehlers, 1999; Holland, 2011; Pitt et al., 2013).

The last three strategies recommended by paramedics for coping with stress related more to developing a particular point of view than to specific actions. Firstly, paramedics advised against engaging in a negative loop of rumination following a job that may have been difficult. This meant that they should approach each job with the understanding or realisation that they did not cause the situation, and so, must not adsorb the responsibility for it. Using self-talk, they needed to realise the patient was in a difficult position, but this was through no fault of the paramedic. The paramedics' job is to attempt to improve the situation and the outcome if possible. What was needed was to appreciate that "*yes, it is a case of life and death sometimes, but it's not your life and death"* (Int. 6). After this fact is acknowledged, the advice from paramedics included being happy to know that they did their best, even if the outcome was negative. Again, it must be recognised that just as the paramedic did not cause the situation, the outcomes of all jobs cannot be fully controlled. An individual cannot accept responsibility for a job going wrong if it was outside their power to prevent it. Humans are fallible, and on occasions mistakes are made. The direct instruction was – don't fall into emotional flagellation. Finally, the advice that paramedics said they would like to impart to new recruits to assist them, was to be in the job for the right reasons. They suggested that if a paramedic craved constant excitement, needed to feel like a hero, or needed to always be on-call, these unrealistic expectations could lead to negative emotions about the value of their work. It is important to remember that when the end goal is to assist someone in need, even the routine and benign jobs are of value and importance, because they make a difference in the lives of individuals caught in a vulnerable moment. More research needs to be undertaken in this specific area to tease apart the particular mindsets that paramedics find themselves in that can either promote or prevent mental health wellbeing.

11.4 Location

Chapter 8 identified that the culture of coping was influenced by the location in which the paramedic lived and performed their role, to the extent that the living and working environment and the population they serviced shaped the relationships they formed, the type of support they received or sought, and the norms and values espoused within the station. The smaller and more rural the population, the more intimate the contact, and the more relationships with colleagues and locals were built and maintained due to natural sentiment (rather than mutual self-interest that occurs in more densely populated areas), the more this affected the level of trust achieved with colleagues. Paramedics in rural and remote areas referred to their culture as more like that of a close-knit family, using terms such as “father figure”, “children”, and “family” in their descriptions of life at the station. They reported that there was a strong community spirit, not just between paramedics, but also with other emergency service personnel who attended some of the same jobs. As a consequence, these paramedics developed a broader skill set as they took on some of the work of other emergency workers. The scope of practice is also broader in more remote areas, given the low numbers of paramedic staff, and the possibility that other emergency service workers may require assistance. A qualitative study conducted in Tasmania investigated this increased scope of paramedic practice, and relationships with the community. One paramedic noted that members of the community would just drop in to his house for anything ranging from a dressing change to anaphylactic shock (Mulholland, Walker, Stirling, & Tourle, 2009). For paramedics working in rural stations, the work is more a part of their everyday life, and an integral component of their identity within the town. This is because they are known within their community for their medical knowledge, just as much as they may be known as a great cricketer, an artist, or a dog or cat person.

Paramedics living in small rural regions are also unable to psychologically or emotionally step away from the role as easily or as completely as their metropolitan counterparts because of the on-call arrangements, which means they take the work home with them and are rarely off-duty. However, even though it is difficult to step out of their role, the number of jobs they are called upon to perform is less intensive. With fewer call-outs, the crews often had sufficient time between jobs to process the clinical and emotional sequelae of the previous call-out before having to attend to the next patient. Commenting on the impact of

work intensity in busy city stations, Clompus and Albarran (2016) in their qualitative study on coping strategies and adjustments to their occupational outlook with seven paramedics, found that not only were these paramedics unable to process traumatic information, but that being 'chased' on the radio made them feel uncomfortable. They stated that the "level of managerial gaze was viewed as overwhelming and affecting the delivery of personalised caring" (Clompus & Albarran, 2016, p. 4). Paramedics in both rural and metropolitan stations found it beneficial to be given the time needed to reflect and engage in the informal debriefing with their partner or another health professional, given this process continues to be the most commonly used informal strategy for coping (Abel, 2002; Avraham et al., 2014; Clohessy & Ehlers, 1999; Shepherd & Wild, 2014). Paramedics working in the rural context found time was available for this to occur.

While the rate of jobs is markedly reduced compared to their metropolitan counterparts, the nature of their jobs can be more intensive and the outcomes more serious for rural paramedics. Given the poor state of some roads in rural Australia, the need to drive at night with less illumination, the increased number and intensity of natural hazards (trees, ditches, wildlife), the faster speed limits, and the fact that some drivers, especially tourists, may be unfamiliar with them, there are more motor vehicle accidents in remote locations. Add to this the vastly slower response times, the amount of time that the crew are without backup when it is desperately needed, and the length of time the paramedic is responsible for a medically fluctuating patient with serious injuries before delivery to a medical facility, all of which are further stressors. All these factors are supported by Crampton (2012) in his study that compared rural and urban paramedics in the U.S.A. For example, he noted that a U.S. Congress Report in 1989 stated that "persons involved in rural accidents are three times more likely to sustain serious or untreatable injuries than those in urban areas" (as cited in (Crampton, 2012, p. 22). All these factors make the stress matrix that rural and remote paramedics are exposed to different to that of their metropolitan counterparts (Revicki, Whitley, Landis, & Allison, 1988).

One of the more constant stressors for paramedics regarding emotionally difficult jobs is when the paramedic identifies with the patient because of their similarity in physicality or circumstance to a member of their family or friends. In the remote areas, where populations are relatively small, all of the inhabitants of the area are known to one another. Because of

this, it is more likely that a paramedic knows, and has a personal relationship with their patient, which increases the likelihood of traumatic reflections.

The country town paramedics were found to be similar to those in remote areas due to their familiarity with the surrounding population and the small number of colleagues they engaged with. Country towns are larger, but still small enough for a paramedic to be familiar with the majority of inhabitants, although not as tightly-knit as in remote towns. The number of colleagues in the team is larger, reducing the family-like feel within the stations, and large enough to produce splinter groups and further segregation. This has an impact on trust relationships with a reduced level of intimacy which, in turn, influences the culture of coping in that the informal peer support debriefing between team members is restricted. Such complete and exposing debriefs now mostly occur only between peers with a stable trusting relationship. In a study of nurses working in rural Canada, this reliance on peer relationships after experiencing trauma was noted and seen as their most helpful method of coping (Moszczynski & Haney, 2002).

