It’s Not in The Job Description: Post-Traumatic Stress Disorder as an Occupational Illness Among Paramedics

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Abstract

Given that the rates of post-traumatic stress disorder (PTSD) are increasing in today's society, it is important to gain a better understanding of how organizational factors shape the work experiences of those who have suffered or suffer from PTSD. Paramedics constantly face hazardous situations on the job and thus it is reasonable to argue that many of these situations may have lasting negative impacts on their mental health such as depression, anxiety, and alienation.

The purpose of my research is to explore the understanding and experiences of workers in these professions who have experienced PTSD either directly or indirectly. I hypothesize that the supports that emergency first responders receive for PTSD are largely based on organizational factors that shape these professions. For example, the inherent masculine culture associated with this line of work, and the emotional and physical labour that is associated with the job. In exploring the aspects of support received by paramedics, a deeper understanding of why the workers in these professions are not talking about PTSD, seeking or offering support will be gained. It will be shown that the support paramedics receive, whether it be through family, friends, doctors, and/or co-workers, determines how PTSD is addressed and viewed within these professions. It is hoped that through this research PTSD within emergency first response professions will be better understood as an occupational illness.

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Dedication

I would like to dedicate this project to my father Enzo Pucci, and my uncles Matt Small and Fred Kempf. Their work and experiences in policing have inspired me to take on this important but difficult research.

I would also like to extend this dedication to the men and women working in Emergency First Response Professions across Ontario, specifically Halton Region Emergency Medical Services. Your service does not go unrecognized. Thank you for sharing your stories and experiences with me.

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Chapter 1

Introduction

Recently, there has been a decided increase in the amount of media coverage of Post-Traumatic Stress Disorder (PTSD) among emergency first responders due to an alarming increase of suicides and diagnoses of this disorder among these professionals. This media coverage can also be attributed to the April 2016 passage of the *Supporting Ontario's First Responders Act* (Bill 163), which amended the 1997 *Workplace Safety Insurance Act* and the *Ministry of Labour Act* to include PTSD as an occupational illness. It is said that this amendment will protect over 73,000 first responders in Ontario (Ministry of Labour, 2016).

While Bill 163 is an important gain for those within the emergency first response professions included in the amending legislation, many question whether it will effectively aid those who are suffering with PTSD. For, while this Bill claims it will allow for "faster access to WSIB benefits, resources and timely treatment" (Queens Printer for Ontario, 2016), the paramedics who participated in the study upon which this paper is based fear the process that may come with it. That is, the participants in my study made it clear that they believe there is no one-size-fits-all solution to PTSD and questioned the resources and treatments that would be made available to them through Bill 163. Additionally, it is feared by those within these professions that this Bill has created a deeper stigmatization of what it means to suffer from PTSD and who is "allowed" to suffer from PTSD.

The purpose of my study was to explore the understandings and experiences of paramedics who have experienced PTSD either directly or indirectly, i.e., they either

suffered from PTSD themselves or observed and/or knew of others in their job who suffered from PTSD. To this end, I conducted twelve semi-structured interviews with paramedics, six of whom were female and six male. Each of these participants worked as paramedics for Halton Region Paramedic Services. As I will outline more fully in my methodology section, the range of service among the twelve participants went from one to over 25 years. They possessed, then, individually and collectively, a rich knowledge of both the rewards and the physical and emotional perils of this very demanding type of work.

Indeed, the interviews revealed a complex and troubling situation. While a few of the workers were unconcerned about the incidence of PTSD, even suggesting that it was an illness being conjured up by certain workers so that they could go on sick leave, the more general response was that PTSD was a real and quite debilitating illness that for a host of reasons was difficult to talk openly about. One of those reasons was the masculine culture that permeates this occupation, meaning, in this context, that workers should expect difficult emotional situations and they should be men and just "suck it up." Another reason related to the ambiguity of the illness; that is, what symptoms constituted PTSD and how many of these symptoms had to be present before one actually had PTSD?

In terms of the experiences with PTSD, the interviews revealed that the level and nature of support was key to how workers with PTSD understood and dealt with their illness. In short, and perhaps not surprisingly, the more support these workers had from co-workers, family, friends, doctors, and their employers, the more they were ready to acknowledge their illness and seek professional help. As I will outline in more detail

below, there was a support hierarchy in the sense that some forms of support were more important to these workers than others, with co-worker support being the most important and employer and medical support being sought only as last resorts.

In exploring PTSD among paramedics, this study thus sought a deeper understanding of their experiences with this illness and, in particular, the sources of support that they could go to and count upon. The study was guided by the hope that it would contribute to PTSD being understood as an occupational illness and thereby lead to more open discussion and more accessible treatment.

Chapter 2

Literature Review

Introduction

This chapter outlines and analyzes studies relevant to both PTSD and emergency first responders. The literature examined for the purpose of this study includes historical, sociological, and medical research. This review demonstrates that PTSD must be examined from many angles in order to understand the disorder in its entirety. Examining the historical, sociological, and medical research on PTSD not only allows us to problematize PTSD as an issue that encompasses many facets of the organization of workplaces, it also allows us to gain a deeper understanding of PTSD as an occupational illness. It is important to note that while there are a wide variety of sources available regarding PTSD, there is a gap in the literature in terms of who is considered a sufferer of this disorder. For example, until recently, women and anyone who was not a veteran of war were not considered to be exposed to PTSD. Only in the last few decades have emergency first responders been studied in relation to PTSD and, more recently, a focus has been put on survivors of sexual abuse and their experiences with trauma. It is evident that the literature explores areas where trauma seems inherent. However, through analyzing each piece of literature within this paper it becomes clear that PTSD needs to be viewed via multiples lenses.

The History of PTSD

According to Monson, Friedman and La Bash (2007), the application of psychological theory and research to psychological trauma or PTSD has a short history,

emerging in the DSM-III in 1980. While it is not doubted that PTSD existed long before psychological studies of it emerged, it is often attributed to arising from the American War in Vietnam.

While much of the literature points to the American War in Vietnam as the start of PTSD, many studies link stress-related disorders to both World Wars (Andreasen, 2010). In fact, the first glimpse into the mental implications of war arose from the concept of "shell-shock" during World War I. This era sparked discussions surrounding stress-related disorders not only for soldiers of war but also for civilians due to the political landscape and living situations in which individuals found themselves during this time period (Andreasen, 2010; Andreasen, 2011). A major theme found in the studies of stress in soldiers and civilians during this time period was that stress was often the outcome of extreme and unusual traumatic incidents. While scholars and psychiatrists were slowly beginning to understand the roots of stress-related disorders, there was no clear conceptual framework to define this phenomena (Scott 1990; Summerfield, 2001; Andreasen, 2010).

While World War I encouraged psychiatrists to make sense of stress and stress-related disorders in general, World War II shifted the focus to who suffered from stress-related disorders and why. The men of war became the central and dominating focus of stress and stress-related disorders during this time as propaganda conveyed the message that nothing was as traumatic or "stressful" as serving on the frontlines (Andreasen, 2010).

Although efforts were made to explore and understand stress-related disorders, specifically PTSD, it became clear during World War II that standardization was needed

in order to fully understand and diagnose these disorders. The first diagnostic manual was created by the US government's Veterans' Administration[1]. This publication encouraged the American Psychiatric Association (APA) to follow suit and develop a manual of their own. The DSM-1 appeared in 1952 and included a category titled "gross stress reaction" (Andreasen, 2010). The gross stress reaction category was outlined as follows:

> Under conditions of great or unusual stress, a normal personality may utilize established patterns of reaction to deal with overwhelming fear. The patterns of such reactions differ from those of neurosis or psychosis chiefly with respect to clinical history, reversibility of reaction, and its transient character. When promptly and adequately treated, the condition may clear rapidly. It is also possible that the condition may progress to one of the neurotic reactions. If the reaction persists, this term is to be regarded as a temporary diagnosis to be used only until a more definitive diagnosis is established.
>
> This diagnosis is justified only in situations in which the individual has been exposed to severe physical demands or extreme emotional stress, such as in combat or in civilian catastrophe (fire, earthquake, explosion, etc.). In many instances this diagnosis applies to previously more or less "normal" persons who have experienced intolerable stress. The particular stress involved will be specified as (1) combat or (2) civilian catastrophe. (Diagnostic and Statistical Manual, 1952, p. 40)

Although this category is vague in many regards, for example the lack of a definition of "normal" persons and the limit to what is considered a severe or extreme emotional stress, this manual was the first to look at the stressor, the stressed and the symptoms of the disorder. In doing these three things, it proved that there were many blurred lines in diagnosing someone suffering with a severe stress disorder.

With respect to focusing on the stressor, questions arose surrounding the severity of the type of stressor and how to compare certain stressors over others. For example,

[1] This organization changed its name in 1988 to the US Department of Veteran's Affairs

could one compare being in a death camp with being in a natural disaster? In addition, if there are a wide variety of stressors causing stress-related disorders, would they all need different methods of diagnoses (Andreasen, 2010, p.69-70)? In evaluating the stressed, it was argued that only individuals who were seen as "normal" prior to the stress they were experiencing should be given treatment. Those deemed normal were those who had not experienced any other mental health issues, traumatic events, and/or lived under "non-average" circumstances. Those already suffering from other mental illnesses would not be eligible for any treatment (Andreasen, 2010, p.69). Lastly, the manual brought to the surface the evaluation of symptoms and how they should be described, how soon they should be experienced, and, most importantly, how long they should last (Andreasen, 2010). While the DSM-I gave some clarification and understanding of stress-related disorders, it did little to provide a clear and official diagnosis of these disorders, including PTSD, and caused many to question not only how to provide evidence of these disorders but also, critically, how to determine the validity of the evidence (Andreasen, 2010, p.70).

According to Mayes and Horwitz (2005, p.250), "The DSM-I published in 1952 and DSM-II published in 1968, made little effort to provide elaborate classification schemes, because overt symptoms did not reveal disease entities but disguised underlying conflicts that could not be expressed directly". For example, some individuals suffering from PTSD showed no symptoms or were able to mask them well. Additionally, sufferers of PTSD were unable to explain their symptoms, thoughts or feelings; in some cases, their symptoms could easily be confused with other issues or they were not experiencing an ongoing PTSD episode. Thus, little change was brought to the understanding of stress-

related disorders and the gross stress reaction category found in the DSM-I. It was not until the DSM-III in 1980 that PTSD appeared and was recognized as its own individual mental disorder. Scott (1990) describes the appearance of PTSD in the DSM-III as similar to the disappearance of homosexuality from the DSM-II: the result of a struggle for recognition and validity. Just as those in the lesbian gay bisexual transgender (LGBT) community fought to have their sexual orientations accepted and not labelled as disorders in the DSM, those suffering from PTSD fought to have their suffering and experiences accepted by the medical professions and supported by the general public. Scott (1990) goes on to state that making the relation between the struggles of the LGBT community and of those suffering from PTSD is important for two reasons. First, it explores the notion surrounding the normal experiences and responses to warfare. For example, it became almost second nature to describe PTSD as a normal reaction to trauma stemming from the war. In normalizing this reaction to trauma, the DSM suggested that it was something that could be overcome in time. However, the "normal" length of suffering remained unclear. Second, the introduction of PTSD to the DSM-III created an important sociological case to explore and illustrate the politics of diagnosis and disease (Scott, 1990).

