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Exploring the nature of resilience in paramedic practice: A psycho-social study

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ABSTRACT

Previous research has identified that paramedics experience high levels of stress and sickness rates which have escalated in recent years due to changes to workforce restructuring. While a number of studies have investigated resilience among healthcare professionals, there is little research exploring how paramedics address work challenges and how they become resilient. Using psycho-social methodology, seven paramedics participated in Free Association Narrative interviewing; all were based at one regional centre. In line with the study design, data analysis adopted a psycho-social approach that generated four themes and 10 sub-themes which, characterised participants' experiences. Coping and resilience was impacted upon via formal methods of support including management, debriefing and referral to outside agencies. Alongside this, more informal methods aided resilience. Informal methods included peer support, support from family and friends and the use of humour. Uniquely, this study uncovered how detachment is used to manage emotions. The study has implications for the services need to support the emotional needs of paramedics.

1. Introduction

The subject of staff resilience in the workplace is an area of growing interest among healthcare professions (Hunter and Warren, 2013; Maunder et al., 2012; McAllister and McKinnon, 2009; Scholes, 2013). However, there is little research on this topic within the paramedic profession.

The nature of modern paramedic practice is demanding and challenging, and often decision making is under public gaze (Sterud et al., 2006). Paramedic crews are regularly exposed to a variety of clinical incidents, which may include fatalities or unsuccessful resuscitation outcomes, and they may even be victims of physical assault and verbal threats (Regehr et al., 2002). All these events can have an adverse impact on the physical and mental well-being of paramedics (Okeefe and Mason, 2010; Sterud et al., 2006). Additionally, in response to a number of government policies (DOH, 2001, 2004, 2005), as in other areas, there has been a profound transformation in the delivery services, leading to increased staff pressures to achieve targets. For example, in the United Kingdom there is a national agreed standard for Category A (life-threatening) urgent calls which requires emergency response vehicles to arrive on the scene within eight minutes in 75 per cent of cases (HSCIC, 2014). Changes to skill mix levels, revised shift patterns and lone working, together with a growing administrative workload, can cumulatively impact on staff performance and ability to cope. This paper reports on the experiences of paramedics from one centre and the coping strategies they adopted, often developed during formative years, to adjust to the demands of their role and emotional scenes encountered in their practice.

2. Background

The concept of resilience within the health sector has drawn from child development literature and tended to focus on causative mechanisms of risk and protective factors for workers (McAllister, 2007; Robinson and Sirard, 2005). However, the notion of resilience being an individual trait has been superseded by the work of Luthar et al. (2000), who conceived it as a dynamic process in which internal (psychological) and external (social e.g. gender, ethnicity, socioeconomic status) factors interact in different ways over time. It is further suggested that an individual's strengths and

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vulnerabilities emerge during the life course in response to changing circumstances, situations and experiences. Individuals are able to draw upon a range of resources which assist in dealing with negative experiences and situations and enable them to 'bounce back' from adversity (McMurray et al., 2008). "Resilience is the interaction between the internal properties of the individual and the set of external conditions that allow individual adaptation or resistance to different forms of adversity at different points in the life course" (Ward et al., 2010, p. 10). Resilience is therefore not viewed as an inborn trait, or as a stable or static individual characteristic. Rather, resilience can be developed or eroded unpredictably and can be viewed as a set of tools and strategies that a person builds up through facing difficulties (Hunter and Warren, 2013), and which may be useful for future situations (Ward et al., 2010).

The subject of resilience has attracted interest within the healthcare professions due to recognition that burnout and stress among health workers can result in poor retention of staff and high sickness rates, or practising with a 'deadened conscience' which leads to 'depleted caring' (Scovholt, 2001). Within paramedic practice, continued exposure to death and trauma can precipitate psychological problems such as post-traumatic stress symptoms and depression among healthcare staff (Bryant and Harvey, 1996; Marmar et al., 1998; Regehr, 2005; Regehr and Millar, 2007). The net effect of this can impact on financial, social and family life (Regehr, 2005) including personal motivation and commitment to work (Jenner, 2007).