As the findings from this research demonstrate, as the surrounding population increases, so does the rate of job allocation. The crews in country towns are called out more regularly than their rural colleagues, which gives them less time for debriefing between jobs. It also has an impact on the culture of coping, in that paramedics in the metropolitan stations prefer to debrief off-station. The culture of coping alters again when the focus moves to paramedics living and servicing a more densely populated metropolitan area. There are many teams and team leaders rotating in and through stations at any time of the night and day. The “lack of personal engagement” (Int. 6) feels palpable. Identity is the organisation alone and all individuality seems to disappear.

In the city stations, the work stream is constant and there is always another job waiting. This relentlessness also affects the culture of coping because there is no time (let alone sufficient time) to fully process the impact of the previous job before needing to move on to the next patient. Occasionally, this can be almost protective; when the paramedic has focused completely on a further number of jobs in that shift, they have emotionally moved on, and the intensity of the emotional response has already diminished. However, most of the time, the lack of time to process between jobs and the constant pressure to clean up and depart

the emergency department within the hospital as quickly as possible does increase the stress felt by paramedics. Similar findings were outlined by Clompus and Albarran (2016) while interviewing seven paramedics in the UK, where it was found that the pressure to attend, transport, and depart quickly became overwhelming: "*Once you get to a job, after 20 minutes, they chase you on the radio (Eve)*" (Clompus & Albarran, 2016, p. 4). Another factor that occurs in the metro area due to the increased rate of jobs is attending a run of similar jobs which can be boring or unchallenging (e.g., hospital transfers), or jobs that individually do not evoke an intense emotional reaction, but when exposed to repeatedly, the cumulative effect of emotional trauma can be considerable (hangings, paediatrics, or heart attacks).

There is a general view that the metropolitan paramedic is more able to compartmentalise and view their patients as 'conditions requiring treatment', because they spend less time with them before arriving at a medical facility. [The issue of 'ramping' was not mentioned during the collection of this data, which accounts for the lack of commentary on this situation]. However, the participants did talk about situations where they were called to jobs that were trivial. For example, a 15-year old girl rang for an ambulance because she was shaking after a bad dream (Int. 21). Such events increase the frustration of paramedics who become annoyed that their skills are not being fully utilised.

The teams in the metropolitan area are more like collections of people working under the same leader, with commitment, but also with impersonal relationships. This differs from the friendly personal relationships made between paramedics in rural and remote stations. In the metropolitan stations, when in need of emotional peer support, the younger and newer paramedics turn primarily to their own social groups outside of the team, specifically the people with whom they spent their internship year or those who attended their university course, which is a consistent observation described by staff working in both emergency and other health services (Jonsson & Segesten, 2004; Regehr, 2005; Regehr & Millar, 2007, in (Clompus & Albarran, 2016). The relationship between the metropolitan team members is more formal, goal-oriented, and clinical. The development of confidential trust relationships is less apparent, which influences which coping strategies are used in specific scenarios.

11.5 Generation

The culture of coping is also considerably influenced by the passage of time, most notably in the generation in which a paramedic was born, as illustrated in Chapter Nine. The Baby Boomers' attitudes to working relationships are similar to those in the rural areas. The view is that loyalty and kinship, hard work, and effort will be appreciated and rewarded. Security comes from the perspective that one is part of that industry 'family' for life. There is a level of trust that is developed similar to that within a family – people discuss their problems with others they trust. For this generation, elders are sought out for support and advice – and an elder would not discuss their problems with a younger member (or less experienced colleague). Elders are supposed to be seen as respected leaders who help younger members to understand their culture, family, community, and life, as explored in Holmes (2018) doctoral thesis, who stated that the advice given by veteran paramedics should actually be included in the undergraduate curriculum. The focus on finding familial-like support from within the organisation partly explains why Baby Boomers are less likely to go to formal peer support. It is also one of the reasons they need to preserve an image of always being 'OK', because "it's not okay to not be okay" (Int. 22). They are more likely to use their internal network of trusted colleagues, usually from the same generation, along with humour as another diversionary coping strategy. They have also generally been working in the industry for a longer period of time and have therefore been exposed to more critical incidents or more events that have a cumulative effect, which must also be taken into account. This will alter the social support they need and who they turn to, thus influencing their culture of coping (Regehr, 2009).

Analogous to the characteristics found by Lamm and Meeks (2009), who investigated the moderating effects of generational differences on the fun experienced in a workplace, the current study found that Generation X are similar to the Baby Boomer generation, but prefer a more informal work environment with face-to-face, direct communication. They share similar characteristics to Gen Y because they are more outcome-focused, realising the necessity of acquiring a diverse skill set, and not committing to one employer for life. This appears to be similar to other health professions, as Weingarten (2009) found that Gen X emergency nurses had no expectations of spending their whole career in one emergency room. Gen X paramedics still develop close trusting relationships with their colleagues and

use them as a support network, but do not socialise with them as routinely as once was the tradition within the service. They attribute the differences to either the increasing bureaucratic culture or the size (population density) of the organisation. Generation Xers also share with the Baby Boomers similar strategies when dealing with stress, even though the concept of workplace fun varies between the generations (Lamm & Meeks, 2009). They were adaptable when they entered the service and absorbed their predecessors' culture, but as the organisational culture changed as a result of the influx of younger paramedics, they were influenced by this.

Many of the factors touched on in the Tramonte (2016) dissertation on "The Misunderstood Generation" are echoed in the current study. The Gen Y paramedics are much more self-centric in that they are aware of what they need and will seek it out (Lyons et al., 2007; Tramonte, 2016). There is less civic engagement and loyalty to organisations, and expectations can even include multiple career changes (Lamm & Meeks, 2009). They are less likely to care about power balances and status in the way Baby Boomers do (Busch et al., 2008). The newer recruits from Generation Y tend to already have strong social ties that were developed during their university years, and do not seek strong social ties from within the service. Gen Y tend to appreciate more formality; they play by the rules, making them more attuned to managerial directives, but they only fully follow the rules they deem to be important; therefore, they do not always follow the chain of command for complaints. They also demand respect, or at least expect their opinions to be heard and even sought after by their superiors as well as their peers. This is in line with the work of Lester and colleagues who, while unravelling the differences between actual and perceived differences between the generations at work, found that Gen Y employees prefer to work with managers "whom they can relate to and who value employee input" (Lester et al., 2012, p. 342). They are competitive but prioritise leisure, friends, and family over work. The impact of this on their culture of coping is seen in their aptitude for, and proficiency in, maintaining their mental health wellbeing. Unlike previous generations who put their work first, this generation will not hesitate to take time off work to deal with mental health issues, which ultimately makes them more self-protective. They come in with healthy coping strategies already in place, such as reflective journaling and healthy physical outlets. They have learned to use the formal peer support service, and also maintain their own support network with other

students with whom they attended university and friends and interests outside of the industry.