Since 1980, the DSM definition of PTSD has undergone three changes: first in 1987 in the DSM-III-R, second in 1994 in the DSM-IV, and lastly in 2000 in the DSM-IV-TR. Perhaps the most important takeaway from each of these revisions is that the manual gradually made it very clear that PTSD was far more common than psychiatrists and scholars had thought it to be upon its first appearance in the DSM-III (National Center for PTSD, 2016). The most recent revision of the DSM, the DSM-5, produced in

2013, has outlined several conceptual and clinical conclusions about the disorder that had not been outlined in the previous manuals (National Center for PTSD, 2016; Spitzer, First, and Wakefield, 2007). Of these conclusions, it is important to note that PTSD is no longer viewed as a disorder that is solely associated with anxiety. Instead, a new category in the DSM-5 titled "Trauma and Stress-Related Disorders" suggests that anxiety is not a specific criterion to determine whether someone is suffering from PTSD. In this most recent edition, the authors suggest that focus should be placed on "exposure to a traumatic or otherwise adverse environmental event" (National Center for PTSD, 2016). While anxiety has been removed as a direct link to PTSD in this version of the manual, it is worth noting that many individuals who meet the criterion of suffering from PTSD are likely to meet the criteria of suffering from one or several diagnoses found within the DSM-5 (National Center for PTSD, 2016). This is the case as the most common symptoms of PTSD according to the DSM-5 are: intrusive thoughts, emotional distress, decreased interest in activities, feeling isolated, irritability or aggression, difficulty concentrating, and difficulty sleeping (National Center for PTSD, 2016). As mentioned these symptoms are often the symptoms associated with other ailments listed in the DSM-5. Thus making it quite difficult to diagnose PTSD.

While the DSM-5 largely helped explain and widen the understanding of PTSD, the definition of the disorder and much of the criteria for diagnosis remains extremely vague. Although the manual has allowed many to understand that the etiology of the disorder is found in outside forces that have lasting traumatic impacts on an individual, the patient remains largely stigmatized for being unable to cope in a "normal" way. It is evident from the introduction of PTSD in the DSM manual in 1980 to this day, that the

etiology of the disorder is subjective and highly scrutinized. Given that what may be traumatic to one person may not be for another, the tasks associated with determining what outside forces are traumatic is made very difficult. While the literature and the DSM-5 suggests that each diagnosis of PTSD be made on a case-by-case or individual basis, it is also suggested that this is a difficult task as it is almost natural to generalize specific experiences (American Psychiatric Association, 2013; Spitzer et al., 2007). Additionally, much of the politics of the disorder pertain to its "invisible" nature. Often it is quite difficult to determine whether or not an individual is suffering from PTSD depending on the symptoms they are presenting (Scott, 1990; American Psychiatric Association, 2013; Kolk and Najavits, 2013). In many instances, it is difficult to attach a traumatic event to the symptoms an individual is displaying.

The political nature of PTSD first became evident in the 1960s, the period of the American War in Vietnam, which later literature discussed. Summerfield (2001) argues that the diagnoses during this time were meant to shift attention from the soldiers' mental state and emphasize the traumatizing nature of war. However, by relating PTSD to soldiers and veterans specifically, the field of psychology and psychiatry neglected potential sufferers in different lived realities (Monson et al., 2007; Spitzer et al., 2007). The literature suggests this was problematic for many reasons. First, it hindered the diagnosis of PTSD in anyone who did not experience anything "quite as traumatic" as the war. Second, it attributed this mental health issue to a specific environment. And third, it gendered the assessment of PTSD for years to come, making it difficult for women to seek proper treatment and diagnosis for this issue (Wolfe et al., 1997; Olff et al., 2007). Notwithstanding these legitimate critiques, attributing PTSD to veterans of the war did

bring awareness to the idea that trauma could have long-lasting negative impacts on an individual's mental wellbeing.

In 1992, Berthold Gersons and Ingrid Carlier outlined PTSD in what they described as "The History of a Recent Concept." Although new, they argued that PTSD has been around for most of military history and known under different names in different time periods. Some of these names include shell-shock, the irritable heart of soldiers and combat neurosis (Gersons and Carlier, 1992). They go on to state that adding PTSD to the DSM-III introduced a new category in the field of psychology: disorders that stemmed from outside or deviant causes in society (Gersons and Carlier, 1992). These outside or deviant causes can be defined as anything that would disrupt the balance in an individual's life. In terms of veterans, as war created imbalance in a society, it was considered a normal reaction for soldiers to come back in an emotional "state of discomfort" and it was also often believed that this discomfort would be temporary once they were back in their normal everyday lives (Gersons and Carlier, 1992). Further, according to their research, the inclusion of PTSD in the DSM-III allowed for veterans of war to be treated without the stigma of being classified as individuals suffering with severe mental conditions such as depression.

The literature suggests that the stigma surrounding PTSD can be linked to the uncertainty of the length of the disorder and the extent to which those suffering should be compensated (Scott, 1990; Gersons and Carlier 1992; Andreasen, 2010). While the normalization of PTSD allowed for war veterans to seek help, it is unclear how much "help" in terms of treatment they actually receive aside from slight monetary compensation. This is problematic for many reasons including the suggestion that PTSD

was something that would disappear with time and in creating mistrust among the general public with regards to the severity of the disorder. The idea that these men should have "known what they were getting into" largely stigmatized what it meant to suffer with PTSD when monetary compensation was involved. In turn, veterans of war who suffered from PTSD and were seeking compensation often began to lose faith in the general public as well as the government. The lack of support for their suffering often made it difficult for veterans to cope with their disorder. After all that they had done serving their country, should the government and the public not support them?

Compensation for Veterans Suffering with PTSD and Other Mental Disorders in the United States

With the recent passage of Bill 163 in Ontario, emergency first responders will be able to pursue WSIB claims for this disorder. While there is little research available on compensation surrounding PTSD among both veterans and emergency first responders, several articles can be found outlining the process individuals must undergo to receive compensation.

Worthen and Moering (2011) stress the importance of looking back in history to understand the role monetary benefits played in providing for veterans suffering from mental ailments and in the determination of which diagnoses were worthy of compensation. Current compensation law in the United States is rooted in 1917 amendments to the *War Risk Insurance Act* of 1914 (Economic Systems Inc., 2004 as cited in Worthen and Moering, 2011), and compensation regulations for veterans stem from Title 38 of the United States Code and are governed by specific legal parameters. It

is said that the processes to attain compensation and pensions are pro-claimant and informal due to the sensitive nature of the claims being made. However, to understand the relationship between the legal parameters that govern mental health evaluations and the parameters set by VA to govern compensation and pension evaluations is to simultaneously understand that being granted compensation can be a difficult process (Worthen and Moering, 2011).

While VA parameters favour the veteran, legal parameters work to determine whether or not the claim can be linked directly back to an occupational cause. For example, according to the Department of Veterans Affairs (as cited in Worthen and Moering (2011), if a medical opinion is provided, those offering such opinions must use specific legal phrases that suggest the claim is 0%, greater than 50%, less than 50% or 100% the cause of an occupational situation or event. It is suggested that through ordering the claims in this manner, the employer is easily able to avoid linking trauma to an occupational cause or factor. Further, if the individual providing the medical opinion is unsure, they must state that further examination of the individual is needed. Moreover, veterans filing claims for compensation or pensions are assigned ratings. "These ratings represent the percentage of impairment in the veteran's average earnings capacity. A rating schedule for mental disorders guides the rating decision. A veteran's rating determines the kind and amount of benefits he or she receives, both monetary and access to other services" (Worthen and Moering, 2011, p. 190). Of course, this is problematic as rating mental trauma is both difficult and subjective. Worthen and Moering, (2001) suggests that a rating scale is problematic as it takes away from the validity of the

suffering of those whose experiences do not directly align with the descriptions within the rating scale.

A study conducted by the RAND Center for Military Health Policy Research (2008) brings to light the large concern surrounding PTSD and traumatic brain injury as combat-related injuries. Approximately 1.64 million troops in the United States have been deployed to Afghanistan and Iraq, possibly pushing the potential rates of exposure to combat-related stress to levels higher than ever before (RAND, 2008). Recently, a study conducted by the United States Department of Veterans Affairs revealed an alarming statistic: 22 veterans per day are taking their own lives as a result of PTSD (U.S. Department of Veterans Affairs, 2016; CNN, 2016). While these studies provide us with an idea of the prevalence of PTSD, it is unclear how many are in fact suffering from the disorder, since receiving diagnoses of PTSD continues to be difficult, vague and time-consuming and is stigmatized by the general public. Many veterans remain undiagnosed or refrain from seeking help due to the process of receiving diagnoses and the limited amount of support outlets provided by the government.

Gender and the Organization of Emergency First Response Professions

In reviewing the literature on the history of PTSD, it is obvious that emergency first responders can be compared to veterans in the sense that they frequently experience traumatic incidents on the job and, for the most part, work within an environment that is physically and emotionally demanding with direct and indirect exposure to deviance or harm on a day-to-day basis. One additional area of potential comparison lies in the changing gender composition of these occupations. Specifically, is the growing number

of women working in these jobs having an impact both on these women workers and the masculine workplace cultures that studies have explored and analyzed (Garcia, 2003; Martin et al., 1996; Prokos et al., 2002)?

The literature on this topic finds that women have been excluded from studies of PTSD. With respect to women in the military, the argument can be made that this is due to the fact that women did not fight directly in the various wars when PTSD began to be recognized. Further, the literature examined makes it clear that societal perceptions of these professions play into the organization of work and stigmatization of workers (Archbold & Schulz, 2008; Lilly, et al., 2009; Prokos & Padavic, 2002). Whether a worker is painted as a "hero" or someone "not cut out for the job" can largely be attributed to both the diagnosis of PTSD and the gender of the worker within these professions. For example, an emergency first responder who suffers from PTSD as a result of responding to a call where he or she saves the life of a small child in a horrific car crash, may be seen as a hero and deserving of help and support due to the nature of the call. However, a police officer who responds to a call where an older person is dead at the scene of a horrific car crash is expected to continue their day as if the events they had witnessed were nothing out of the ordinary. In turn, the expectation of an emergency first responder to hold the status of a "hero" may deter them from seeking support or diagnosis from work-related trauma (Alexander & Klein, 2009).

Through examining the literature it is interesting to note that oftentimes "heroes" are referred to as being male (Prividera & Howard, 2006). According to a study conducted by Prividera and Howard (2006), the language surrounding heroism is strongly linked to gender, race and nationalism. While this study focuses exclusively on men and

women who fought in the Iraq War, connections can be made to those within the emergency first response professions. Prividera and Howard's (2006) study finds that both society and the media represent soldiers in a way that fits ideologically with a specific role. For example, because men are associated with strength and power, and women are associated with compassion and dependence, the perception of these two genders working on the frontlines is extremely different. When men serve and return from war they are covered by the media as being heroic leaders of their country. However, when women return they are often portrayed in the media as mothers or daughters finally being reunited with their families (Nantais & Lee, 1999; Prividera & Howard, 2006). The hero status is rarely, if ever, mentioned for women as "Women are predominantly identified in their relation to others" (Turpin, 1998 as cited in Prividera and Howard, 2006, p. 36).