More recently, the organisational context to achieve nationally set performance targets has further increased the work pressure of front line healthcare workers including paramedics (Adomat and Killingworth, 1994). For example, changes to skill mix and roles have led to the introduction of emergency care assistants, single manned rapid response vehicles (RRVs) and the use of 'standby points', all of which have eroded informal team support and opportunities for immediate feedback and debriefing from peers (DOH, 2011).

Recent research by Maunder et al. (2012) suggests that the rate of clinically relevant symptoms in paramedics (high burnout, depressive symptoms and multiple physical symptoms) is approximately 60% higher in those who report previous child abuse or neglect. Childhood abuse may be more common in paramedics than in other healthcare workers, at least in women. Childhood abuse and neglect is associated with acute stress responses to critical incidents. Despite the non-generalisability of Maunder et al. (2012) study, due to its low response rate, it raises important questions regarding how resilience is influenced via biography and how work can influence vulnerability, particularly for staff with unresolved aspects of their life history. Work can become a vehicle for staff to manifest related defences arising from their biographies. In addition, the hegemonic masculine culture within paramedic practice may inhibit the expression of emotions (Boyle, 2005; Steen et al., 1997), which in the long-term can be detrimental. The predominance of a 'male coping culture' has prompted a call to challenge and change the cultural attitudes towards emotional work and expression within paramedic practice (Steen et al., 1997).

Within the field of paramedic practice, there has been little research examining what challenges individuals experience and how they learn to become resilient. This aspect merits investigation and how paramedics respond to work related pressures needs to be better understood (McAllister and McKinnon, 2009). The organisation Mind (2014) conducted a survey which indicated that people working within the emergency services are at much greater risk of developing stress or poor mental health. Additionally, 43% of emergency services personnel had taken time off work to deal with mental health issues. In the absence of a specific body of literature relating to resilience within paramedics, the aim of this study was to explore the question of how paramedics 'survive' their work within the current healthcare climate.

3. Methodology

Free Association Narrative Interviewing (FANI) has emerged as the key approach for generating data within psychosocial studies (Hollway and Jefferson, 2013). FANI was adopted in this study as it provided an alternative lens to explore how paramedics become resilient within their practice. Specifically, FANI employs biographical narrative interviews as a first phase, which is followed by a semi-structured interview (Hollway and Jefferson, 2013). During biographical narrative interviews, participants are encouraged to 'tell their story' in the order that is important to them allowing aspects of their unconscious mind to emerge in their narratives. The uniqueness here is that participants' narratives unfold without interference. This approach can in turn reveal much of an individual's biography and how early experiences can shape future life choices, decisions and occupation. To develop a more comprehensive understanding on the phenomenon of inquiry, a second stage of face-to-face semi-structured interviews guided by data from biographical narrative interviews is undertaken (Hollway and Jefferson, 2013). Hollway and Jefferson (2013) claim that the method is 'psychodynamically informed' and psycho social researchers seek to explore the kinds of defences of ordinary life, traces of which can be found in all human interactions and practices and are not exclusive to therapy. The expression of repressed material, (although a bonus), was not the central aim of free association narrative interviewing. The aim of these interviews is that they can be containing enough to enable the participants to relax their defences and open up to their previously guarded experiences.

4. Sample

An advert, with a brief study outline, was placed in a regional Paramedic bulletin which was circulated electronically to staff with an invitation to participate. Inclusion criteria were as follows:

- Paramedics or emergency care practitioners employed at the study centre
- Grade of paramedic, technician or emergency care practitioner
- Willing to volunteer their time

Interested volunteers contacted the lead author via email (SC), who then replied with an information sheet and a consent form. Those who returned the completed consent form were subsequently contacted and a suitable venue and date for data collection was arranged. Ten individuals initially responded, however three became unavailable. In total, seven participants were recruited from a regional urban and rural paramedic centre in England, of these five were female. All were White British and aged 30–50 years with two having the qualification of emergency care practitioner. Initially, a sample size of 10 participants was deemed sufficient to address the research question and potentially achieve data saturation. However, despite many attempts to recruit participants, only seven individuals volunteered. In common with qualitative research inquiries, psycho-social research relies on participants engaging in long and intensive interviews to generate quality data that inform the aims of a study, moreover, it became evident after the sixth interview data saturation was reached.

4.1. Data collection

For the biographical narrative interviews, participants were invited to "tell the story of their life." This was supported by the use of open questions, enabling them to order the flow of their story