11.6 Societal Evolution / Humour

Chapter 10, the final findings chapter, concentrates on the differences that the passage of time has made on society as a whole, which then influences the culture of coping. Western society has become increasingly diverse, with policies in place to translate that diversity into the workforce. This has led to a reduction in tolerance for any form of discrimination, whether based on gender, ethnicity, or religion, and a change in vocabulary to reflect this; for example, exchanging pre-modified nouns (disabled people) with post-modified nouns (people with a disability) (Halmari, 2011). This has inevitably also altered the acceptable usage of a foundation coping strategy: humour.

As found by several researchers, humour has been used to relieve tension, reduce anxiety, promote objectivity, reinforce cultural norms, solidify inclusion, strengthen cohesion (by enhancing social support), and build emotional resilience (Caudill & Woodzicka, 2017; Clompus & Albarran, 2016; Lee & Kleiner, 2005; Lyttle, 2007; Samson & Gross, 2012). In paramedicine and other emergency and medical services, it is also used to dehumanise a situation, and thereby, diffuse pressure (C. T. Beck, 1997; Donnelly & Siebert, 2009; Harries, 1995; McCreaddie & Wiggins, 2009; Moran & Massam, 1997).

Now as political correctness meets with the use of humour in paramedicine, its use needs to be more circumspect. As Lamm and Meeks (2009) found, fun in the workplace depended very much on who instigated it and, as in this situation, it becomes important to determine "fun for whom?" The original intention of the new politics of respect was to focus on eliminating disparaging comments. In recent years, this has broadened out into not offending anyone's sensibilities which, in turn, has had an impact on the use of black humour, which by its very nature is deemed as disparaging to minority groups. Newer recruits, the generation who are more protective of diversity, frown on the use of black humour as a coping strategy. More seasoned paramedics find this difficult, given the management support for this new approach to black humour. Older paramedics understand

how much humour is relied upon as a coping strategy, appreciate its use, and are reluctant to lose this option. They argue that Australians are known for their irreverent humour, especially towards authority figures, and have no intention of eliminating humour from their coping repertoire, despite managerial requests. However, the new culture of political correctness means that paramedics have to be mindful of who is around and within earshot when they use this coping technique. Older paramedics reported that they now tend to be selective of where they can be, curbing their use when in large open areas and being more aware of who is around them when they make black humour comments. Firm trusting relationships need to have been well established with knowledge of personal circumstances and social networks /allegiances, before a relaxed jovial use of this well-entrenched coping strategy is employed.

11.7 Changing Culture and Societal Cohesion

The main findings chapters (8, 9, & 10) demonstrate a diversity of the cultural norms and values across place, generation, and the passage of time. There have been a number of sociological theories generated in the late 19th and the 20th century that have grappled with the radical change in culture from an agricultural to an industrial society, such as those put forward by Durkheim, Tönnies, and Marx (Cheek et al., 1995). It is useful to go back and see whether these theories help explain the results of this study.

What this research found was that individuals within the ambulance service manage the stressors of the job in different ways. Coping styles are shaped by where one works, one's generation, and the impact of the prevailing culture. Shifts in rapidly changing culture and the impact this has on social institutions has been readily explored by a number of social theorists over the last 100 years. For example, Emile Durkheim, 'the Father of Sociology', looked for social explanations rather than individual interpretations of behaviour to explain the rapid changes occurring in the 1800s. He understood that social facts had differing impacts on individual people according to their social position. In attempting to explain these differences, he separated societies into categories according to the division of labour. He coined the term 'mechanical solidarity' for the social cohesion that characterised pre-modern societies; that is, people in these societies were bound together by commonalities and likenesses in an almost mechanical way (Pope & Johnson, 1983), which Durkheim called

collective consciousness (similarity). Under 'mechanical solidarity', individuals share the same norms and values and engage in similar or the same work often within the family. There is also a limited division of labour. However, modern societies are held together by what Durkheim referred to as 'organic solidarity', which embraces differences in religions, occupations, experiences, and values. Like the different organs of the body, individuals are each doing their specialised work to keep the whole system working, but each organ is different and separated. There is little similarity, limited to very general and indeterminate ways of thought and sentiment, which leaves room for a growing variety of individual differences. Organic solidarity is characterised by individualism, where the emphasis is on the values and interests of the individual rather than wider society, and it is particularly visible in the culture of consumerism. Despite these individual differences, there is still social cohesion because each organ (or specialisation within the division of labour) needs the others to function (Giuffre, 2013).

Durkheim developed this typology to explain the transition from feudal society to industrialised society in the 19th century. He saw it occurring as a result of the transition from pre-modern mechanical solidarity to modern organic solidarity. This transition occurred as a result of industrialisation which, in turn, produced a significant division of labour within the workforce and within the family. It was also caused by what he referred to as dynamic density – the number of people in a society and the increasing degree of interactivity between them. We can see this in contemporary globalisation – dynamic density is increasing, and with it, competition increases, creating a drive for society to find more efficient ways of doing things. Organic solidarity and interdependence come from greater density and interactivity (Adler, 2015).

11.7.1 Gemeinschaft and Gesellschaft

Instead of defining society using a typology based on the division of labour like Durkheim, Ferdinand Tönnies grouped individuals together on the basis of social ties between the members of society. For Tönnies, Durkheim's pre-modern mechanical solidarity became Gemeinschaft. This term refers to small groups (small families and close-knit kinship groups) that make up these communities, where all members are usually of similar backgrounds and life experiences. Gemeinschaft "implies interactions between humans who know each other

more or less and, above all, who care for each other" (Nilsson & Hendrikse, 2011, p. 346). In such communities, there is a limited division of labour because every member has to do the same work in order to earn a living: each person needs to be able to hunt, prepare food, grow crops, build shelters, make clothes, or attend a road accident, etc. Members of this style of community know everyone in their community and are known by everyone in return. The social interactions between members of these communities are more intimate and familiar. A person's own business becomes everyone's business. Social norms and values are shared and there is limited individualisation (Christenson, 1984).

Organic solidarity was refocused by Tönnies to the concept of Gesellschaft. This form of collectivity is more apparent in large technologically advanced societies. As described by Durkheim, for these societies, the division of labour becomes a necessity because no single person can hold every job available. Interdependency is essential for group survival. Moving on from this, Tönnies concentrated on the nature of the social ties under such social arrangements. In Gesellschaft communities, most people are strangers. "Gesellschaft concerns human interaction when the actors are unknown and anonymous to one another … and implies that the individual exhibits a calculative behaviour" (Nilsson & Hendrikse, 2011, p. 346). Each person has their own background and they have little in common with other people within the same community. Most individuals are not original members of the community from the start; they are usually people who migrated from smaller, more rural areas from differing backgrounds to larger urban areas. As a result, relationships and social interactions are formed by social rules or the immediate shared tasks, such as purchasing an item or arranging a business meeting, rather than by ties of kinship. This means that social interactions are less personal and more individuated. One's personal problem is their own problem, and nobody is interested in knowing about it (Giuffre, 2013).