While women are often marginalized in emergency first response professions and excluded from being labeled as "heroes" (Nantais & Lee, 1999; Boldry, Wood, & Kashy, 2001; Prividera & Howard, 2006; Prokos & Padavic, 2002), Archbold & Schulz (2008) argue that many females in emergency first response professions hold the "token" status, whether they admit it or not. From this research, one can assume that being a "token" may force women to "tough it out" in order to prove that they can do the job. Thus, these women would be forced to avoid seeking help for trauma in order to prove themselves. Additionally, while this label is applied to many women working in these professions, it holds little appeal as it further marginalizes women and makes them feel as if they are only filling a quota rather than qualified for their role.

In addition to the notions of the "hero" and "token", gender stereotypes within these professions may explain why it is assumed that more women than men seek help for PTSD. For example, research conducted by Prokos and Padavic (2002) explored the masculine nature of training within the police academy. Their research made evident that women excelled at more social and caregiving tasks, while men mainly excelled at physical tasks and challenges. However, although women proved to be just as capable as men at performing physical tasks, the men poked fun and/or criticized the women for being more caring and social. Men, in attempts to assert their dominance, will also refrain from seeking support in order to prove they are stronger and more capable at the job than women. While women seek help more often, there is also pressure to not report PTSD so as to remain "one of the guys" and avoid their so-called token status."

Stress and PTSD…Is There a Difference?

According to Deahl et al., (2000, p. 77), "many individuals are routinely and predictably exposed to potentially traumatizing events in connection with their employment." For example, journalists sent to war-torn countries can find their experiences just as problematic as those fighting the war. Their study goes on to state that while PTSD can be found in 1-2% of the general public, within the population of emergency first responders this rate is estimated to be around 30% or higher. Based on these rates, Deahl et al., (2000) have labeled emergency first responders as "high risk" individuals when it comes to PTSD. Regardless of this "high risk" categorization, it remains the case that much of the general public is unable to understand how or why individuals work in emergency first response professions if they are so "easily impacted"

by the situations they encounter. As mentioned earlier, a comparison of soldiers and veterans of war can be made to emergency first responders. However, with the strong portrayal of what the environment of war looks like in the media, it is often hard to equate emergency first responders with soldiers or veterans of war. For example, in the media war is portrayed as an ongoing brutal and dehumanizing exchange of armed conflict. While emergency first responders are also at times exposed to situations involving armed conflict, they are also exposed to incidents that are more commonly experienced by the general public such as a car accident or a fire. An issue lies in comparing emergency first responders to veterans of war in the sense that war is constantly being viewed as something that has the power to destroy a society. Therefore, it is somewhat understandable why the public has an easier time supporting soldiers and veterans of war than emergency first responders.

It is implied that those working in emergency first response professions know what they are getting themselves into when they are "signing up" for these jobs. Thus, confusion arises surrounding the difference between the general stress associated with work on the one hand, and PTSD on the other. Emergency first responders constantly place themselves in harm's way to help serve and protect others from danger (Carleton, 2016). When asked, many emergency first responders refer to their careers as being among the most challenging yet rewarding jobs available today (Carleton, 2016). Further, these individuals are asked to describe the level of stress associated with a typical day on the job, their answers vary. For this reason, it is important that we begin to look at stress as a possible factor that may lead to PTSD.

According to Carleton (2016), when dealing with job-related stress, emergency first responders are often labeled by society as strongly resilient. When asked, the participants in this study stated that many first responders would argue that stress is something that can be overcome or dealt with. So when an individual is unable to overcome job-related stress, should we classify it as something much more debilitating than stress? As mentioned several times in this paper, what is considered traumatic to one may not be considered traumatic to another. As such, a situation that causes stress in an individual may not cause stress in another. In any case, we must find ways to deal with and understand operational stress.

Bill 163: The Role of the Government, Media Coverage and Societal Perceptions

The call for Canadian governments to aid and support emergency first responders suffering from PTSD can largely be attributed to the rise in suicides and trauma-related workers' compensation(?) claims put forward by emergency first responders. Unfortunately, it is hard to pinpoint the exact rate of PTSD within Canada and beyond due to the lack of awareness, understanding, and support surrounding this disorder. However, much of the literature on the rates of PTSD are based on the U.S. population and thus generalizations of this rate can be made to represent the Canadian population.

The Ontario Government passed Bill 163 on April 5, 2016. In short, this Bill will allow for emergency first responders to seek treatment and compensation for PTSD based on the presumption that PTSD is work-related for those within these professions (Queens Printer for Ontario, 2016). Ultimately, "the presumption allows for faster access to WSIB benefits, resources and timely treatment. Once a first responder is diagnosed with PTSD

by either a psychiatrist or a psychologist, the workers' compensation claims process will be processed without the need to prove a causal link between PTSD and a workplace event" (Queens Printer for Ontario, 2016, p. 1). As this legislation has just been passed, there is no research assessing whether these processes are in fact leading to the said faster access to workers' compensation benefits, resources, timely treatment etc. Current information made available to the general public, however, consists of the narratives of those affected by PTSD working within these professions through media outlets, and blogs. Bruce Chapman, the President of the Police Association of Ontario, recently wrote an article on the success Bill 163 has brought to the Police Association while commenting that there will still be a long and rough road ahead to travel on as there is no one-size-fits-all method to aid and protect those suffering from PTSD.

Conclusion of Literature Review

It is made clear through the literature that PTSD is a disorder which requires further research and understanding in various regards. Due to its political and controversial nature, our current knowledge and understanding of PTSD is one that is outdated, subjective and very much gendered. Turning to historical, medical, and social accounts of PTSD allows us to gain a deeper understanding of what it means to suffer with this disorder.

As rates of PTSD increase, specifically amongst those within the emergency first response professions, we must emphasize the importance of the individual experience with PTSD in order to find ways to adequately support those who are suffering from this

mental health issue. This study will proceed by examining the experiences of those who have experienced PTSD whether directly or indirectly within their workplace. It is through these experiences that participants will be asked to reflect on the levels of support they have received, know to be available, and believe are sufficient in supporting those combatting PTSD.

Chapter 2

Methodology

Introduction to Me

My father, and several members of my family, serve as emergency first responders. For as long as I can remember, I was taught to highly value the men and women who put their lives at risk to help the public on a day-to-day basis. During my Master's program in Labour Studies, the value I placed on these professions became quite interesting to me as it seems odd to deem certain professions more admirable than others. In addition, this program has sparked a strong interest in occupational health and safety in me, prompting me to question the seeming double standard between the admiration some in the public hold for emergency first responders and their hesitancy to support them when suffering from mental trauma. It is extremely thought-provoking that we deem members of certain professions worthy of support when suffering and others undeserving.

I feel it is necessary to share a glimpse into my background as I believe that my connection to the "world" of emergency first responders has allowed me to gain a deeper connection to the individuals who participated in my study and may have encouraged participants to speak more freely about their experiences with PTSD, whether direct or indirect, within their professions. Additionally, being brought up in a family where one of my parents worked as an emergency first responder, I have a strong understanding of how a bad call can have lasting negative mental health consequences on an individual. With this understanding I could empathize with participants and stress the importance of first responders sharing their own personal narratives to advocate for change and awareness in both the public and the workplace.

Insider Status

Prior to each interview I disclosed to the participants that I have connections through my father to individuals in emergency first response professions. I felt this was important for a few reasons. First, it allowed me to show participants that I have a personal connection and genuine interest in the research topic. Second, it allowed participants to feel more comfortable with sharing stories they otherwise may have refrained from sharing as they were able to relate to me as someone who understands the professions in which they work. Third, it is common for those working in emergency first response professions to have a close tie or connection to others. I felt that it was necessary to disclose that my father was a police officer on the off chance that someone who was participating in the study knew him. This would then give them the option to opt out of the study if my insider status made them feel uncomfortable in any way.

Experiences With PTSD in the Workplace

According to the U.S. Department of Veterans' Affairs, about 6 of every 10 men and 5 of every 10 women will experience at least one trauma in their lives (Veterans Affairs, 2015). That being said, it is obvious that everyone will experience trauma in different ways. One's personal experience with trauma cannot and should not be compared or rated to another's. What affects one person negatively may not have the same affect or any affect on another person at all. Often, the support an individual receives after a traumatic event determines the extent to which they can cope or overcome the trauma they have undergone.

This study used the experiences of paramedics working in Ontario who are at high risk of experiencing some form of trauma on a day-to-day basis. Learning about these experiences and the levels of support available to these workers allowed participants to share their understandings of PTSD whether they were directly or indirectly impacted by it. Further, in sharing their experiences they were able to create their own narratives and understandings of the disorder which allowed for deeper discussions of the topic.

Before conducting this research, I had several personal discussions with friends and family members working within emergency first response professions about their experiences with PTSD in the workplace. After each discussion I began to feel as though something was missing not only in the literature but also in the media that fails to challenge the stigma associated with mental illness. With the passing of Bill 163, I feel that it is extremely important to examine what this legislation actually means to individuals at risk or suffering from PTSD and if they believe they are receiving sufficient support as they find their ways through their PTSD experiences.

Semi-Structured Qualitative Interviews and the Importance of Individual Experiences

As demonstrated in the research, PTSD cannot be defined or explained with a one-size-fits-all approach. My research emphasizes the unique and individual experiences with PTSD and how these experiences collectively impact the levels of support received. Semi-structured qualitative interviews were conducted with each participant in order to allow these participants to actively guide the conversations in ways they felt necessary to

explain their experiences with PTSD and share information on how their professions and peers shape the perceptions of PTSD.

Many studies suggest that mental illness can best be described and understood through the narratives of those who are experiencing certain phenomena (Riessman. 1993; O'Kearney and Perrot, 2006). By allowing participants to help guide the discussion, it became easier for them to explain how they believe PTSD exists within the world of emergency first response professions. In addition, it also allowed participants to locate their association to PTSD within the workplace.

Recruitment, Setbacks and Successes

I had originally only planned on interviewing male police officers and paramedics. My reasoning for this was that these professions are often categorized as being inherently masculine in nature. Only in the last few decades have we seen an increase of women in the police force, and studies have shown that there is almost an even split of men and women working as emergency first responders (Garcia, 2003). However, as I began to do more research on PTSD I started to notice a common theme in the literature: women were almost always left out of the discussion. This can be largely attributed to the fact that women did not serve as soldiers in any of the major wars throughout history until more recently (Afghanistan, Iraq, etc.). Additionally, as my study aims to determine if there is a gender component in regards to the levels of support men versus women receive, and who is more likely to seek help when experiencing PTSD, I thought it best to include women to get their perspectives on PTSD directly. More

importantly, PTSD is an important issue that calls for discussion and should not be explained through the experiences of one gender.

The recruitment process included emailing the chief of various paramedic and police services in the Greater Toronto Area (GTA) asking for permission to conduct my research within their region (Appendix B). Once permission was received I asked the chief of that region to circulate a recruitment e-mail (Appendix B) and a recruitment poster (Appendix A) to their employees. The letter of information and consent (Appendix C) to participate in the study was also circulated to employees with both the recruitment email and poster. I did not have access to any personal or contact information of any of the employees.