Gemeinschaft and Gesellschaft are both governed by different types of social control. In Gemeinschaft, social control is maintained through informal means such as moral persuasion, gossip, and strong ties of kinship, friendship, and belonging to the group. These techniques work effectively because in these communities, people genuinely care about how others feel about them (Brint, 2001). This is where they belong, and there is limited sense of a world outside their community. However, in Gesellschaft, more formal techniques of social control are used: laws, sanctions, and incentives are among the

methods used to ensure stability. In this type of society, the informal community-based techniques are less successful because people are less concerned about how others feel about them given they are strangers, and there is little consensus concerning values or commitment to society.

One potential negative issue that arises in Gemeinschaft societies is that too much personal interaction comes at a cost. Privacy is almost non-existent as everybody knows about the private life of everybody else. On the other hand, in Gesellschaft cultures, individuals are less concerned about others who are not in any way involved in their lives. Another downside of Gemeinschaft is that prejudice and discrimination is more prevalent. People in these communities are more often labelled by ascribed status (race, religion, gender identity) rather than their unique skills, talents, and achievements. Gemeinschaft societies and cultures generally distrust those who desire to be creative or different. Finally, for Gemeinschaft, social change is relatively limited; for example, family members stay in the family trade rather than branching out on their own. They are more conservative and believe that traditions should be upheld (innovation in thinking is considered a transgression of the old ways). However, in Gesellschaft societies, people put more emphasis on achieved statuses, the task to be performed may be more important than the relationships between people, and privacy is valued as is self-interest and individualism (Adler, 2015; Christenson, 1984). Tönnies believed the evolution from community to society was a negative phenomenon, stating "[t]he substance of the common spirit has become so weak or the link connecting [a person] with the others worn so thin that it has to be excluded from consideration. In contrast to the family and cooperative relationship, this is true of all relations among separate individuals where there is no common understanding and no time-honoured custom or belief creates a common bond" (1887, pg. 65, as cited in Giuffre, 2013, p. 20). While this may be true, and individuals may mourn the loss of the close bonds that come with communities that are closer to the Gemeinschaft end of the continuum, modern society now values diversity and privacy, which are primarily Gesellschaft qualities. Table 3 below outlines the key characteristics of the two types of society.

The applicability of Tönnies' view of society, culture, and societal ties in this research is immediately apparent. When discussing the differences that location made on the culture of coping in paramedics, the most prominent factor was the number of colleagues each

paramedic regularly interacted with. The rural and remote locations with their reduced populations resonated with Gemeinschaft sensibilities, which was demonstrated in the other characteristics mentioned by the paramedics. For example, they spoke about the intimacy of the connections, the feeling of community, everyone knowing everyone, the informal social control, and less tolerance of deviance. Family references, overlapping skill sets, and ascribed identity rather than achieved (notwithstanding the educational journey to become a paramedic) were valued. In these small communities, population density had an impact on how well paramedics were acquainted with a patient or not. Conversely, the paramedic was well known by the people in the town and, as a result, their behaviour was also well monitored.

Table 3. Compiled list of characteristics of Gemeinschaft and Gesellschaft

GEMEINSCHAFT	GESELLSCHAFT
Rural areas	Urban areas
A feeling of community	No feeling of commonality
Intimate interactions	Impersonal interactions
Unity of will	Self-interest
Relationships and tasks are one	Tasks are more important
Little privacy	Plenty of privacy
Informal social control	Formal social control
Less deviance tolerance	More deviance tolerance
Ascribed statuses	Achieved statuses
Little social change	Plenty of social change
Substance	Surplus
Community	Society

As in Gemeinschaft communities, the rural and remote community comes together in a more cohesive manner when situations require more resources. For example, the rural paramedics worked in the hospital emergency department when required, and the local rural fire service may be trained by the paramedics in logistics, demonstrating the transferability of certain tasks between these two professions. The sharp division of labour that characterised urban emergency workers was not present in the rural sites. In urban areas, given the intensity of the population, this blurring of tasks and the division of labour does not occur.

The typology is also helpful in understanding the differences in attitudes between metro and rural teams. Metro teams are more like collections of people under the same supervisor rather than close-knit intimate friendship groups. Relationships are more formal, clinical, and goal-oriented. This has an impact on the culture of coping because a paramedic is less likely to disclose information about their personal perceived vulnerabilities to colleagues that they do not have complete trust in, or who they believe would not put their interests before their own in this situation. This is partly because these relationships may not be as strongly bound by ties of emotion and loyalty (Crampton, 2012).

The passage of time has also affected the culture of coping in its influence over the generations, the change in style of job, and societal expectations. This is very indicative of Gemeinschaft communities where values were congruent. The Baby Boomers grew up developing close relationships with their work colleagues or industry 'family'. They developed greater organisational loyalty and were rewarded for it. It also explains their protective nature towards their close colleagues (supporting solidarity within their paramedic group), and also why they prefer to seek advice and guidance from elders rather than to use a formal peer support program member, who may be a counsellor who is less experienced than themselves and has a slightly different set of values and beliefs. They may also distrust the confidentiality, given it is a managerial endorsed program. They still have a sense of community and connection, and they more often look to the good of all, rather than operating only on self-interest. The closeness of this generation may explain their inflexibility, as "dense social ties have been associated with conformity to the dominant morality in a society" (Brint, 2001, p. 4).

Generation X is very much in the middle of the Gemeinschaft/Gesellschaft continuum, tending to display characteristics that are at neither extreme. They are the first generation to really appreciate diversifying their skill set and not committing to one employer for life, but they have still developed close trusting relationships with work colleagues and appreciate the comfort of being on the inside of a group. Gen X members who put others first are less likely to focus on themselves and their own wellbeing. This affects their culture of coping, and certainly the strategies that they choose to employ, for they are less likely to take the time or effort to really concentrate on dealing with their own mental health challenges.

The values and interests of Generation Y, on the other hand, are much more aligned with Gesellschaft characteristics, where there is task orientation, tolerance of diversity, and a capacity to manage rapid change and to appreciate achieved status more than status ascribed according to position or time in the service. This is why Gen Y members are 'better' able to recognise their own needs and take the time to address them. They do not consider recognition of a 'less than ideal rebounding ability' as a character flaw, as previous generations may have attributed to it. Because of this, they are **not** reticent to address their issues, and work towards resolving or processing them so that they do not interfere with life and work.