All individuals interested in participating in my study contacted me via email to arrange a place that was mutually agreed upon and safe for both the participant and myself. When meeting with each participant, I first went over the letter of information/consent form (Appendix C) which explained the study and outlined their right to withdraw at any time. Once the participant made clear that they were interested in participating they signed the letter of information/consent form to show their understanding and willingness to participate within the study.

I had difficulty securing a police region to participate in my study for several reasons. Some were already conducting research with students from other universities, while others did not get back to me in time to participate in my study due to the time restrictions I faced. I was lucky enough to hear back from two paramedic services in Ontario. I went with the first region who responded to my recruitment request.

Ultimately, twelve paramedics from the Region of Halton participated in this study. Six were male and six female. The years of service by the men and women who participated ranged from one to 40 years. Some had been working full-time for Halton for their entire career while others were fairly new to the region. Several participants were working part-time with Halton and part-time with another region. There was an even split between primary care and advanced care paramedics who participated in the study.

Participant Suitability

All individuals working as paramedics in the region of Halton were eligible to participate within my study. It is important to note that the paramedics participating in the study did not need to suffer or have suffered directly from PTSD. Rather, all paramedics were encouraged to participate as each experience related to PTSD, whether direct or indirect, is unique and important. Having the perspectives of all experiences and perceptions of PTSD allowed for a deeper insight into the levels of support received by individuals suffering with PTSD or generally struggling from work-related stress.

Data Collection

Semi-Structured Qualitative Interviews

Semi-structured qualitative interviews were used as the primary source of data collection for this study. Two sets of interview questions were used to collect data from participants. The first set consists of general questions asked to those who have not experienced PTSD directly but who wished to participate in the study to share their perceptions of PTSD within their workplaces. The second set of questions were directed

towards individuals who had direct experience with PTSD. Each interview began with this statement:

> "Only you and I will know whether you were involved in this study unless you choose to tell others. However, we are often identifiable through the stories we tell; you should therefore think carefully about what stories you tell and how you tell them. In addition, since I am asking about your direct and/or indirect experiences with PTSD, you may well tell me about other people's experiences. Please be aware that others have not given you consent to tell their stories and that they might very well not want to be identified. Tell your stories in the most general terms possible. I will do my best to avoid including any identifying remarks, both about you and others, in my thesis."

The statement was then followed by introductory questions to get to know the participant in terms of their work history and experience with Halton Region. After these questions I was more or less able to determine which set of questions to ask the participants.

Debriefing and Personal Reflections on Interviews

Over the duration of my research it was crucial to keep in mind that it was not my responsibility to act as a support worker in any way to the participants. If it became visibly obvious that a participant was struggling emotionally or physically during the interview, I immediately suggested that we take a break to stretch and clear our minds. If when we came back to the interview the participant was unable to continue I would suggest that we end the interview at that moment and allow them some time to think over whether they wish to continue at a later date or opt out of the interview entirely. After the completion of each interview I contacted the participants to ask them how they felt after the interview and reminded them that should they begin to feel uneasy from something that came up during our discussion, they should seek support from a friend, family

member, co-worker or medical professional. I am unaware if any of the participants required these forms of assistance after the interviews, as I did not ask if they had sought out help after our interviews.

In order to protect my emotional well-being, after the completion of each interview I created a systemic plan to debrief. First, after every interview I wrote out my notes and transcribed the interview recordings immediately. This allowed me to process all of the information transferred during the interview and prevented the possibility of horrific stories from lingering. Once I had written out my notes from the interview I engaged in an activity that I enjoyed which allowed me to shift my focus on to something else. For example, after every interview I went on a run through my neighbourhood. Lastly, I ensured that all interviews were scheduled at least 2-3 days apart in order to prevent the possibility of having to deal with the discussion of such a sensitive topic in a short period of time.

Informed Consent

Each participant was provided a copy of the letter of information/consent form prior to the interview to review in order to determine if they were interested and willing to participate in my study. During the interviews I ensured that the participants understood the letter of information/consent form by going it over with them and having them ask me any questions they had about the study confidentiality, etc. It was made clear that a participant could opt out of the study at anytime or refrain from answering any questions with which they were uncomfortable. If at any point during the interview the participant wanted to take a break from the discussion it was also made clear that they were able to

do so. If a participant wanted clarification on an interview question or something outlined in the letter of information/consent form it was given to them when asked.

Ethical Considerations

The McMaster University Research Ethics Board approved my research after the process of a formal submission through a McMaster Research Ethics Board Application. Confidentiality is assured to each participant within this study. No names or identifying factors will be used when discussing the findings that arose from the interview process. All of the data compiled during this process was kept in a password-protected file on my personal computer, or in a locked and secured cabinet. Only I am aware of the individuals who participated and the information they chose to share during their interviews. In order to protect individuals from second hand exposure, participants did not use the names of others when participating in the study.

Reflecting on the Research and Interview Process

Looking back on the interviews I have conducted for this study, it is hard to find the words to accurately reflect my experience. I was fortunate to have 12 interviews, which were all equally rich in data. The men and women who participated in my study not only outlined their perceptions and experiences with PTSD in their workplace, but also shared with me a glimpse into a private and vulnerable part of their lives on a daily basis.

While all the information shared in my study is completely anonymous and confidential, I struggled with deciding exactly how much detail I could share even if I

was not going to list names, or descriptive factors of the participants. Although many participants assured me that I was able to share their stories in my study, as I began the writing process I felt that it was important to avoid sharing certain stories and experiences as it is possible that some stories were shared with me in the moment as some participants may have felt that we shared a common ground with my father being a police officer. Additionally, it is possible that these stories and experiences were shared with me so freely as I was allowing these men and women to speak candidly about PTSD for the duration of our interview. Through this study it is evident these men and women are rarely able to do this.

Each interview was raw, emotional, and deeply moving. I left almost every interview feeling a sense of heaviness and longing to help make a difference or do more to raise awareness for PTSD in order for these men and women to be able to speak out and seek help and support for their sufferings. To have someone look you in the eyes and beg for your research to make a difference in educating the public, is a feeling I will truly never forget.

This experience has taught me a lot more than I expected to learn about PTSD. After conducting this research I believe that it is my responsibility to raise awareness surrounding the legitimacy of mental health issues in the workplace. For far too long we have doubted and undermined the feelings and experiences of workers. In order to improve the work experiences of workers everywhere we must be willing to take their mental health seriously.

Chapter 3

"It Can't Be That Traumatic if You're Exposed to it Everyday"

This chapter will outline and discuss the major findings of this study as they were revealed in the interviews. Twelve one-on-one interviews were conducted with paramedics working out of Halton Region Emergency Medical Services. Six participants were male and six female. Each participant was asked a series of questions regarding their experiences with and perceptions of PTSD in their workplace. The men and women who participated in this study had served as paramedics from one to 40 years, with the average years of service being 25. Participants were either a primary care or advanced care paramedic. Some participants held managerial positions while others did not. The men and women who participated in this study were not encouraged to do so by their employer or myself, nor was their employer given a copy of the interview findings.

Working as a Paramedic in Halton Region

Halton Region Paramedic Services employs roughly 200 paramedics in 11 paramedic stations throughout the Region of Halton. Prior to being "Halton Region Paramedic Services," the region was amalgamated with Hamilton Paramedic Services. These two services broke apart in the year 2000 when Halton Region Paramedic Services was established. Several paramedics who participated in the study had worked for Hamilton/Halton before the split. When asked about the change, participants said that they have been more than happy with the outcome and believe that all changes the employer has made have been a step in the right direction.

Many of the participants came to work as paramedics in Halton for several different reasons. Some had different careers before becoming paramedics and were inspired to work within this profession as they were directly involved in an accident or witnessed an accident in which a paramedic dealt with a situation “flawlessly” and they wanted to give back to the community by doing the same. Some joined the profession out of the belief that they would have a steady job for life and be able to provide for their families comfortably. Others had only ever been a paramedic and joined the profession out of interest. Many of the participants have at some point held part-time jobs in order to supplement their wages if they were only employed part-time, or early on in their careers. All but one of the full-time paramedics who participated in the study did not hold part-time jobs as a paramedic or in any other field.

When asked to describe their experiences with the region of Halton as an employer, there was an even split between those who said they could not be happier with the environment and support received from their employer and those who were satisfied but believed that things could be changed in certain areas. When asked about such changes, participants refrained from providing any concrete suggestions.

As the discussion surrounding support from their employer progressed, all but two participants brought up their employee assistance program (EAP). The EAP in Halton Region is provided by Shepell Fgi. This program offers free 24/7 confidential telephone and support services to employees. Participants stated that this was important to them as it showed that the employer cared about their overall wellbeing. However, a majority of the participants stated that although they were grateful and impressed with their EAP, it was of little use to them. They were either skeptical about what ‘confidential’ meant

between Shepell Fgi and the employer, or they felt that they should avoid using the services offered as they did not want to take advantage of a service when they were unsure as to whether they truly "needed to use it." Of two participants who did not bring up the EAP, one was unsure if there was one in operation as they were relatively new to working in the region. The other brought up another program they believed was much more impressive than the EAP established by their employer. This participant, along with several others, made it very clear that Halton, in their opinion, was leading the way in changing the discussions and perceptions of PTSD and mental health within the workplace. This program was a peer-support program that was created in-house and consisted of several employees working together with the employer to create a safe space for all workers to discuss mental health and other issues found in their profession. As this program is in its early stages, little light was shed on what the program would offer employees. However, all participants seemed to share more excitement and pride in this program than they did their EAP.

The First To Respond

Although there is little evidence to support this claim, study participants all assumed that paramedics and firefighters arrive to a call before police officers due to the nature and call volume associated with policing. Simply put, a paramedic is a health care professional who provides urgent care in emergency situations. Paramedics provide basic and advanced care for patients while transporting them to hospitals to seek treatment from medical doctors when necessary. While the literature and general public would argue that paramedics primarily deal with emergency and urgent situations, those who

have participated in this study have made it quite clear that their work varies from call to call, and in many circumstances they provide simple acute care within a patient's home.

The work paramedics do is quite unique. For example, unlike jobs in an offices or retail environments, there is no specific labour process that paramedics follow. Their work cannot be collapsed into a routinized day-to-day or week-to-week set of tasks. Rather, each day for the men and women in these professions is different – each call brings a new set of goals or tasks to work towards. In order to understand how paramedics go about their work one must understand that there is a variation in calls to which these men and women attend. In this profession there is no such thing as a "typical" shift, or a "typical" call.