Also with the passage of time, social expectations and tolerances have changed. But simple tasks have also altered. Thirty years ago, ambulance officers were able to sleep at the station when not required for jobs, and then get up in the morning and go to another job. They were required to remove deceased persons and pick up body parts after very traumatic event. This is no longer the case, as increasing specialisation within society means there is now a marked division of labour. For example, the coroner's department now has the resources/capability to field enough workers to fulfil this requirement so that paramedics no longer have this task. With the increased population, there is an associated increase in specialisation, evidenced by the number of paramedics moving into different more specialised roles. The interdependency is more apparent as the paramedics are able to gain advice from Intensive Care Paramedics and Extended Care Paramedics, with the mobile medical team also being available to provide greater assistance with complicated extractions and medical events.

Figure 4 below demonstrates the continuums that alter the culture of coping: Location moves between Rural and Urban, and Generation moves between Baby Boomers and Generation Y. Any movement in these directions parallels the characteristic shift between Tönnies' Gemeinschaft and Gesellschaft. This passage of time also demonstrates societal evolution and its effect on the acceptable usage of the coping strategy of "humour." The attitude to black humour reflects the shift from the intolerance of variation that is characteristic of Gemeinschaft to a greater acceptance of diversity within a society that aligns with the values of Gesellschaft. Depending on where an individual paramedic sits on this continuum, their culture of coping will be different.

Given the extreme differences in social interaction between the values and norms of Gemeinschaft and Gesellschaft, it is understandable to propose that a 'one-size-fits-all' style peer support program will not be suitable for all members. It is now important for managers to understand that these differences in the culture of coping exist, and that they need to take them into consideration. Paramedics in different locations and from different generations have different needs, based on cultural differences when it comes to support in relation to their mental health wellbeing. To provide a service that really supports their members, it must be flexible enough to cater for these differing needs.

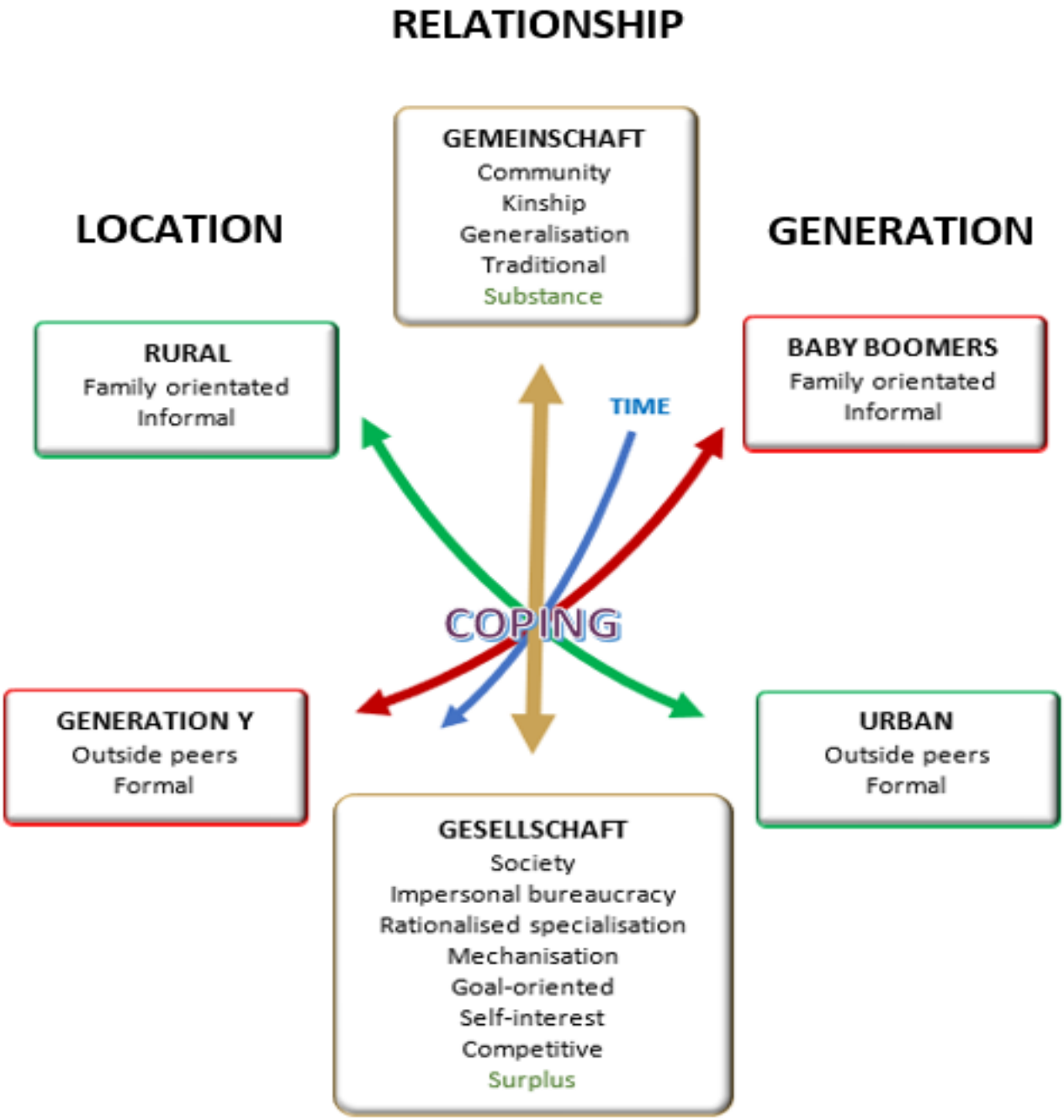


Figure 4: The four continuums that influence the paramedic culture of coping

Neither extreme of this continuum is superior to the other. To provide adequate support for the mental health wellbeing of paramedics, individuals, supervisors, and organisations need to accurately ascertain where the member is placed in the diagram above, to determine which supports and resources would be of most benefit. To appreciate the different levels and to use this knowledge to guide decisions on resource provision would be of benefit to

members, and also to the greater sphere of social life, as it is “the balance between the two modes of interaction [that] determines the degree of success of an individual or organisation” (Nilsson & Hendrikse, 2011, p. 347).