> "The good thing about this job is that you're never really stuck in a routine. It's not the same thing every day because every situation you're faced with is different in so many ways. From the people involved, the skills you need to use at a certain call, and the outcome of that call." (P1M2816)

> "A normal workday…that's hard to answer…I could get called to a car accident with 3 kids and a co-worker of mine could get called to someone's home for something that is urgent but doesn't necessarily require the care of professionals at the hospital. For both of us this would be a normal workday but it's not necessarily the same. It's just part of the job you know…normal is different for everyone." (P3M4016)

Men and women in this profession use and develop their skill sets based on the calls they attend. Study participants identified three important factors that ensure one could "do the job." First, each individual must be competent and able to provide patients with proper and effective treatment while in their care. This is where their educational background proved to be important. Participants stated that they are constantly updating their skills and learning new ways to care for their patients. Second, paramedics must be

able to distance themselves or "turn off their emotions" while treating patients to avoid attachment. Many participants stated that it was human nature to empathize with their patients but found this distracting when trying to get their job done. It was mentioned that the best way to care for their patients was to detach themselves from their "humanity" in order to ensure that they are doing the best they can without their emotions getting in the way. One participant stated that "sometimes…no matter what you do or how hard you try to do something or fix someone…you just can't. If you're not emotionally involved it won't hurt as bad." Third, participants must be physically fit to do this job as there is a lot of lifting associated with their work, e.g., lifting patients on and off stretchers and lifting stretchers in and out of their trucks.

> "You never know when you'll be put in a situation where you can't fit a stretcher through a door, or have to run back and forth for something…so if you can't keep up it could really take a toll on the way you're able to do your job." (P2F2616)

Never Prepared for a Shift

Perhaps the most common theme that arose within the study was the idea of coping and how to prepare oneself for a shift. All participants agreed that there was no way to ever be prepared for a shift and hence feared that their mental health was at risk. Although each participant had their own methods for coping, they found that these methods were constantly changing as each call brought them face-to-face with a new challenge. During each interview, it became quite clear that paramedics must cope with at least three different issues: the loss of a patient, the visual nature of the incident, and "being human."

According to Palmer (1983), paramedics encounter death and dying almost routinely on the job. Throughout these encounters Palmer suggests that six principal coping aids are used: educational desensitization, language alternation, humour, scientific fragmentation, escape into work, and rationalization. Throughout the interviews, it became quite clear that these coping mechanisms were utilized readily by the participants in the study.

Educational Desensitization

As outlined by Palmer (1983), educational desensitization suggests that the schooling paramedics undergo teaches them to detach from the human aspect of their professions by understanding how to speak professionally and scientifically, categorize patients by their ailments, and form patient/provider relationships. The schooling paramedics go through is extremely technical with an emphasis on the sciences to ensure that proper care and medical treatment is administered. In many ways, as it is the first and most central, educational desensitization is linked to each of the following coping aids presented by Palmer (1983).

For many participants, however, educational desensitization as a coping mechanism is contradictory and its effects limited. For example, many of the participants stated that while they used educational desensitization as a coping method, it only helped for so long. One participant stated that using education as a coping mechanism helped him while he was on a call, it allowed him to stay focused and organize his thoughts so he got the job done safely. However, once the call was over and his shift had ended he

was left alone to his thoughts constantly wondering if he could have done things differently.

> "When you go to school they teach you everything you need to know and of course things change over time. So you learn again…as a paramedic you're constantly learning. But it doesn't matter how much you learn because when you start working all that matters is that you're doing your job or how good of a job you can do. But at the end of the day you've seen…things. Mind you, not all calls are bad, some are quite simple and easy actually. But when they're not simple and easy…you do the job, you do what you've been told and what you've learned…and then you go home and think…shit…now what? Why do I feel like this? You know…if you're thinking like that then you obviously haven't learned how to detach…so you start to wonder maybe I could have done more." (P2F2616)

Another participant stated:

> "At the end of the day you go to school to become a paramedic…So they teach about your job from a technical point of view….and you learn the ABCs of what drugs to administer for this problem, and not to for the next. You learn about the body and how to determine something is really wrong….how to determine if someone is dead…that kind of stuff…You know, everything we "need" to know…but what they don't think we need to know is how to deal with patients, their families, our feelings…because they don't need to. We don't need to know that stuff because it's not important. What is important is doing our job and our job does not involve feeling bad about…" (P12F4016)

Language Alternation

Palmer (1983) argues that, like educational desensitization, the use of language alternation—namely the use of technical terms and codes that only those in their profession would understand—allows paramedics to distance themselves from their patients. When I asked participants in my study if they used language alternation as a

means to cope, the answer was almost always no. The men and women who participated made it clear that yes they do have a specific set of codes and terminology that they follow on the job; however, it is almost second nature for them and not done to distance themselves from a patient.

> "Even if we did use a secret language to communicate with one another you have to keep in mind that there are families involved. If something goes wrong with a loved one we have to tell their family and it would be wrong to complicate things for them with things they couldn't make any sense of." (P5M3716)

Humor

According to Palmer (1983), humor serves as an escape from the reality of calls tended to by paramedics. In many cases humor is used to lighten the mood and deflect away from the actual situation at hand. In his study, he suggested that paramedics may poke fun at their patients after a call, or at their partners in order to be able to discuss their call in an easier way.

When asked about using humor as a coping mechanism, at first a majority of the participants responded stating that they would never poke fun at a patient as they believed it to be insensitive. However, as they began to discuss how humor was used, they realized that to an extent a patient may be indirectly involved in such talk.

> "You have to be able to have a good sense of humor working here. If you don't you'll start to take things way too seriously and screw yourself over. If every situation was the worst situation you'd never be able to handle it." (P8M5016)

> "I would never make fun of someone I was helping. I might make fun of the situation, but only to put a twist on it. Not like it'll make it positive or anything…but it will at least become…funny?" (P10F4816)

Additionally, several participants stated that nine times out of ten they would use humor towards their partners, not to make fun of them or the job they have done, but rather to lighten the mood and shift their focus onto something more upbeat and positive.

Scientific Fragmentation & Escape into Work

Palmer (1983) suggests that through fragmenting their work and focusing on each task associated with their job, paramedics are able to manage stress and cope with loss on the job. His study argues that paramedics are able to lump patients into categories based on their symptoms and/or ailments, etc. In doing this, paramedics are able to detach from the human and focus on the "biological fixing" that they must do. This is considered scientific fragmentation. Further, Palmer (1983) suggests that due to the high pressures of the job, paramedics may get so caught up in tending to their patients that they are able to avoid forming little to any connection with the patients.

When participants were asked about scientific fragmentation and the idea of escaping into work, many were visibly bothered by the idea of these coping mechanisms. The participants felt as though suggesting that they are able to detach from their humanity so easily through categorizing patients or getting caught up in the job was as one participant put it, "an absolute pile of crap." Further, another participant stated:

> "The reason why people don't take PTSD seriously is because they assume we have ways of dealing with shit that works no matter what. If it was so easy to lump every damn Tom, Dick and Harry together by what was wrong with them and move on with our lives as if it were normal PTSD obviously wouldn't exist." (P10F4816)

Scientific fragmentation and the idea of escaping into work is problematic as it suggests that paramedics are able to move on easily from a bad call without any

repercussions. Thus, Palmer (1983) neglects to understand that trauma can appear even when a paramedic is heavily involved in his or her work.

Rationalization

Simply put, Palmer (1983) suggests that paramedics will rationalize situations to help them cope with the severity or traumatic nature of a call. For example, the inability to provide aid appropriately or the death of a patient could be rationalized through a lack of time, or an existing illness of the patient who passed. Like scientific fragmentation and the idea of escaping into work, many participants had an issue with this coping mechanism, as it was too subjective. One participant stated that "it's human nature to rationalize something going wrong or not being able to do something to the best of your ability…you don't have to be a paramedic to rationalize things."

"War Beers"

"War beers" was a term provided by a study participant. He suggested that while many of the coping mechanisms identified by Palmer (1983) could apply to any one in various situations, the best coping mechanism for him and others in this profession was going out for drinks with friends and colleagues "to lick each other's wounds and compare battle scars." When asked what he meant by this, he stated that it was not out of the ordinary for co-workers who consider each other close friends to have a couple of drinks, catch up, and talk things out.

> "You don't really plan on going to talk about what you see at work. You're really just going to catch up…but it's common ground so you know if it comes up it comes up. And when it does come up you feel normal because everyone else has a similar story to tell that's just as fucked up as yours if not worse. So you go home feeling okay

> because you got it off your chest, and you think to yourself okay maybe that situation wasn't so bad after all..." (P3M4016)

The concept of "war beers" is important as it highlights the community and camaraderie between those within this profession. It is this camaraderie that allows us to understand why colleagues are so important to have as a support system.[2]

It is evident that paramedics are constantly teaching themselves how to cope on the job and that there is no one way to cope with a given situation, however, there are trends and tendencies of coping mechanisms used by paramedics. One coping mechanism might work for one individual but not another, and one coping mechanism may apply to one situation but not another. Palmer's (1983) study was used to get participants discussing their coping mechanisms or what they believed others in their professions did to cope. A major problem with Palmer's (1983) study that many of the participants shared was that it over-generalizes about those in their profession. They all believed that it should be stressed that what they see on the job on a daily basis coupled with PTSD is far more complicated to deal with than can be explained through a set of coping mechanisms. Thus, it is important to understand that although coping mechanisms exist, paramedics can still experience PTSD.

[2] It is common for jobs which a prone to mental and/or physical trauma to have a strong level of social ties amongst the workers. For example, there is a significant amount of research which highlights the strong social ties amongst miners to the shared experience of danger (RL Lewis 1987; Rennie 2008; Kemnitzer 1973).

Good Calls vs. Bad Calls

Throughout the study it was obvious that just one call had the potential to cause a significant impact on the mental wellbeing of a participant. Several times throughout my interviews I noticed that many of the participants would refer to some of the calls they tended to as “good” and others as “bad.” I believe that this is an extremely important theme to focus attention on as PTSD can be triggered by just one event.

When asked to distinguish between a good call versus a bad call, each participant had their own way of answering this question. This is important to note as what may be a good call for one, may be a bad call for another and vice versa. Generally, it was found that a good call was one in which the paramedic was able to do everything they could that resulted in the best possible outcome. A bad call, one the other hand, was one in which the paramedic was left feeling as if they could have done more. For example, many good calls were ones in which the patient had survived or their medical status had improved while under the care of paramedics. However, a bad call did not necessarily mean that a patient had passed. Instead, a bad call was one that a paramedic found her/himself unable to cope with or comprehend what they were experiencing while providing care. In other words, experiencing a lack of control over the situation in which they could not separate themselves from. For example, one participant stated that one of her first calls in this profession was a car accident with four young adults whom she believed to be around the same age as her. When she got to the call, the car was a wreck and she found herself relating to each of the passengers in the accident. For her, this was a terrible call as she never imagined having to deal with something as tragic.

As the interviews progressed it became clear that defining a good call versus a bad call is just as challenging as describing a typical day at work for these men and women.

> "You can ask anyone who works a desk job if they had a good or bad day at work and their answer is a simple one. I bet right now I could ask you how your day went and you could tell me without even thinking about it….but for me, you know, my day could start off great and end very badly depending on what I see or what goes on out there." (P9F2916)

Further to understanding the difference between a good call versus a bad call, I was curious to see if there was a gendered difference in these descriptions. During the interviews, the participants were asked if they believed that men and women experienced working within this profession differently and if there was a gender bias within the profession. All but two participants responded saying that a gender bias did not exist in their workplace. However, some of the responses to the questions asked throughout the interviews suggest otherwise. For example, when asked if there was a gendered bias in the EMS profession, I asked participants if they felt that a good call and a bad call would differ for men and women. A majority of the men who participated in the study believed that women would consider a bad call anything that had to do with children as they felt that their maternal instincts would kick in at the sight of a child in harm. To confirm whether this was true I asked several of the female participants. A few agreed that this in fact would be considered a bad call for them; however, two female participants stated this was not the case. Instead, a bad call for these women were calls in which a patient had passed or they had to deliver bad news to a family member. All of the women who

participated in the study felt as though they experienced good calls and bad calls the same as men.

Stress or PTSD?

There is a general agreement among the participants that being a paramedic is a very stressful job because you are dealing with patients with physical and/or mental vulnerabilities while also trying to manage the feelings and emotions of friends and family members who may also be around. In addition to dealing with patients and their family members, paramedics must do their best to protect their own mental wellbeing at all costs.

> "At the end of the day this is a job. The only difference is there are people involved. You can't afford to make any mistakes big or small. So right there…that's a lot of pressure." (P6F3516)

While paramedics are to protect their own mental wellbeing, perhaps one of the most interesting points revealed during one of the interviews in this study was this idea that their physical and mental wellbeing comes last. This in itself is worth exploring as it acknowledges the fact that paramedics must look after themselves, yet it highlights the notion that they feel responsible for protecting not only the physical wellbeing of their patients, but the mental wellbeing of their partners.

> "There are four people you have to think about when you're at work and doing what you need to do. The patient, the family member or friend who is with them, your partner and yourself. Who do you think comes first and last here?" (P8M5016)

According to the findings of this study, it appears that the men and women who participated found themselves to be the most "stressed" about how a call would impact their or their partners' mental wellbeing.

> "You know you go to a call and you see something. You handle it, and then you have a break in between your next call. You try not to think about it but hell how can you not? You don't think about it because it was "cool" or "exciting" but you think about it and wonder … is this what's gonna get me?" (P1M2816)

> "Being on the job for only a year now I wonder when it's appropriate to talk about some calls that I'm just not okay with." (P9F2916)

> "Sometimes I wake up and remember this accident. When I wake up I don't think shit how am I gonna feel today … Nope, I wonder how X is handling all of this?" (P3M4016)

For some participants, this job was particularly stressful and hard to do because they found it almost impossible to avoid relating to the patient or their family members. While they did their best to turn off their emotions at a call, some made it clear that in order to do your job efficiently you need to form a relationship, which allows the patient to feel comfortable. This is interesting as in addition to their technical work, paramedics are performing a significant amount of emotional and care work on the job. This is a unique concept to address as many emergency first response professions are not understood as careers in which workers are to perform any sort of emotional labour, as for the most part emotional labour has tended to be predominantly female. Utimately, determining how much of a relationship to form for the duration of the call is extremely difficult for these men and women.

> "These are people too. You can't go in there stone cold, but you can't go in there and be their best friend or their mom

> or dad. You need to be comforting of course … but you also need to do your job. You do what you're paid to do." (P5M3716)

An important trend identified by several of the participants is the difficulties they faced when dealing with patients and their family members. For some, the thought of having to be the "bearer of bad news" was enough to stress them out for the rest of their shifts.

> "You know the first thing you think about when you see someone is … wow that could've been me, or even worse it could've been my kid. So I try my best to deliver a message the same way I would wanna hear it." (P5M3716)

> "One of the worst things I have ever had to do was look someone in the eye and say "I'm really sorry" … whatever you say next doesn't even really matter at that point but you have to say it. It's your job … you have to say it." (P12F4016)

> "Giving someone bad news, or explaining to them why you need to bring their loved one to the hospital is really tough. The look on people's faces is really heartbreaking. That kind of shit sticks with you." (P8M5016)

Perhaps the most interesting common theme surrounding stress on the job was the confusion between being stressed and suffering from PTSD. All but two of those interviewed had a difficult time both understanding and explaining the difference between stress and PTSD. It is interesting to note that while the men and women were unable to resolve their confusion, they insisted that they were stressed and found it to be unlikely that they were suffering from PTSD as they believed that they were "okay."

> "Seriously…what's the difference here? I'm always stressed about my work but I wouldn't say I'm insane or need help for anything." (P3M4016)

> "I think we're all just stressed and overworked. Because we deal with so many emotions on a daily basis it's easy to get

> caught up in thinking that something is wrong with us. But you know it's normal to feel things." (P9F2916)

When discussing the distinction between being stressed oand suffering from PTSD, the participants often referred to those suffering as not being "all there" or not being "normal." However, at the same time, when discussing their colleagues who they believed were suffering from PTSD, they spoke with fear and worry.

> "Well so he has PTSD, and I think to myself…why? I was there with him for almost every call. I saw everything he saw and I'm still working but I wake up some mornings and I think to myself … I should not be working … Should I be working? Is it SAFE for me to be working? Do I have PTSD or am I just stressed? But at the same time I have a lot going on at home. A lot going on, so I could just be feeling a mix of things" (P8M5016)

Throughout the study it was clear that a majority of the participants believed PTSD to be a legitimate mental trauma. Many participants were excited to participate and hoped that their involvement in the study would help contribute to provide education and awareness for the general public, their employer, and the government surrounding PTSD. It was important to these participants that an understanding of the jobs they do and the environments in which they work are unique, changing, and in many cases prone to trauma. However, two participants did not believe in PTSD, nor did they think that it was an issue both in their workplace and in general. Throughout the interviews these two individuals challenged the notion surrounding what it meant to suffer from PTSD. Both of these individuals were male and had worked as paramedics in Halton Region for well over 25 years. Both were advanced care paramedics and each believed that they had "seen everything" on the job and had come out of it "unscathed.'

> "This whole Bill 163 thing in my opinion is a crock. It's hard enough to get worker's comp for a physical injury and

> now were gonna comp people who claim to be unstable? That's not our problem. You know what you signed up for." (P7M5616)
>
> "You know in my X years working I can sit here and tell you that I've seen it all. And guess what? I'm fine. I've always been just fine. So you're telling me that people who've only been on the job for 5-10 years are having some issues? Gimme a break." (P11M5516)

It is unclear why these men do not believe that PTSD is a legitimate mental health issue, or why they feel as though working in their profession does not expose people to significant trauma. While these men made it very clear that they do not see a purpose in exploring issues surrounding PTSD, they stated several times throughout the interview that their employer did a great job at keeping workers within the region happy and safe while maintaining a positive working experience. These men believed that focusing on PTSD in emergency first response professions took away from the meaning of their jobs and stigmatized them.

Lastly, it is worth noting that both male and female workers found themselves to be equally confused surrounding the difference between stress and PTSD. However, through the duration of the interview process it became clear that women found it easier to manage their stress through the support they received and therefore were less likely to believe that they could be suffering from PTSD.

Finding Support: "The Double-Edged Sword"

Support and the levels of support perceived by the paramedics who participated in this study varied slightly. It is quite clear through the interviews that support is the bread

and butter of overcoming and understanding what it means to experience and suffer from PTSD.

In general, the participants believed that support should start at an educational level and be extended into their workplace. Unfortunately, however, many of the participants stated that they either do not remember learning about mental health, specifically trauma and PTSD, while in school for paramedicine, or that a curriculum for this just did not exist. Instead, participants stated that they had learned about mental health issues and how they affected the patients that they may one day be working with.

> "You're always learning about the patient … never about the worker." (P1M2816)
>
> "This job isn't about you. This job is about THEM. What you need to do for THEM, what you need to know about THEM. What's wrong with THEM." (P1M2816)

Participants also stated that they believed there was a lack of seminars or educational sessions in their workplace on mental health initiatives for workers. These participants believed that if workshops took place in their workplace more often, PTSD would be spoken of more freely.

> "A lot of people just don't know and that's a scary thing. We deal with trauma every single day and we don't know how or when it will affect us. If we had, you know, a class or two then maybe we would know what we should be looking out for." (P10F4816)

The men and women who participated in this study believed such workshops to be crucial as they felt the general public knew little about PTSD and did little to support those working in emergency first response professions when it came to this mental health issue.

Aside from the believed necessity to have educational institutions and the employer include workshops that focus on PTSD, study participants identified four key sources and/or levels of support: colleagues, friends and family, employers and doctors.

Colleagues

A majority of the participants in my study stated that their colleagues were the most crucial support system available. This was because, they stated, their colleagues would not judge them for wanting to discuss a bad call, whether it was fresh in their mind or had been sticking with them for a while. In speaking to a colleague about a work issue, workers were able to feel a sense of normalcy. However, one participant in the study made it clear that he was unsure if this sense of normalcy was a good or bad thing.

> "Sometimes you just need to get out for a drink and lick each other's wounds. Doesn't mean you're going to be okay in the morning but it sure helps at the time." (P3M4016)

> "Being able to talk to your co-workers is a great thing. You should be able to feel comfortable enough to talk to them because they get it. The reality is though … I just don't know how much it actually helps." (P2F2616)

While colleagues proved to be of the most important support systems for men and women in these professions, some of the participants characterized supporting and receiving support from colleagues as a "double edged sword."

> "So many guys out here have … you know … are probably suffering with "something" … and it becomes an issue because on the one hand you want to make sure they're safe, heck you wanna make sure you're safe working with them … but there is a fine line between asking 'How's it going man, are you okay?' and flat out saying 'Buddy you need to get out there and get some help." (P3M4016)

> "You know I would appreciate any help I could get if I was suffering from any sort of trauma. But if someone came up

> to me and offered it to me … fuck I would be humiliated." (P1M2816)

For these workers to say that their colleagues are the most important sources of support is revealing. On one hand, it 'allows' workers in this profession to feel normal in that they can easily relate traumatic and challenging situations to their colleagues. On the other hand, it is evident that, because of the stigmatization of PTSD, these workers believe such disclosures may hurt both their careers and their ego. There is no doubt that the men and women in these professions see the importance of seeking help when suffering from mental trauma or PTSD; yet, it seems as though they are "walking on eggshells" when seeking support.

Friends and Family

According to the participants in my study, friends and family members seemed to be just as important as colleagues were when seeking support. Friends and family members were important to participants as they felt that, no matter what, they could be their true selves with these individuals and knew that they could turn to them when they needed to without question. However, a majority of the participants stated that they would seek support from a colleague before they would seek support from a family member. This can largely be attributed to the sense of normalcy they get when speaking about a bad call at work with a colleague.

According to those who listed friends and family members as important actors when seeking support, these actors were able to provide a listening ear or a shoulder to cry on. Despite this fact, many participants chose not to tell their friends or loved ones in fear that they "couldn't handle it" or "didn't want to know something that traumatic."

During the interview process one participant began to cry discussing the toll his work took on his family. He felt as though he was unable to talk about work in a way that his family could understand. Instead of realizing that he may have been suffering from mental trauma it was assumed by his family that the participant enjoyed the morbid stories he brought home from the job. It was not until the participant had educated himself on PTSD and what it means to suffer from mental trauma that he understood why he was speaking about work in this way. When asked about his family's perceptions of the job and their reactions to his stories, he suggested that it was not their fault and that our government and education system has failed to teach us about PTSD.

Although participants stated that they could turn to their friends and family members at any time, they were hesitant to do so as they feared that they would cause worry among them. Others felt that although they knew they were there, they just would not understand. Three participants felt as though talking to friends or family members about work would only "traumatize them about some of the harsh realities of the job."