11.7.2 Tönnies: limitations and critique

Tönnies’ theory is a useful starting point because there are many concepts that resonate with the current study, but there are also aspects of 21st century culture that do not resonate with his typology. For example, some researchers believe that Tönnies’ theory was too simplistic, that his “highly connotative approach invited confusion about the defining coordinates of community, and it encouraged the tendency of subsequent writers either to romanticize or debunk community” (Brint, 2001, p. 3), which did not assist in developing systematically usable generalisations, and also did not account for certain outcomes and variations.

There are situations where the research results do not conform with Tönnies’ edicts. The current study is consistent with Tönnies’ predictions, as the different generations and locations have all described differences in their friend/family interactions and particularly in relation to their expectations of relationships with certain peers. However, on the contrary, in a study from several year ago, Fischer (1976) “found few differences between town and city dwellers in their rates of visiting family and friends, their number of friends, their feelings of connection to other people in their environment” (cited inBrint, 2001, p. 6).

An alternative perception of community is a model by Brint (2001), which provides another way of presenting the concept in the style of a Gemeinschaft/Gesellschaft within the workplace, as opposed to ideas around community groups. In Figure 5 below, his distinction between Gemeinschaft and Gesellschaft is divided between *activity-based* and *belief-based* forms of community. *Activity-based* communities refer to the workplace, whereas *belief-based* refer to religious, political, or philosophical groups an individual may belong to in civil society. Brint’s approach focuses more on the collective interests that gather people together, such as occupation, sport, or exercise (activity-based), and religion, philosophy, or literature (belief-based).

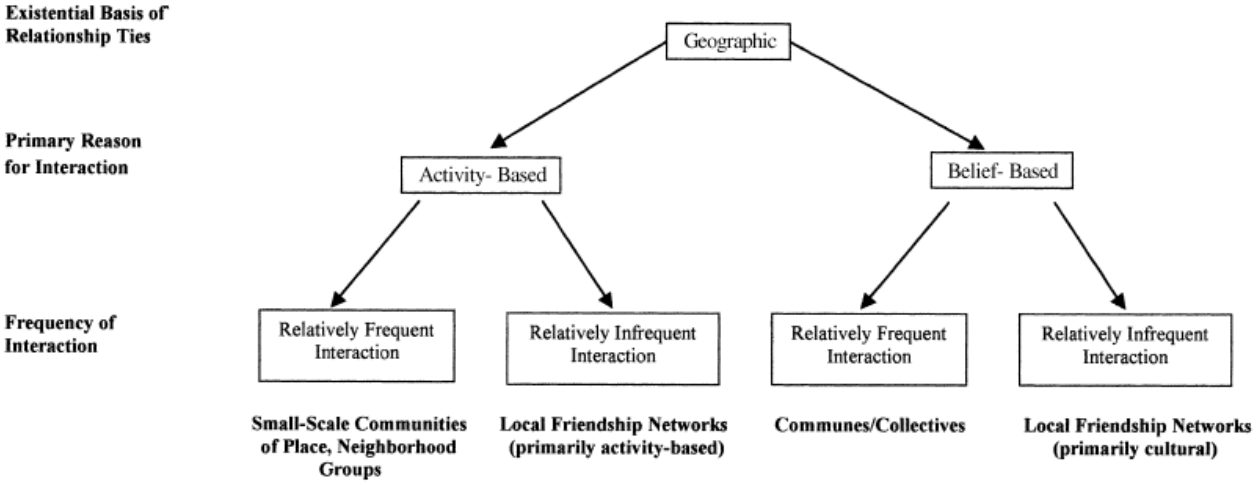


Figure 5: Community Types from Brint's Model (2001)

It is relatively straightforward to appreciate the activity-based interactions prevailing in an occupation such as paramedicine. However, the notion of political correctness is part of the belief-based branch of the Brint model, and is one of the aspects that is responsible for some dissonance encountered, as there is a tension in the model in terms of geography. In the rural and regional areas, it could be said that the culture of the older generation dominates. The older members drive or control the prevailing culture and determine what the most important values are. However, when looking at societal evolution, it is essential to appreciate how society has changed over the course of several decades. The increasing tolerance and protective attitude towards diversity that is prevalent in Australian society today is a specific characteristic of the younger generations, and is more of a belief-based aspect layered on top of the activity-based reason for interaction. With the managerial deference to society driven political correctness, the power to drive the culture has basically been presented to the younger generation. As the older generation tends to be more resistant to change, especially when it comes to altering a well-used and successful defusing strategy such as black humour, the younger generation then construct the older generation as deviant and exclude them from the community.

Finally, when everything is considered, on the continuum mentioned above, the paramedics have a sense of community (Gemeinschaft), but they are in an organisation that manages operations with strict Key Performance Indicators and that works to a rational, litigious

authoritarian style (Gesellschaft). An understanding by management of the difference in perspectives, values, interactions, and relationships of their members is paramount to providing mental health support that will be of the greatest benefit to assist in their wellbeing.

One last point is that these concepts used above are essentially *ideal types* as conceived by Weber. The motivation for their use is predominantly heuristic as "it helps the social scientist to get a better handle on empirical reality, and this is done primarily through a comparison of reality with the ideal type" (Swedberg, 2018, p. 184). The limitations in using ideal types is that they can never truly reflect reality, and that "it is imperative not to confuse the concepts that are used in the analysis with the reality that is being analysed" (Swedberg, 2018).

11.8 Recommendations

This thesis has highlighted the extent of the variation within the culture of coping of paramedics. Recommendations should ideally be grounded in the fact that there needs to be increased flexibility in support delivery depending on the individual needs of each member concerned and the culture of the location or the generation.

It would be valuable for peers to understand the requirements necessary to develop trust/intimacy in a working support relationship to assist paramedics in their role of helping others. Research has demonstrated that talking about stressful situations with social supports (as opposed to chronic avoidance) is beneficial to recovery from trauma (Regehr & Goldberg, 2002; Riolli & Savicki, 2010; Schwartz & Kline, 1995). Extra training is required for counsellors and peers to understand the complex nature of trauma exposure and to develop skills to elicit a trusting regenerative disclosure. Allowances can be made where possible, and response strategies can be targeted towards the culture that the individual most aligns themselves with. Knowledge will make the application of support more beneficial for the individual in need.

The Senate Education and Employment References Committee (2018) and Lawn et al. (2019) have made a range of recommendations. Those pertinent to the current research include funding ambulance services appropriately so that past and present members and families

can source external resources to address their mental health wellbeing needs, and ensure that counsellors are more adequately trained to deal with the specific types of issues that they will be presented with. These recommendations (funding, reduction of treatment barriers, and increased training) are in line with the current findings, without having a cultural aspect. If viewed through the cultural lens, they would equate to, above all, recognising the differing needs of the different cultural cohorts. This would lead to an increase in training dedicated to understanding the cultural aspects of coping, and therefore, the differences in utilisation of strategies for the different cultural cohorts. This training should include counsellors, managers, and paramedics alike.