Employers

The employer was another important actor to whom participants felt they could turn when in need of support. All of the participants in this study had immense praise for the Region of Halton Emergency Medical Services. Each participant believed that their employer really cared about their wellbeing and was doing what it could to aid those suffering with mental trauma. However, while the participants stated that they had a good relationship with their employer, they feared discussing their experiences with management as they did not want the employer to think that they were incompetent and could not do their jobs. Those participants who held management positions stated that

they wished more workers would come out and talk to them when they were stressed or experiencing any form of mental trauma. They believe that the employer would do whatever it could to help support these workers. However, they understood that often times the perceptions held by workers is that the employer "has a business to run."

Doctors

Seeking medical attention from their family doctors or other health care professionals was only rarely done by the participants in this study. The participants generally agreed that doctors were the last to be contacted for support and only when all other options had been exhausted.

Several participants stated that they often avoided seeking medical attention for issues surrounding stress as they were afraid of the possibility that they were suffering from PTSD.

> "When you go to the doctor everything becomes real." (P6F3516)

> "I'm okay with being stressed out as long as nobody wants to put a name on it." (P7M5616)

It can be argued that the support received from a doctor is very different from the support received from a colleague, friend, family member, or employer. When seeking medical help, it is assumed by the participants that there is an issue that must be dealt with, whereas seeking support from a colleague or friend is done to lift some weight off the worker's shoulders.

Union/Association Absence

It is necessary to bring up the absence of unions or associations in the interviews. One would assume that, with paramedics being unionized, the union would be active in

supporting members suffering from stress or mental trauma, specifically PTSD. However, in only one interview was their union brought up.

While it is quite possible that many workers in the Region of Halton Emergency Medical Services are receiving support from their union, it can be argued that the union has a small presence in the workplace as the workers and the employer have a strong and positive relationship. Thus, the union is not necessarily required for support when the workers are willing and trusting of their employer with sensitive and confidential issues.

The Body and PTSD

Working as a paramedic requires one to be both mentally and physically fit. In fact, in order to become a paramedic one must pass a physical test to ensure that they are physically competent to do the job. In order to prepare individuals for this test, many schools offering paramedic programs require students to take a course surrounding the physical components of the job. However, recently many schools have removed this as a specific requirement in order to graduate from the program. Regardless, maintaining one's physical fitness is believed by many who participated in the study to prove their eligibility and worth both as a paramedic and on the job.

The body was a unique theme that came up within many of the interviews. Many participants shared their fear of losing their ability to use their bodies on the job and felt that this was constantly on their minds due to many of the calls they had witnessed over time where they had seen many other people's bodies injured. The body was also an interesting theme that came up with two participants who actually did not fully understand or believe PTSD to be legitimate. These participants had strong criticism for

Bill 163, and believed that more focus should be put on physical rather than mental trauma.

For a majority of the participants, having your mind and body on the job is "everything." When asked why, one participant responded,

> "If you are not mentally competent then you shouldn't be responsible to provide care for anyone. If you can't physically lift a patient, lift a stretcher, anything that requires a little extra physical effort you really can't be doing this job in a way that's safe for you or the patient … it's as simple as that." (P10F4816)

> "You have to really think of the job we're doing. In some cases … *laughs* … okay in a lot of cases we're overworked. We get home, do our thing, go to bed and were achy … mentally achy … physical achy … we think about things we saw that day, maybe a week or month ago … and we wake up and we don't know what or where we're hurt from so we get up and go to work anyways." (P5M3716)

> "At the end of the day a job is a job and you have to get yours done." (P12F4016)

All participants felt that in order to be of any value to their employer they had to be mentally and physically fit at all times, regardless of how they truly felt when prepared for work.

For the two participants who did not view PTSD as legitimate, the body was an extremely important concept. One of them stated that if PTSD was in fact a real issue, then he would rather have that than a physical ailment because with "a little therapy PTSD can be fixed but you can't fix a failing body." However, when it came to workers' compensation, both participants agreed that they would rather see someone off with a physical injury or ailment than mental trauma because "how do you even prove that?"

Understanding the connection to the body and mental health is worth further exploration, as it has been known historically that gaining compensation for physical ailments is something that is both challenging and stigmatizing for the worker. Additionally, in my study there proved to be a generational dynamic associated to who deserves compensation, for what, and why.

Process of Analysis: Good Calls vs. Bad Calls and How Good Support is Defined

In the first few interviews it became clear that a common theme in my study was how participants defined a good call versus a bad call and what they believed support systems needed to look like. To distinguish a good call from a bad call, participants were asked to briefly discuss their ideal call where things go as well as they possibly can. Once this was explained, they were then asked to discuss what they felt was a bad call. Surprisingly, this was quite difficult to do as many reacted by saying "no call is a good call." All participants stressed that the details of the call or the exact situation they found themselves did not matter as long as they got their job done as flawlessly as possible and left feeling as though they had made a positive impact on the patient and others who may have been affected and had done their due diligence to the job. However, at the same time, all participants rated bad calls as any call that they could still vividly remember no matter how much time had passed. Throughout the duration of the interview process it became quite clear that the definition of a good call versus a bad call was subjective. The definitions of bad calls also seemed to stray away from gender norms. For example, one might assume that a woman may have a difficult time attending a call where a small child is harmed. However, many female participants stated that this was not always the case.

Instead, a bad call was one in which they could do little to help someone (dead on arrival, or not certified to provide certain medications or procedures). Most of the participants in this study, both male and female, stated that the worst type of call you could ever respond to was one in which you had to deliver some form of bad news to a family member, friend or peer.

Defining support, and what a good support system looked like, seemed to be one of the more difficult and thought-provoking questions participants faced. For the most part, it was generally agreed that a good support system was one in which the participant felt they could reach out to someone without burdening them. Several common themes arose when asking participants to explain what a good support system was to them. Many believed that support could be found on different levels but the most important type of supports were those that took their experiences with PTSD, whether direct or indirect, seriously. All participants were torn on how they should define support when helping others. This proved to be as, if not more difficult, than defining support in general. Participants often wondered if they should support others, and, if so, what could they do? They also wondered when they should back off or draw a line? For the most part, all participants assumed that police officers and firefighters received the same levels of support across the board. However, they felt that police officers may have more structured support from their employer and the government due to their roles in society.

Support from the Public & Media Attention

The unfortunate reality that exists in our society today surrounding mental health, and specifically PTSD, is that we deem certain incidents more traumatic and worthy of suffering than others. This is extremely problematic as the general public seems to hold

the belief that those working in emergency first response professions are a unique breed of individuals who are working these jobs simply because they are "cut out for them." Although the media has outlined stories of depression and suicide faced by the men and women in these professions, our society seems to have many criticisms for those who work in emergency first response professions yet are unable to handle or cope with trauma.

The stigmatization of the men and women with PTSD in these professions is deeply rooted in our society. With little education provided by the government and health care professionals, it is unlikely that society will begin to understand that more aid and support is needed for those working in emergency first response professions when it comes to mental health issues, specifically PTSD.

During the interview process, several participants stated that they felt as though the public was not on their side during their battle for help and recognition.

> "The public needs more education … hell we need more education. No one really knows a damn thing about PTSD, what it means and who can be affected." (P3M4016)

It is hoped that in educating the public, the stigmatization of those with PTSD within these professions can be broken down. As this study shows, the levels of support paramedics receive are profoundly impacted by the stigmatization of PTSD sufferers that exists within this line of work. Through stigmatizing the men and women working as emergency first responders as individuals who should be able to deal with trauma naturally, we are creating a taboo around the discussion of PTSD. Further, we are painting the men and women who suffer from this mental health issue as weak and unworthy of working within this line of duty.

What can we really expect from Bill 163?

Being the first of its kind in Ontario, it is hoped that Bill 163 will significantly shift the way PTSD is viewed within the emergency first response professions. As mentioned previously, this Bill amends the *Workplace Safety and Insurance Act*, 1997 and the *Ministry of Labour Act* to include Post-Traumatic Stress Disorder as an occupational illness for emergency first responders. This Bill is an important and long overdue recognition for emergency first responders across the province who have had to suffer silently for many years. Bill 163 will allow for faster access to WSIB benefits, therapy and mental health resources, and timely treatment (Ministry of Labour, 2016).

While there is much praise for this Bill among those who participated in this study, my findings make one wonder how many will actually make use of it. As while participants had some praise for this Bill, many of the participants spoke of PTSD as something taboo. Two participants were quick to dismiss it while others made it quite clear that it was something to be feared. How are individuals supposed to seek help from the government when they have been ignored and let down for so long? How is one supposed to seek help and the necessary resources when there is still so much stigma and shame associated with suffering from PTSD? Many of the participants in my study had these questions. While a majority of participants had immense praise for the Bill, many wondered if it would actually bring about any change.

Through the interviews, it has been made clear that support is crucial to helping one cope and manage suffering with PTSD whether directly or indirectly. The types of support listed by the participants were outlined in order in which they felt they were

understood without being stigmatized or painted as weak or mentally unstable. While the Ministry of Labour is right to increase the speed of access to benefits and resources for those suffering from PTSD, more resources should be allocated to ensuring that each individual is receiving the support best suited to them. For example, if funding were directed towards improving the quality and nature of peer support, and/or providing educational programs on mental health to paramedics over the duration of their careers, we may be able to significantly remedy the impact PTSD has on those who are suffering. Additionally, it is crucial that the Ministry makes it a priority to educate the public and promote awareness and create a general understanding of the severity of work-related mental health issues.

Conclusion of Findings

Although the paramedics who participated in the study had a general understanding of PTSD, all participants would agree that the official definition of the disorder is unclear. Further, while participants generally agreed that PTSD is real and very dominant in their workplace, others doubted it. Most, if not all, found it difficult to understand the difference between stress and PTSD.

After examining the interviews, it is quite clear that stigma, the fear of stigma, and seeking support are intrinsically linked. It is ironic that these men and women work in a profession designed to help others survive physical trauma, yet fear seeking help and/or support for their own mental health.

Chapter 4

Conclusion

From its first diagnosis onward, PTSD has proven to be a mental health issue that is both political and controversial in nature. Despite this, cases of PTSD in our society are rising at an alarming rate. It is unfortunate, however, that the true rate of this increase remains largely unknown to the public because many men and women suffering from PTSD feel as though they must do so in silence. Specifically, those working within the emergency first response professions feel as though they are unable to seek support for PTSD and other mental health issues as they will let the public down or prove to be not "cut out for the job."

Treating PTSD as a work-related health issue is important to ensure that men and women suffering receive proper support and treatment. It has been shown in this study that men and women who feel as if they are supported by their colleagues, friends, family members, employers and the public, are likely to speak out about their sufferings and seek help in battling PTSD.

It is clear through this study that PTSD must continue to be studied. Bringing awareness to this mental health issue is only one small step towards understanding this disorder. We, as a society, must be willing to accept and encourage those who are suffering indirectly or directly to share their experiences and seek out support so that we are able not only to better understand PTSD but better able to provide those who are struggling with beneficial support. During my study I had the opportunity to sit down with Jean-Paul Bedard, an author, sufferer and advocate for PTSD sufferers. As someone suffering from PTSD, Jean-Paul made it quite clear that, although it can be managed,

PTSD just does not go away. “You can have all the support in the world and you can still wake up in the morning feeling lost … But if you go to bed that same day knowing you have support and people who will listen and believe that you are suffering … trust me it just gets that much easier.” When I asked Jean-Paul to describe what it feels like to suffer from PTSD he responded: “PTSD is like the cupboard in your kitchen that is a chaotic mess of Tupperware. Whenever you go in it you have more than enough containers but never enough lids. The most important piece is always missing and without the lid you just can’t keep it together.” Through continuously supporting those who are suffering with PTSD it is hoped that while we may not be able to eliminate the disorder completely, we will be able to largely alleviate the symptoms associated with it and better their quality of life of those suffering from it both at work and at home.

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Appendix A

Recruitment Poster for Paramedics

PARTICIPANTS NEEDED FOR RESEARCH IN *POST-TRAUMATIC STRESS DISORDER*

We are looking for volunteers to take part in a study of "**It's Not in the Job Description: Post-Traumatic Stress Disorder as an Occupational Illness Among Paramedics"**

You would be asked to: *take part in a one-on-one interview and answer questions surrounding your work experiences perception, knowledge and experiences of PTSD*

Your participation would involve *one interview*;
this interview will be approximately 60 minutes long. The interview will take place in an area that is most convenient and safe for you. It is possible that there may be a follow up interview.

For more information about this study, or to volunteer for this study, please contact:

Lauren Pucci

School of Labour Studies

McMaster University

E-mail: Puccil@mmaster.ca

This study has been reviewed by, and received ethics clearance by the McMaster Research Ethics Board

Appendix B

Email Recruitment Script for Paramedics

Lauren Pucci, BA
Masters Candidate in Labour Studies: Work & Society
Study Title:
It's Not in the Job Description: Post-Traumatic Stress Disorder as an Occupational Illness Among Paramedics

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E-mail Subject line: McMaster Study – PTSD as an Occupational Illness

Dear Employees,
Lauren Pucci, a McMaster University Graduate student, has contacted Halton Paramedic Services asking us to inform our employees about research she is conducting on post-traumatic stress disorder in the Emergency First Response Professions. This research is part of her Masters program in Work & Society at McMaster University.

Miss Pucci is inviting you to take part in a one-on-one interview discussing post-traumatic stress disorder. The interviews will be approximately 60 minutes in length and take place in an area that is most convenient and safe for you It is possible that there may be a follow up interview. Logistics of the interview will be arranged with yourself and Miss Pucci. She hopes to determine how PTSD is perceived in the paramedic communities, and how paramedics receive and/or seek support. Participants in this study can choose to opt out at any time, or choose to refrain from answering certain questions during the interview process. Attached to this e-mail you will find a letter of information and consent that will go into more detail on this study.

If you are interested in getting more information about taking part in this study please **CONTACT LAUREN PUCCI DIRECTLY** by using her McMaster e-mail address puccil@mcmaster.ca**.** Please keep in mind that the researcher will not tell me, or anyone at Halton Paramedic Services who participated or not. Taking part, or not taking part, in this study will not affect your status or any services you receive here at Halton Paramedic Services.

In addition, this study has been reviewed and cleared by the McMaster Research Ethics Board. If you have questions or concerns about your rights as a participant or about the way the study is being conducted you may contact:

McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142
Gilmour Hall – Room 305 (ROADS)
E-mail: ethicsoffice@mcmaster.ca

Sincerely,

DATE: _____

Appendix C

LETTER OF INFORMATION / CONSENT FOR PARAMEDICS

It's Not in the Job Description: Post-Traumatic Stress Disorder as an Occupational Illness Among Paramedics

Faculty Supervisor:
Dr. Robert Storey
School of Labour Studies
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140 ext. 24693
E-mail: storeyr@mcmaster.ca

Student Investigator:
Lauren M. Pucci
School of Labour Studies
McMaster University
Hamilton, Ontario, Canada

E-mail: puccil@mcmaster.ca

What are we trying to discover?
You are invited to take part in this study on the impact of post-traumatic stress disorder among police officers and paramedics. This study aims to explore post-traumatic stress disorder as an occupational illness among police officers and paramedics, and how this mental health issue is perceived in these professions. I will be using factors such as the organization of work, union/association involvement and institutional/agency policies to help draw conclusions. This research is being conducted as a requirement for the Masters Work & Society program at McMaster University.

What will happen during the study?
In this study, you will be asked to answer a series of interview questions related to your work and PTSD. The interviews will be conducted one-on-one and last approximately 60 minutes. All information will be collected via handwritten notes, audio recording (if you allow it), or both. It is possible that I will follow up with you after completion of an interview for clarification on a response you have given during the study. In this case, I will request to contact you over the phone.

This interview will take place in Spring 2016, at a location of your choice that is safe and most convenient for you. During the interview I will ask you questions such as; how do you perceive post-traumatic stress disorder? Are you aware of the prevalence of PTSD in your profession?

Are there any risks to doing this study?
The risks involved in participating in this study are minimal. At some point during the interview process you may feel uncomfortable or anxious about some of the questions you are asked. Or, you may worry about how others will react to what you say. In any of these cases, it is important to keep in mind that you do not have to answer anything that you do not feel comfortable answering.

It is possible that the interview may trigger a PTSD episode. It is advised that if this is to occur you should reach out to a friend, family member, or medical professional. A list of resources on PTSD will be provided to you at the end of the interview. Although measures will be taken to protect your identity, there is a possible danger that a worker or supervisor my find out you have participated in this study. In this event, it is possible that you will become stigmatized as a sufferer of PTSD, or lose social status within your workplace.

Below, I describe steps that I am going to take in order to protect your privacy.

Are there any benefits to doing this study?
This research will not benefit you directly. Ultimately, I would like to determine how this mental health issue is perceived within the policing and paramedic professions, whether or not the police officers and paramedics receive sufficient support for PTSD and if these perceptions and levels of support can be attributed to the organization of work within these professions. As an individual you will benefit by being able to speak freely on your views and or experiences with PTSD in your place of work. This study could also help the society at large gain an understanding of what more can be done for those working within these fields who are suffering from PTSD. In participating in this study you will be able to help emphasize the importance to recognize that in order to improve safety and job satisfaction at work, we must call recognition and awareness to PTSD.

Who will know what I said or did in the study?
You are participating in this study confidentially. I will not use your name or any information that would allow you to be identified. Only you and I will know whether you were involved in this study unless you choose to tell others. The information that is recorded during this study will be kept in a locked desk where only I will have access to it. Any of the information that has been transferred and kept onto a computer will be password protected. None of the data collected will be saved with your name on it. I will be using code names for each participant in this study in order to protect your anonymity. For example your information may be saved as P001. Once the study is completed all of the information provided during the duration of this study will be destroyed. However, we are often identifiable through the stories we tell.

What if I change my mind about being in the study?
Your participation in this study is completely voluntary. If you decide to be part of the study, you can stop (withdraw), from the interview for whatever reason, even after signing the consent form until approximately May 31, 2016. In cases of withdrawal, any information you have provided will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, and may still participate in the study.

How do I find out what was learned in this study?
I expect to have this study completed by approximately **June 2016.** If you would like a brief summary of the results, please let me know how you would like it sent to you.

Questions about the Study:
If you have questions or need more information about the study itself, please feel free to contact me directly at:

puccil@mcmaster.ca

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

McMaster Research Ethics Secretariat
Telephone: (905) 525-9140 ext. 23142
C/o Research Office for Administrative Development and Support
E-mail: ethicsoffice@mcmaster.ca

CONSENT

- I have read the information presented in the information letter about a study being conducted by Lauren M. Pucci, of McMaster University.
- I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
- I understand that if I agree to participate in this study, I may withdraw from the study at any time or up until approximately May 31, 2016
- I have been given a copy of this form.
- I agree to participate in the study.

Signature: _____ Date: _____

Name of Participant (Printed) _____

1. I agree that the interview can be audio recorded.
… Yes.
… No.

2. …Yes, I would like to receive a summary of the study's results.
Please send them to me at this email address _____
Or to this mailing address: _____
_____
_____

… No, I do not want to receive a summary of the study's results.

3. I agree to be contacted about a follow-up interview, and understand that I can always decline the request.
... Yes. Please contact me at: _____
... No.

Appendix D
Interview guide for face-to-face interview

Introduction Questions:

1. How long have you been working as a paramedic?
2. Why/how did you come to be a paramedic?
3. How long have you been working within the region of Halton?
4. What led you to this region?
5. What do you find satisfying/unsatisfying about your job, generally speaking?
6. Moving to the subject of our discussion I have a few questions on PTSD. In as much detail as you would like to share, what has been your experience with PTSD?

General Questions:

7. How are individuals with PTSD perceived within the policing/paramedic service?
8. What about your workplace makes it easy or difficult to approach someone you believe is suffering with PTSD?
9. I'm wondering whether gender plays a role on speaking out about PTSD within these professions. If you read up on this issue, some would suggest that a masculine culture in the workplace hinders men from speaking about PTSD? Do you agree, how would you describe the culture of your workplace? Do you think it is different for women?
10. Who do you think are the main actors in supporting individuals with PTSD?
11. Do you think there is enough support for individuals who suffer from PTSD? If not, what do you think needs to be put in place.
12. What needs to be changed/done to encourage more support surrounding PTSD in your profession?
13. Do you have any questions you would like to ask me?

Direct Experience Questions:

14. What about your workplace made it easy or difficult to talk about your experience with your employer?
15. Based on your experience, who did you turn to for support – your employer, union/association, or any coworkers?
16. Is there anyone we missed who was important in supporting you through your experience?
17. What needs to be changed/done to encourage more support surrounding PTSD in your profession?
18. I'm wondering whether gender plays a role on speaking out about PTSD within these professions. If you read up on this issue, some would suggest that a masculine culture in the workplace hinders men from speaking about PTSD? Do you agree, how would you describe the culture of your workplace? Do you think it is different for women? What needs to be changed/done to encourage more support surrounding PTSD in your profession?
19. Do you have any questions you would like to ask me?

Appendix E
Post-Traumatic Stress Disorder Support Sheet (Halton/Hamilton)

In addition to reaching out to a family member, friend, or family doctor you may find more information or support on post-traumatic stress disorder from one of the following:

Ontario Mental Health Helpline
1-866-531-2600

Canadian Mental Health Association – Hamilton Branch
905-521-0211
INFO@CMHAHAMILTON.CA
www.cmha.ca
131 John Street South, Hamilton, ON, L8N 2C3

Centre for Addiction and Mental Health (Run through the Canadian Mental Health Association)
905-521-0211
www.camh.ca

St. Joseph's Hospital – Anxiety Treatment and Research Clinic
*Support groups available
905-522-1155

The Anxiety Disorders Clinic at the McMaster University Medical Centre, Hamilton Health Sciences
905-521-5018
1200 Main Street West, Hamilton, ON L8S 1M4
www.macanxiety.com

Appendix F
Participant Codes

In order to protect the privacy of the individuals who participated in this study, codes have been assigned to each individual.

P#-M/F-AGE-YEAR OF INTERVIEW

For example, P0M2516 = participant zero, male, 25 years of age, 2016.