The current thesis took a narrower focus than the Senate Inquiry, asking the paramedics about the specific culture of coping and what supported or influenced it and what did not, leading to the following set of recommendations:

Culture includes norms, beliefs, values, and expectations; in this case, those that involve coping. Managers need to know the culture and identify whether it needs to be changed or not, or modified in any particular way. The organisation also needs to understand the culture and know whether it promotes mental health practices and behaviours, or whether it works against it. The findings of this thesis suggest that it is necessary to comprehend that cultural mores and norms transform as one moves from country to city and through the age ranges from old to middle to young employees, and therefore, the responses of the organisation to different geographical or age cohorts will need to differ. One size does not fit all given this variability. Knowing the cultural differences based on geography, age, and the shifting norms would be useful for organisational leaders. This knowledge would enable them to frame supportive programmes and to encourage supportive norms and beliefs according to geography and age. There is clearly a recommendation around managerial support for nurturing positive aspects of the culture that protect paramedics from mental illness. For example, members who are closer to the Gemeinschaft end of the continuum (those from the older generations and more remote locations) are less likely to actively seek peer support through formal channels within the organisation, because they are not entirely comfortable with someone who is not familiar with their working conditions. They require time to seek informal social support from close, very well-known and trusted workmates, as well as giving them the financial support to seek outside professional help.

It is imperative for the organisational leaders to recognise that paramedics work within teams with a strong sense of community based on place, age, and/or values, while management is required to meet bureaucratic/rational/legal requirements linked to funding. Managers may be driven by key performance measures that focus on productivity/efficiency. Achieving these targets requires a set of practices. Managers need to realise that there can be a clash of cultures between their aspirations and that of paramedics working on ambulances. These cultural differences can be understood in terms of community and society (Gemeinschaft and Gesellschaft).

There is a need for strong, understanding team leadership, with extended training for team leaders, because location makes a difference in the culture of coping. Team leaders need to be aware of the cultural differences according to location, and be provided with the skills to meet the particular needs and qualities required, depending on place or age, or both. The training should be global, but emphasis should be made on the need to respond by working with the prevailing cultural norms, rather than expecting standardised approaches or responses. The organisation may introduce universal strategies throughout the whole service, but it needs to be aware that responses to change will vary depending on where individuals are placed.

Communication with education providers can enhance the development of a positive culture of coping in paramedical courses, with attention paid to instruction that includes the six factors, perspectives, or thought processes that current paramedics believe all new recruits should be endowed with to ensure their mental health preservation (self-awareness, non-avoidant communication, priorities, responsibility, motivation, and confidence).

The organisation would find it beneficial to become aware of the changing societal norms and to identify what they expect the appropriate responses to stress are within the current climate. There needs to be clarity in what constitutes bullying and harassment, and what is not *universally* insensitive. There needs to be some guidance in redirecting a seasoned coping strategy such as humour away from a socially unacceptable path and aim it in a more appropriate direction, rather than merely requesting its elimination without substitution. The organisation would need to be precise in identifying political correctness parameters

and be able to articulate this for paramedics, working with them to increase understanding and behaviour adjustment over time. Black humour does not necessarily need to be derogatory; there can be mildly insensitive, and perhaps distasteful, humour that will make light of a situation, without it being derogatory to a particular minority group. The regular educational in-services that are conducted throughout the organisation need to acknowledge the cultural differences and articulate these differences by making them overt.

It can be useful for an organisation that seeks collaboration to recognise and name the cultural differences within it; to highlight those they see as positive and to draw attention to, and discourage, those they see as negative, but also to realise that they are in a constant state of transition. All of these recommendations are areas identified for further research to assist in the mental health wellbeing of paramedics now and into the future.

11.9 Summary

This chapter has demonstrated that the perceptions of the current cohort of paramedics are not unlike those found in other studies (Avraham et al., 2014; Gayton & Lovell, 2012; Holmes, 2018; Regehr & Goldberg, 2002). Stressors come in the form of critical incidences. This includes traumatic stressors, dealing with paediatric trauma, or organisational responses, specifically managerial responses as well as the cumulative impact of events. All these processes influence paramedics' mental health. The chapter also examined the paramedic viewpoint regarding the formal peer support program, it's utilisation, and the factors that influenced their opinion of its benefits, thus affecting the general culture of coping. A summary of how the paramedics believe they need to think in order to protect their mental health wellbeing was also presented.

The three findings chapters that discussed the factors that influence the culture of coping (location, generation, and societal evolution) were explored in relation to the current literature, including an interpretation of the effects of political correctness on the use of humour as a coping strategy. Finally, the social theory used to explain these findings was Tönnies' Gemeinschaft/Gesellschaft typology based on the strength and type of social ties between members.

To conclude, it is important to explicitly state that there is no single unified culture of coping in paramedics. The culture varies according to the predominant values of the prevailing generation which is, in part, determined by the location of practice. In remote locations, the older generations tend to drive the culture, with a familial approach to support and the appreciation of informal methods of social control. However, with the advent of political correctness restrictions, management endorsement now strongly aligns with the beliefs and values of the more tolerant, diverse, and inclusive Generation Y. Because of this, the younger generation are now driving the culture, which is particularly noticeable in the metropolitan stations where there is a larger population of younger recruits. Suddenly, more formal methods of social control are more heavily relied upon.

As the different generational values are so divergent, their approaches to dealing with mental health issues are also dissimilar. The Baby Boomers are more likely to avoid talking about emotional stressors unless they are with a close colleague with whom they have a friend/family style relationship. They are not as likely to use organisationally provided peer support as a coping strategy, because often, the support officer will be younger than them, and it appears that such a conversation is acceptable with an equal or a superior, but not with a junior. On the other hand, Generation Y are far more aware of themselves and their triggers, and will not only recognise more quickly that they are not coping as they feel they should, but they will address the situation, taking time off to meditate, diarise, exercise, or engage in outside activities to re-achieve a balance.

Because of these considerable differences, a ‘one-size-fits-all’ style peer support program will not be suitable for all members. It is now increasingly important for managers to understand that these differences in the culture of coping exist for the different locations and generations, and that they need to take them into consideration when providing support.

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Appendices

APPENDIX 1: Ethics Approval

FINAL APPROVAL NOTICE

Project No.:	**6845**
Project Title:	The culture of coping in an urban based ambulance service: a case study in managing the risks of mental health related trauma
Principal Researcher:	Ms. Elizabeth Goble
Email:	elizabeth.goble@flinders.edu.au
Approval Date:	1 June 2015
Ethics Approval Expiry Date:	**31 July 2019**

The above proposed project has been **approved** on the basis of the information contained in the application, its attachments and the information subsequently provided.

RESPONSIBILITIES OF RESEARCHERS AND SUPERVISORS

1. **Participant Documentation**
   Please note that it is the responsibility of researchers and supervisors, in the case of student projects, to ensure that:

   - all participant documents are checked for spelling, grammatical, numbering and formatting errors. The Committee does not accept any responsibility for the above mentioned errors.
   - the Flinders University logo is included on all participant documentation (e.g., letters of Introduction, information Sheets, consent forms, debriefing information and questionnaires – with the exception of purchased research tools) and the current Flinders University letterhead is included in the header of all letters of introduction. The Flinders University international logo/letterhead should be used and documentation should contain international dialling codes for all telephone and fax numbers listed for all research to be conducted overseas.
   - the SBREC contact details, listed below, are included in the footer of all letters of introduction and information sheets.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 'INSERT PROJECT No. here following approval'). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au.

2. Annual Progress / Final Reports

In order to comply with the monitoring requirements of the *National Statement on Ethical Conduct in Human Research (March 2007)* an annual progress report must be submitted each year on the **1 June** (approval anniversary date) for the duration of the ethics approval using the report template available from the Managing Your Ethics Approval SBREC web page. *Please retain this notice for reference when completing annual progress or final reports.*

If the project is completed *before* ethics approval has expired please ensure a final report is submitted immediately. If ethics approval for your project expires please submit either (1) a final report; or (2) an extension of time request and an annual report.

Student Projects

The SBREC recommends that current ethics approval is maintained until a student's thesis has been submitted, reviewed and approved. This is to protect the student in the event that reviewers recommend some changes that may include the collection of additional participant data.

Your first report is due on **1 June 2016** or on completion of the project, whichever is the earliest.

Modifications to Project

Modifications to the project must not proceed until approval has been obtained from the Ethics Committee. Such proposed changes / modifications include:

- change of project title;
- change to research team (e.g., additions, removals, principal researcher or supervisor change);
- changes to research objectives;
- changes to research protocol;
- changes to participant recruitment methods;
- changes / additions to source(s) of participants;
- changes of procedures used to seek informed consent;
- changes to reimbursements provided to participants;
- changes / additions to information and/or documentation to be provided to potential participants;
- changes to research tools (e.g., questionnaire, interview questions, focus group questions);
- extensions of time.

To notify the Committee of any proposed modifications to the project please complete and submit the *Modification Request Form* which is available from the Managing Your Ethics Approval SBREC web page. Download the form from the website every time a new modification request is submitted to ensure that the most recent form is used. Please note that extension of time requests should be submitted prior to the Ethics Approval Expiry Date listed on this notice.

Change of Contact Details

Please ensure that you notify the Committee if either your mailing or email address changes to ensure that correspondence relating to this project can be sent to you. A modification request is not required to change your contact details.

3. Adverse Events and/or Complaints

Researchers should advise the Executive Officer of the Ethics Committee on 08 8201-3116 or human.researchethics@flinders.edu.au immediately if:

- any complaints regarding the research are received;
- a serious or unexpected adverse event occurs that effects participants;
- an unforseen event occurs that may affect the ethical acceptability of the project.

Kind regards

Andrea

Mrs Andrea Fiegert and Ms Rae Tyler
Ethics Officers and Executive Officer, Social and Behavioural Research Ethics Committee
Andrea - Telephone: +61 8 8201-3116 | Monday, Tuesday and Wednesday
Rae – Telephone: +61 8 8201-7938 | ½ day Wednesday, Thursday and Friday

Email: human.researchethics@flinders.edu.au
Web: Social and Behavioural Research Ethics Committee (SBREC)

Manager, Research Ethics and Integrity – Dr Peter Wigley
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Research Services Office |Union Building Basement
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Sturt Road, Bedford Park | South Australia | 5042
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APPENDIX 2: Interview Durations and Participant Demographics

Table 4: Interview Durations and Participant Demographics

Interview	Total recording time (Hr:Min:Sec)	Gender	Generation	Location
1	2:20:34	Male	Gen X	Remote
2	1:05:55	Male	BB	Remote
3	0:16:04	Female	Gen X	Remote
4	0:41:30	Male	BB	Remote
5	0:59:10	Male	Gen X	Remote
6	1:13:32	Female	Gen Y	Remote
7	0:39:30	Male	BB	Country town
8	1:16:32	Male	BB	Country town
9	0:14:53	Male	BB	Country town
10	1:01:15	Female	Gen X	Country town
11	0:44:14	Male	Gen Y	Country town
12	0:41:34	Male	BB	Country town
13	0:50:57	Male	BB	Country town
14	1:46:14	Female	Gen X	Metro
15	1:10:04	Female	Gen X	Metro
16	1:21:41	Male	Gen X	Metro
17	0:34:37	Male	Gen Y	Metro
18	0:49:41	Male	Gen X	Metro
19	0:56:40	Female	Gen Y	Metro
20	1:03:36	Male	Gen Y	Metro
21	1:16:28	Male	BB	Metro
22	1:13:13	Female	Gen Y	Metro
23	1:00:28	Female	Gen X	Metro

APPENDIX 3: Informed Consent Form

CONSENT FORM FOR PARTICIPATION IN RESEARCH

I ……

being over the age of 18 years hereby consent to participate as requested in the

Participant Information Sheet for the research project on:

The culture of coping in an ambulance service:
a case study in managing the risks of mental health related trauma.

1. I have read the information provided.

2. Details of procedures and any risks have been explained to my satisfaction, including the nature of my participation, privacy and confidentiality matters and the anticipation of length of time of my participation.

3. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.

4. I understand that:

   - I will participate in an in-depth interview of approximately 60 minutes duration, which will be organised in consultation with the researcher.
   - Interviews will be audio recorded with my knowledge and consent.
   - I may ask that the recording be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.
   - If I become distressed during an interview, the interview will be terminated immediately and I will be given information and contact details for my organisation's and an independent counselling service.
   - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
   - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential. However, even though information provided will be treated in the strictest confidence by the researcher, participant anonymity cannot be guaranteed given the small population pool and closed community from which participants will be drawn.

- I may not directly benefit from taking part in this research.
- I would like to see a summary of the project outcomes. ……. Yes / No

5. I have had the opportunity to discuss taking part in this research with a family member or friend.

Participant's signature……Date……...

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name…….....

Researcher's signature……..Date……

NB: Two signed copies should be obtained.